ORIENTATION PACKAGE CONTENTS:

1. Schedule (to follow on Orientation day)
2. Objectives
3. The Paediatric History
4. Student Evaluation Criteria & Evaluation Forms
5. Appendix

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If you have any problems with the schedule or experience any illness during your rotation, please contact:

Joanna Barnes in the Undergraduate Medical Education Office
at the Hospital for Sick Children (416-813-6664).
EVALUATION OF STUDENTS IN ASCM-2

In accordance with the Faculty of Medicine’s in transcription of grades, ASCM-2’s final transcription of grades will appear as Credit or No-Credit. Students however, will receive evaluations on a five point Likert scale for quantitative feedback on their performance indicating increasing degrees of competence. Each component mark will be available for feedback purposes to students on MedSIS.

Ratings:

1. Unsatisfactory - Indicates a failing performance
2. Borderline – below expectations
3. Pass – meeting expectations
4. Performing above expectations
5. Performing at level which far exceeds expectations

The course work comprises 50% of the final mark:

Specialty session tutors are asked to complete very specific evaluations in order that students receive formative and summative feedback on oral and written presentation throughout the course as a whole. It is essential that students receive this feedback in a timely manner. (i.e. within 4 weeks)

- Geriatric Unit: One case report 7.5%
- Psychiatry Unit: Mental Status Examination Report 7.5%
- Core session: One oral presentation 7.5%
- Paediatric Unit: One oral presentation 7.5%
- Observed focused history and physical examination 20%.

Students are required to keep track of the ASCM-2 skills log. The faculty must sign the log to indicate that the student has performed the clinical skill satisfactorily. **IF STUDENTS DO NOT HAND IN THE SKILLS LOG, THIS WILL BE CONSIDERED A BREECH OF PROFESSIONALISM.** Students must have demonstrated competence in performing the clinical skills listed in the log and will be required to hand in the skills log at the end of the academic year in order to pass ASCM-2.

Students will need to hand in a written reflection assignment at the end of the year as part of the evaluation for the Portfolio portion of the course. Students will need to pass this assignment in order to pass the course.

Demonstration of ethical and professional behaviour is also required to pass ASCM-2. The guidelines are found in the Standards of Professional Behaviour for Medical Undergraduate and Postgraduate Students (Appendix 1). Students will be evaluated on professionalism using the Preclerkship Professionalism Evaluation Form (Appendix 5). Students will be required to pass the professionalism evaluation in order to pass the course.
The final OSCE comprises 50% of the final mark - Content covered in specialty sessions is examined on in the final OSCE.

The OSCE has ten stations. **Students must pass 7 stations on the OSCE in order to pass this component of the course. Students must pass the OSCE in order to pass the course.**
FINAL GRADE

The final grade will be derived from the grades obtained in the course components. Students will be required to pass every component of the course in order to pass the course as a whole. Students are expected to have mastered the basic skills of history taking and physical examination in order to pass the course. Generally, the minimum passing grade for all course components and the course as a whole is 60%. However, marks between 60-69% are considered borderline and the student may be required to complete extra work in order to meet the requirements of the course. Students are expected to exhibit the attributes of professionalism in order to pass the course. In the case of inadequate performance or borderline performance, supplemental or remedial work and/or examinations will be recommended by the Course Director to the Board of Examiners. Decisions about whether students have passed or failed the course as a whole or require remediation in order to pass the course are made by the Board of Examiners. Students deemed to have failed the course by the Board of Examiners will be required to repeat the course in the following academic year. Students granted supplemental or remedial privileges by the Board of Examiners must successfully complete the work or examinations prior to commencing Clerkship.

PROCEDURES FOR EXTRA WORK AND REMEDIATION

The requirements for extra work are determined by the course director in consultation with the Preclerkship Director. Extra work exercises are tailored to the identified areas of deficit. Relatively minor issues are handled with simple correction of submitted work. For instance, if a case report is deemed to be unsatisfactory, the student will be required to either submit a revised version or to do a new case report.

More significant deficits may require the student to review the relevant topics in detail, with tutoring to be provided by the Course Director or others as needed, and then to undergo formal reexamination of the material. The standard for successful completion of such a re-examination is to be decided by the course director in consultation with the Preclerkship Director. Generally, this standard will be the same as the standard required for a clear pass in the course. If the student is not successful in reaching this standard, then they will be presented to the Board of Examiners, for consideration of formal remediation.

In cases where a student has frankly failed to meet the requirements for credit in the course, the student will be presented to the Board of Examiners for consideration of remediation as described in the . If the Board of Examiners agrees that remediation is required, then the remediation activities and assessment procedures will be determined by the course director in consultation with the Preclerkship Director. The student will be required to review the relevant topics in detail, with tutoring to be provided by the Course Director or others as needed, and then to undergo formal re-examination of the material. The standard for successful completion of this re-examination is to be decided by the course director in consultation with the Preclerkship Director. Generally, this standard will be the same as the standard required for a clear pass in the course.
**Medsis**

All evaluations ASCM-2 will be handled through MedSIS—the Faculty of Medicine’s web-enabled database except for the Observed History and Physical and the final OSCE.

MedsIS stands for Medical Student Information System. It is an online administrative system and database; this system will assist the faculty and staff in the collection and reporting of data—including student and tutor evaluations.

**Tutors who are responsible for completing student evaluations are required to use MedSIS.** As an evaluating tutor, and thus a MedSIS user, you will complete all of your student evaluations online. Correspondingly, our students will submit their tutor evaluations electronically.

**As an evaluating tutor, how do I get started with MedSIS?**

As a University of Toronto tutor with a valid email address, you may already be registered as a MedSIS user. If you are unsure, please contact your local hospital medical education office and ask them to verify that you are listed as a supervisor in MedSIS. It is also a good idea to double-check that your primary email address is the one that has been entered on MedSIS as you will only be contacted by email for evaluation purposes. Once registered and at the appropriate time in the academic year, you will be contacted by email to log on to MedSIS and evaluate your students. Website: [http://medsis.utoronto.ca/](http://medsis.utoronto.ca/). Use the “Forgot your password?” link on the login screen if you have forgotten your password.

**Need help?**

If you need help with any aspect of MedSIS—either logging on or completing your evaluations—the administrative staff at your hospital will be pleased to assist you.
ASCM ON THE INTERNET: INFORMATION FOR STUDENTS & TUTORS

Students and faculty will be able to access UME course materials by logging into http://portal.utoronto.ca with their active UTORID and password

1. All course materials for ASCM 2 are posted on the portal. Starting this year, tutors will also have access to all ASCM 1 material on the portal.

2. Videos on the site demonstrate interviewing and physical examination skills which introduce the focused history and introduce new physical examination skills for ASCM 2.

3. Videos are meant to be an educational resource in addition to the manual, texts and readings already present in ASCM 1 and ASCM 2.

This web site is password protected. Students and tutors must use their UTORID and corresponding PASSWORD. For assistance with obtaining UTORID and PASSWORD and access to the portal please refer to the following website for instructions: http://dc.med.utoronto.ca/content/identity-authentication-and-sso-utorid

If you have a UTORID but are unsure as to what it is, or if you require assistance regarding your UTORID, please refer to the above noted website.

If you currently have a UTORID and would like access to the Portal site, please forward your name, UTORID, and which course you would like access to Bektu Abidta; she can add you to the appropriate course. Her email address is: bektu.abidta@utoronto.ca

Please note that it takes approximately 5 days to create a UTORID so it is recommended that you start this process well in advance of the start of the course.
EXPECTATIONS OF FACULTY IN ASCM 2

- Faculty should read background material in the course book, as they are often leaders of the discussion in the first hour of the session.

- Faculty is responsible for obtaining suitable patients for the students to interview. One student per patient is ideal, and each student should have the opportunity to work alone at least some of the time. Assigning students in pairs is acceptable if necessary.

- As teachers are role models for students, it is expected that teachers will follow the guidelines found in the Standards of Professional Behaviour and will be accepting of the diversity of students and patients.

- Students are required to have an oral case presentation marked. Teachers are asked to complete evaluations on MedSIS. A copy of the formative feedback and global assessments of the case report will be available to be viewed on MedSIS. Guidelines for marking reports are found in the syllabus. Please use these guidelines to evaluate students at the level which is appropriate for their stage of learning.

- Faculty is expected to give regular, specific advice, guidance and feedback to students regarding the performance of clinical skills. It is up to the individual teacher and group to decide how best to divide faculty time among students.

- Faculty is expected to observe students with respect to professional and ethical behaviour. Please read appendix 1: “Standards of Professional Behaviour for Medical Undergraduate and Postgraduate Students” and review the Preclerkship Professionalism Evaluation form in the appendix. In order for a student to successfully complete ASCM 2 they must have demonstrated appropriate professional behaviour. If students are observed to have lapses in professionalism, faculty is asked to contact Dr. David Wong immediately at wongdav@smh.ca.
ASCMS: CLINICAL EXPERIENCE IN PAEDIATRICS

By the end of the 5 weeks in paediatrics, the student will:

- be able to obtain an appropriate paediatric history
- be able to outline the important components of a physical examination on children of different ages
- be able to perform a physical examination of an infant and toddler
- be able to outline the normal physical and neurobehavioural development of children
- evaluate a newborn infant and be able to demonstrate how to determine the integrity of the major systems (e.g. neurological, cardiovascular)
- be able to take a detailed adolescent history
- be able to discuss the unique challenges in communicating with and examining children and strategies to overcome these challenges.

HSC Program

Day 1:
- Begins at 8:00 a.m.
- Introduction and orientation to HSC (what is expected of the students)
- Introduction to interviewing a family of an ill child
- Interview with parent of a sick child
- Review of adolescent history
- Break (10-15 minutes)
- Physical exam of a young child on the ward (approximately 2 hours)

Day 2-5:
- Begins at 8:30 a.m.

*Block 1 (October 29, 2015) Room 1250** (The Hospital for Sick Children, 1st floor Black Wing)

*Block 2 (December 3, 2015) Room 1250** (The Hospital for Sick Children, 1st floor Black Wing)

*Block 3 (January 21, 2016) Room 1250** (The Hospital for Sick Children, 1st floor Black Wing)

*Block 4 (March 31, 2016) Room 1250** (The Hospital for Sick Children, 1st floor Black Wing)

*Please see your schedule in MedSIS to find out your block.

**Room number is subject to change; please see your schedule in MedSIS for exact location.

***Mississauga students will NOT be attending the first session at HSC. Please check MedSIS for the location of the pediatric sessions.**
NEWBORN NURSERY SESSIONS

Mount Sinai Hospital / Sunnybrook Hospital / St. Michael’s Hospital

The student will have an examination of a normal newborn child demonstrated. The students will then have the opportunity to examine a newborn infant while being observed by their instructor. They will be required to demonstrate parts of the examination. A history will be obtained from a mother who has recently delivered a baby. Some students will learn the newborn assessment in community hospitals or offices.

The Hospital for Sick Children / Community Office / Community Hospital

The emphasis will be on history taking and physical examination as it relates to children of various ages, particularly infants and toddlers. Students will have the opportunity to perform histories and examinations themselves.
SPECIFIC LEARNING OBJECTIVES - ASCM 2 - PAEDIATRICS

Skills

Prior knowledge and skills acquired during the first year should include:

- Basic knowledge of the general history and physical examination, including an understanding of different styles of questions used in the medical interview, such as open-ended, directed, follow-up, and summary questions.
- Elementary knowledge of growth and development, organizational and problem solving skills.

Interviewing

1. Patient interviews occur in a variety of clinical settings, including: initial history for a hospital admission or first ambulatory visit, health maintenance visit, acute care visit, interim visit for a child with an acute or chronic health condition. The student should develop awareness that in conducting a medical interview in a variety of settings, it is sometimes appropriate to obtain a complete medical history, while at other times a more limited, focused or interval history is appropriate. At the beginning of the clerkship the emphasis should be on obtaining complete medical histories. Opportunities to do more focused work-ups should be available as the student builds competence.

2. Obtain a medical history from a second party (usually the parent), as well as from the patient as the patient matures. The student must be aware of issues of appropriate privacy at all ages and confidentiality in older children and adolescents.

3. Obtain the historical information that is unique to paediatrics in addition to the standard medical history.

   **Past History:**
   Neonatal history, including birth weight; approximate gestational age; maternal complications, such as extent of prenatal care, infections, exposure to drugs, alcohol or medications; and problems in the newborn period, such as prematurely, respiratory distress, jaundice and infections

   **Immunizations**
   Development, noting the importance of assessing developmental milestones in evaluating the health of the child

   **Diet,** noting the importance of assessing the amount, type, and method of infant feeding

   **Family History:**
   Number and ages of siblings; consanguinity, known genetic disorders, early childhood deaths, cardiovascular disease, depression and alcohol abuse
Social History:
Assessment of the home environment, school and peer relationships

Review of Systems:
The relevant items are limited, but expand as the patient’s age increases

4. Modify the medical history depending on the age of the child, with particular attention given to the following age groups: neonate, infant, toddler / preschool aged child, school aged child, adolescence.

The Physical Examination

1. Establish rapport with children of various ages in order to perform the physical examination.

2. Recognize that the age of the child influences the areas included in the exam, as well as the order of the examination, and the approach to the patient.

3. Recognize the important role of observation as a method of obtaining data in the assessment of the child.

4. Perform a complete physical examination on an infant, child and adolescent, including the observation and documentation of normal physical findings.

5. Demonstrate the appropriate use of the limited or focused examination, particularly in the ambulatory setting.

6. Include developmental assessment as part of the physical examination for all ages.
   - Observe how normal behaviours, such as stranger anxiety, affect the ability of the examiner to perform the examination, and develop strategies for improving rapport.

7. Observe and demonstrate physical exam findings unique to the Paediatric age group, and understand how findings have different clinical significance depending on the age of the child. Some examples are:
   - **Appearance:** 1) recognize signs of acute illness in an infant, toddler and child by evaluating skin color, respiration, hydration, mental status, cry and social interaction; and 2) recognize the importance of observing the psychosocial condition of the child, as well as behavior, development, body habitus (height, weight, body fat), relationship to parent and examiner, and general condition, including cleanliness.
   - **Vital Signs:** 1) measure heart rate, respiratory rate, blood pressure and temperature in an infant and child, demonstrating knowledge of the appropriate sized blood pressure cuff, interval to count respirations, and normal variation in temperature depending on the route of measurement (oral, rectal, axillary or tympanic); 2) understand that normal values of heart rate, respiratory rate and blood pressure change with age; and 3) recognize the importance of assessing vital signs in the evaluation of acute illness.
   - **Measurements:** 1) accurately measure height, weight and head circumference, calculate body mass index (BMI) 2) plot the data on an appropriate growth chart, 3) understand the normal relationships between height, weight and head circumference and 4) recognize the usefulness of longitudinal data.
• **HEENT**: identify the anterior and posterior fontanelles and assess them for fullness or turgor; recognize the need for careful observation of the head size and shape, symmetry, facial features, ear size and hair whorls as part of the examination for dysmorphic features; recognize the red reflex and strabismus; assess hydration of the mucous membranes; examine the tympanic membranes including pneumatic otoscopy, and throat examination.

• **Neck**: palpate lymph nodes, know what anatomic areas they drain; know that lymph nodes are more prominent during childhood; recognize and demonstrate manoeuvres that test for nuchal rigidity.

• **Chest**: recognize how the rate and pattern of respirations change with age, and that abdominal respirations are normal in infants; observe the rate and effort of breathing as a measure of respiratory distress; recognize stridor, wheezing and crackles and be able to distinguish between inspiratory and expiratory obstruction; interpret less serious respiratory sounds such as transmitted upper airway sounds.

• **Cardiovascular**: palpate pulses in the upper and lower extremities and auscultate the heart for rhythm, rate, quality of the heart sounds and murmurs.

• **Abdomen**: know that the liver edge, spleen tip and kidneys may be palpable in the normal newborn; examine the umbilical cord for signs of infection; examine the abdomen for distension, tenderness, rebound and mass lesions in an infant or young child with lethargy, irritability or signs of acute illness, noting the inability of the patient to communicate symptoms of abdominal complaints.

• **Genitalia**: recognize the appearance of normal male and female genitalia in the newborn; recognize abnormalities, including cryptorchidism, hypospadias, testicular mass and testicular pain in the male; be able to examine the external genitalia of a female patient, recognize the need for privacy at all ages.

• **Extremities**: examine the hips of a newborn for dysplasia; recognize arthritis; evaluate gait and limp.

• **Back**: know how to test for scoliosis.

• **Neurologic Examination**: elicit primitive reflexes; assess tone, gait, strength and reflexes, recognizing the importance of symmetry; assess developmental milestones; recognize that much of the neurologic examination of infants and children is accomplished through observation alone.

• **Skin**: recognize jaundice, petechiae, purpura, common birth marks, (such as nevus flammeus and Mongolian spots), vesicles, urticaria and common rashes, such as erythema toxicum, impetigo, eczema, diaper dermatitis and viral exanthems; recognize common skin findings associated with child abuse; assess skin turgor.
Communication Skills

1. Communication with the patient and / or family.
   - Establish rapport with the patient and family.
   - Identify the primary concerns of the patient and / or family.
   - Recognize the triangular relationship between physician, patient and parent and be able to communicate information to both the patient and parent, making sure both understand the diagnosis and treatment plan and have the opportunity to ask questions; be aware that the relationship changes with increasing age of the child.
   - Provide anticipatory guidance during health maintenance visits, including the newborn nursery visit.
   - Recognize the important role of patient education in management of acute and chronic illnesses.

2. Oral Communication Skills
   - Present a complete, well organized summary of the findings of the patient’s history and physical examination, modifying the presentation to fit the situation.
   - Explain the thought process that led to the diagnostic and therapeutic plan.
   - Use precise descriptions of physical findings and avoid vague terms and jargon, such as “clear” and “WNL”

3. Clinical Problem Solving Skills
   - Identify patient problems, combine when appropriate and develop a differential diagnosis.

4. Competencies
   - Evaluate patients from infancy through adolescence in a variety of clinical settings, establishing rapport with the patient and family in order to obtain a complete history and physical examination.
   - Prepare a complete written summary of the history and physical and orally present the case in a focused and chronological manner.
   - Identify clinical problems and outline and initial diagnostic plan.

REQUIRED READING

Paediatric Examination Handbook 2nd Edition
RECOMMENDED RESOURCES

6. Cecil’s Textbook of Internal Medicine (the full sized textbook)
7. Clinical Anesthesiology, 4th edition 2005, Lange Textbook (there may be a new one out soon) G Morgan, MageeMikhal and Michael Murray McGraw-Hill Medical
8. Current Surgical Diagnosis and Treatment. Edited by Doherty and Way.
14. Harrison’s Internal Medicine
WEBSITES

www.pedsinreview.org
Pediatrics in review journal. Excellent review articles that are easy to understand.

www.cps.ca

www.aap.org
Website of American Academy of Pediatrics

www.med-u.org
Computer Assisted Learning in Pediatrics (CLIPP) Cases. Thirty-two comprehensive interactive cases that cover important core topics. Use your utor id and password to access.

www.comsep.org
Website of Council on Medical School Education in Pediatrics. They have a video on their website on the pediatric physical exam under the “Multimedia Teaching Resources” section.

www.or-live.com/cpi/1556/
Website for teaching on otitis media. You must register on the site to use it.

http://eradiology.bidmc.harvard.edu/
Website for enhancing skills in X-ray interpretation.

http://www.canadiantaskforce.ca/
The Canadian Task Force on Preventive Health Care

www.aboutkidshealth.ca
Common paediatric diagnoses with patient information and handouts.
Paediatric History and Interviews

The key to any diagnosis or management of a child’s problem is a thorough history and complete physical examination. Obtaining a paediatric history can be quite different than with adults. The history is usually through a third person which can add complications to the history taking, but the paediatric history is usually quite a bit shorter. Medicine is both a science and an art, and part of the art of medicine and the management of a child’s health problem is in developing a warmth, mutual understanding and trust between the physician and the family. This can be done by showing that you are thorough, concerned, and interested, and the key to this is a complete interview and history. The adolescent history also presents unique challenges especially with regard to asking about high risk behaviours and ensuring trust and confidentiality.

1. Develop a rapport with parent and child
   a. Introduce yourself.
   b. Speak at their level, both in their language and physically with eye contact with the family and child at their level.
   c. Be comfortable. Often a child is more comfortable sitting in the mother lap or may be happy playing at the bedside on the floor with some toys.
   d. The first contact is most important. Strike up a conversation with the child and the family to put them at ease. Ask them about common interests. Talk to the child to show that you are interested in the child.
   e. Don’t use jargon or medical terms. Don’t interrupt mother or father or try to talk at the same time. Don’t ignore the family’s comments and try to respond to the parents’ questions. Be willing to give explanations and always make sure you use words that can be easily understood.

2. Third person history

   The paediatric history usually comes not from the patient but from a third person. Because of this:
   a. The histories may be vague and not as precise or correct as a history with an adult patient.
   b. The histories may include the concerns and the anxieties of the historian. The family’s main concern may be quite different from the stated chief complaint.
   c. Mothers are usually the better historian, but when you talk to both parents, try to get a feel of who can provide the best history and direct more of the questions to that parent.
3. Try to obtain as much history as you can from the child with the parents’ help. You will find much better co-operation from the child if you show that you are concerned and care for the child and talk to the child. With an older child you can direct many of the questions towards the child, but keep an eye on the parent to see that the history is correct.
   a. During the interview - watch the child and the parent / child interaction. Much can be learned in paediatrics simply by observation.
   a. Try to get a “feel” for the family, the relationships between the child and the family and whether this is a happy, strained, tense, or anxious family.
   a. Ask specific questions rather than general questions. You will get a much better answer if you ask “has the sister ever had febrile seizures” rather than “is the sister well?”

4. Chief complaint
   a. It is best to start with the Chief Complaint and try to get a list of the family’s main concerns. At the very beginning it is important to think of a good differential diagnosis for that complaint so that you will ask the appropriate questions that will be helpful in making a diagnosis.
   b. For acute problems it is usually best to start with the present illness. For chronic problems it is often better to start with the background history and work forward in time to the presenting problem. If there is more than one Chief Complaint, list them separately.

5. Family history
   It is important to ask about the siblings - their names, ages and health, and about the parents - their ages - occupation - health and consanguinity. The questions asked will vary depending on the Chief Complaint. For a child who is small, it is important to get the size, the heights and weights of the parents. For a child who is having difficulty in school it is important to ask about school attainments for the parents.

6. Mother’s pregnancy and delivery
   The pregnancy and delivery is much more important in a paediatric history than in that of an adult. It is important to ask birth weight, the gestational age of the child, medications during pregnancy, illness during pregnancy. It may be important to ask specific questions such as “were you on any medications, drugs, iron or vitamins?” rather than simply “did you take any medication during pregnancy?” It is important to ask the duration of the labour and the type of delivery and any resuscitation necessary. For neonatal complications it is important to ask about jaundice, dyspnea, cyanosis and convulsions. Some families do also know the Apgar scores at birth. It is important to record any complications that might have taken place at the time of birth.
7. **Infancy**
   a. Feeding and nutrition. Ask what type of milk/formula used, when solids were started and if there were any food intolerances.
   b. It is important to ask about feeding problems, sleeping problems and colic during infancy.
   c. Infant development including sitting, rolling over, walking, talking in individual words and phrases, and toilet training. It is important to ask how the child compares with the siblings.

8. **Past illness**

   Besides asking a general question such as “what illnesses has the child had in the past?” you might have to ask for specific problems such as recurrent ear infections. It is important to ask about illnesses, hospitalizations, operations, allergies, and accidents. Remember that sometimes families assume that an illness is “normal” and may not tell you about illnesses such as chickenpox. Ask about immunizations and don’t accept simply the fact that “they are up-to-date” but try to get an idea of specific immunizations /ask for immunization record.

9. **History of present illness**
   a. If there are different complaints, address them separately but be aware that they may be related.
   b. Start at the beginning of the illness and then progress through the course of the illness. You may ask “when were you first concerned about your child’s health?, or, “when was he perfectly well in the past?” For the present illnesses there is a very short history, but for some illnesses the problems start right from birth.
   c. Ask in detail about the initial problems and then work ahead in time with the progress of the illness and development of new symptoms. Ask for a good description of the complaint and associated symptoms. Again it is important to be aware of a good differential of the Chief Complaint so that you will ask the appropriate specific questions.
   d. Ask about management of the problem. It is not wrong to ask what other physicians may have said or investigations have been done or treatment given.
   e. For an infectious disease ask about possible contacts.

10. **Functional inquiry**

   It is important to have an organized set of questions about the child’s general health. One approach is to ask the general questions and then start at the head and neck, including eyes and ears, progressing to the chest and respiratory symptoms, progressing to the heart and cardiovascular symptoms, to the abdomen including urine and stool problems, to the extremities bones, joints and then skin. If you think in an organized fashion then you are less likely to leave out important questions.
11. Background

It is important to try to get to know about the family including:

a. Living conditions.

b. Whether the parents are together or not, and if the child attends Daycare.

c. School, grade and progress.

d. Other interests for the child including music, sports, clubs such as Cubs, Brownies and Sunday School, friends, interests and plans for the future.

12. Concluding the interview

At the end of the interview, it is helpful to briefly summarize the problem, so that you and the family will be sure you have understood the problem. It is helpful to ask one last question:

- “Is there anything that I have forgotten to ask you? or

- “Is there anything else you think I should know?”

Finally, although this may not be important for 3rd year students, it would be best to develop some communication skills as a physician, and ask the family if they have any questions for you. At your stage of training, you may not be able to answer these.

- “I know that I have asked you a lot of questions, but is there anything I can do for you? Do you have any questions?”

13. Special situations

a. In an emergency situation you may have to take the history while doing a brief exam and starting some of the initial management all at the same time. In this case the history will be very brief, but relevant.

b. Languages. Occasionally you may need an interpreter if the family are not fluent in English. This again adds complications to the history and makes the history more vague and less reliable.

c. The history can be a form of parent education and counselling. Asking about the immunization history will help to teach the family about the immunization that are needed for their child.

d. The parent may have hidden or unexpressed worries and concerns. It may be important to ask the family if they are concerned about a specific illness. It is also important to try to get and idea of the parents’ reaction to the child’s illness and the response of the family.

e. Interview with or without the child present. Many families want to discuss their child’s problems without the child being present. At the beginning it is helpful for the whole family to be together as the child needs to know what are the concerns of the family. Later there should be an opportunity to have the family discuss concerns that they did not want to express in front of the child. As well, it will be important to discuss with the child some concerns or questions that they may not want to discuss with their parents present.
• Adolescents. In most cases adolescents should be treated as young adults and the history and physical examination should usually be taken with the family waiting outside. Even if the family is present, it is important to direct all the questions to the adolescent. There are many unique aspects of the adolescent history (see HEADSS below)

• The paediatric interview and history is so important that frequently the diagnosis may be made by the end of the history. One must always be prepared to interpret families’ answers and it is unlikely that questionnaire sheets or computers will ever replace the good physician’s history, although some are very useful e.g. the Nippissing developmental screen. Developing a good rapport with a child and the family provides the basis for good medical care.

14. The Adolescent Interview: HEADSS

• H ome
  • How are things at home?
  • Who lives at home with you?
  • Have there been any changes at home lately?
  • Have you ever run away from home?

• E ducation
  • Name of school
  • Current grade
  • Academic performance
  • Amount of school days missed
  • Behavior at school

• A ctivities
  • What do you do when you aren’t at school?
  • Exercise/play sports
  • Hobbies
  • Social groups
  • Do you go out to parties/clubs a lot? Part-time work? How do you pay for the things you do?

• D rugs
  • Do you have any friends who smoke or use drugs?

• What would/does your family think if they knew that? What do you think about it?
• Have you ever tried smoking or drinking alcohol? What did you think? What about other drugs?
• Have you ever gotten into trouble because of using these substances?

• S exuality
  • Questions about sexual development or sexuality
  • Current/past sexual activity
  • Age of first intercourse
  • Sexual orientation (M/F/B)
  • Number of total partners
  • History of STI
  • History of pregnancy
  • Contraception use
  • History of sexual abuse

• S uicide and mental health
  • How is your mood (SIGECAPS)
  • Suicide assessment
  • Past attempts
  • Protective factors
  • Current plans and means to carry it out
Family Centered Care

Health care professionals are second-in-line providing health care to both children and adults. Families and individuals provide much more health care than we do. This applies to preventative health care and is equally true when we examine care-giving tasks when someone is sick. Sometimes, when our involvement, advice and prescriptions are not accepted, we call families “non-compliant.” Alternatively we might wonder if we have been successful in gaining the families’ cooperation. Eliciting another person’s cooperation is a function of the relationship that we form together. There are a number of ways to make a collaborative relationship more likely:

1. Recognize the partnership; treat patients and their families as full members of the health care team. This implies that families need to:
   - recognize that they require (and have every right to) full and clear information about the health of their children.
   - to understand what we are doing, why we are doing it and why we think it is important. They need to know who does what, what they can expect from whom, who can answer their questions, etc…
   - express their perspectives and what is important to them. Remember that they know the child from many points of view; we see the child only when he/she is sick. Remember that families have many responsibilities, not just the health problem they are bringing to us.

2. Become aware of what they might need help with in order to fulfill their responsibilities as members of the health care team; e.g., education about the illness, emotional support, financial help or other support to deal with all of the responsibilities that families have.

3. Recognize the strengths and the healthy aspects in what families do.

4. Know your own role on the health care team; ensure that the professionals are well organized and communicating effectively among themselves as well as with the family.
Criteria for Formative Evaluation & Feedback of Students

ASCM 2 Paediatrics

The following are some guidelines or criteria to be used in providing formative feedback and an evaluation of the students in ASCM Paediatrics.

**Interviewing**
- Greets parents / child using appropriate language that they understand
- Addresses child if old enough
- Shows empathy / sympathy
- Obtains history using a mix of open and closed questions. Follows an organized approach
- Listens to answers, allows parents / child to tell story without interruption.
- Follows leads / keeps parents / child on track
- Clarifies and summarizes
- Covers all aspects of history including HPI, HPH, FH, systemic review, the pregnancy, the perinatal history, developmental milestones, feeding, immunization, psycho-social and school
- Is aware of the special problems of obtaining a history from adolescents around issues such as drugs, sexual behaviour

**Examination**
- Is able to perform an age appropriate examination / is observed during the examination
- Informs the child / parent of the next step in the examination. Attends to the comfort and modesty of the patients (e.g. the adolescent)
- Appreciates the different approach necessary to examine newborns, infants, toddlers, preschool and school age children and adolescents
- Demonstrates an opportunistic approach to physical examination
- Can plot a child’s height and weight, BMI and head circumference on a growth chart
**Paediatric Knowledge**

- Major developmental milestones such as sitting, standing, talking, walking and toilet training
- Behavioural characteristics of children of different ages (e.g. infant, toddler, school age child, preteen)
- Describe the age of onset and sequence of the development of secondary sex characteristics in boys and girls

**Formal Evaluation**

- The students will be required to present a history and physical exam on at least one patient which will form the basis of their formal evaluation. In addition the students will receive a narrative assessment from each of their clinicians (clinical skills feedback).
Portfolio Session: Communicating with Children

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: Communicating with Children

Purpose: This session uses the experience of interviewing families and examining children to encourage you to think about communicating with children and how your view of being a doctor is evolving.

NOTE: You tutor may choose to incorporate this one hour segment of the ASCM 2 session throughout the 5 pediatric sessions in 10-15 minute blocks, or at the end as a 1 hour session. You will have at least one opportunity to interview families and examine children prior to being asked to prepare your story and reflection.

Before Portfolio Session

Task: Pre-session reflection on “communicating with children” to prepare to share thoughts and reflection during the ASCM 2 session.

Format:

1. Self-reflection: You have had the opportunity to work with children and their families in ASCM2 and challenged with the experience of communicating with children. 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 were some of the challenges in communicating with children (i.e. both in understanding them and in having them understand you)? What strategies were helpful in facilitating communication?”

• “What were some of the challenges in examining infants and children of various ages? What strategies did you use to overcome these challenges?”

• “What role might consent, autonomy, culture, and age play in communicating with, examining, performing investigations in, and providing treatment for children and adolescents?”

• “Were you able to empathize with patients and their family members and how did you show this?”

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 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:

________________________________________________________________________

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

________________________________________________________________________

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________________________________________________________________________
APPENDIX

1. Standards of Professional Behaviour for all Health Professional Students
2. Preclerkship Professionalism Evaluation Form
3. Oral Presentation Feedback Form and Oral and Written Reports Assessment Guidelines*
4. ASCM Teaching Tips

*Please note that the forms located in these appendices are samples only. Slight variances may occur between the appendix forms and the forms that will be used for the current academic year.
APPENDIX
Approved by University of Toronto’s Governing Council
June 17 2008

Standards of Professional Practice Behaviour
for all Health Professional Students

Preamble

Health professional students engage in a variety of activities with patients/clients under supervision and as part of their academic programs. During this training, the University, training sites, and society more generally expect our health professional students to adhere to appropriate standards of behaviour and ethical values. All health profession students accept that their profession demands integrity, exemplary behaviour, dedication to the search for truth, and service to humanity in the pursuit of their education and the exercise of their profession.

These Standards express professional practice and ethical performance expected of students registered in undergraduate, graduate and postgraduate programs, courses, or training (for the purposes of this policy, students includes undergraduate/graduate students, trainees including post doctoral fellows, interns, residents, clinical and research fellows or the equivalents) in the:

(a) Faculty of Dentistry;
(b) Faculty of Medicine;
(c) Lawrence S. Bloomberg Faculty of Nursing;
(d) Leslie Dan Faculty of Pharmacy;
(e) Faculty of Physical Education and Health;
(f) Factor-Inwentash Faculty of Social Work:
(g) Ontario Institute for Studies in Education (OISE Programs in School and Clinical Child Psychology; Counselling Psychology for Psychology Specialists; Counselling Psychology for Community and Educational Settings).

By registering at the University of Toronto in one of these Faculties or in courses they offer, a student accepts that he/she shall adhere to these Standards. These Standards apply to students in practice-related settings such as fieldwork, practicum, rotations, and other such activities arranged through the Faculty, program of study, or teaching staff. Other Faculties that have students engaged in such activities in health settings may also adopt these standards.

These Standards do not replace legal or ethical standards defined by professional or regulatory bodies or by a practice or field setting, nor by other academic standards or expectations existing at the University of Toronto. Action respecting these Standards by the Faculty responsible for the program or course does not preclude any other action under other applicable University policies or procedures, action by program regulatory bodies, professional bodies, or practice/field settings, or action under applicable law including the Criminal Code of Canada.
Breach of any of these Standards may, after appropriate evaluation of a student, and in accordance with applicable procedures, be cause for dismissal from a course or program or for failure to promote.

Standards of Professional Behaviour and Ethical Performance

All students will strive to pursue excellence in their acquisition of knowledge, skills, and attitudes in their profession and will uphold the relevant behavioural and ethical standards of his or her health profession or Faculty, including:

1. Keeping proper patient/client records
2. Where patient/client informed consent to an action is required, the student will act only after valid informed consent has been obtained from the patient/client (or from an appropriate substitute decision-maker)
3. Providing appropriate transfer of responsibility for patient/client care
4. Being skilful at communicating and interacting appropriately with patients/clients, families, faculty/instructors, peers, colleagues, and other health care personnel
5. Not exploiting the patient/client relationship for personal benefit, gain, or gratification
6. Attending all mandatory educational sessions and clinical placements or provide appropriate notification of absence
7. Demonstrating the following qualities in the provision of care:
   (a) empathy and compassion for patients/clients and their families and caregivers;
   (b) concern for the needs of the patient/client and their families to understand the nature of the illness/problem and the goals and possible complications of investigations and treatment;
   (c) concern for the psycho-social aspects of the patient’s/client’s illness/problem;
   (d) assessment and consideration of a patient’s/client’s motivation and physical and mental capacity when arranging for appropriate services;
   (e) respect for, and ability to work harmoniously with, instructors, peers, and other health professionals;
   (f) respect for, and ability to work harmoniously with, the patient/client and all those involved in the promotion of his/her wellbeing;
   (g) recognition of the importance of self-assessment and of continuing education;
   (h) willingness to teach others in the same speciality and in other health professionals;
   (i) understanding of the appropriate requirements for involvement of patients/clients and their families in research;
   (j) awareness of the effects that differences in gender, sexual orientation, cultural and social background may have on the maintenance of health and the development and treatment of illness/problems;
   (k) awareness of the effects that differences in gender, sexual orientation, and cultural and social background may have on the care we provide;
   (l) respect for confidentiality of all patient/client information; and,
The ability to establish appropriate boundaries in relationships with patients/clients and with health professionals being supervised;

These Standards articulate the minimum expected behaviour and ethical performance; however, a student should always strive for exemplary ethical and professional behaviour.

(b) A student will refrain from taking any action which is inconsistent with the appropriate standards of professional behaviour and ethical performance, including refraining from the following conduct:

8. Misrepresenting or misleading anyone as to his or her qualifications or role
9. Providing treatment without supervision or authorization
10. Misusing or misrepresenting his/her institutional or professional affiliation
11. Stealing or misappropriating or misusing drugs, equipment, or other property
13. Unlawfully breaching confidentiality, including but not limited to accessing electronic records of patients/clients for whom s/he is not on the care team
14. Being under the influence of alcohol or recreational drugs while participating in patient/client care or on call or otherwise where professional behaviour is expected
15. Being unavailable while on call or on duty
16. Failing to respect patients’/clients’ rights and dignity
17. Falsifying patient/client records
18. Committing sexual impropriety with a patient/client
19. Committing any act that could reasonably be construed as mental or physical abuse
20. Behaving in a way that is unbecoming of a practising professional in his or her respective health profession or that is in violation of relevant and applicable Canadian law, including violation of the Canadian Criminal Code.

Assessment of Professional Behaviour and Ethical Performance

The Faculties value the professional behaviour and ethical performance of their students and assessment of that behaviour and performance will form part of the academic assessment of health professions students in accordance with the Grading Practices Policy of the University of Toronto. Professional behaviour and ethical performance will be assessed in all rotations/fieldwork/practicum placements. These assessments will be timely in relation to the end of rotation/fieldwork placement/practicum and will be communicated to the student.

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1 Students who have (or have had) a close personal relationship with a colleague, junior colleague, member of administrative staff or other hospital staff should be aware that obligations outlined in the Provost’s Memorandum on Conflict of Interest and Close Personal Relations pertain to these Standards. http://www.provost.utoronto.ca/policy/relations.htm
Each Health Science Faculty will have specific guidelines related to these Standards that provide further elaboration with respect to their Faculty-specific behavioural standards and ethical performance, assessment of such standards and relevant procedures.

Breaches of these Standards or of Faculty-specific guidelines related to these Standards are serious academic matters and represent failure to meet the academic standards of the relevant health profession program. Poor performance with respect to professional or ethical behaviour may result in a performance assessment which includes a formal written reprimand, remedial work, denial of promotion, suspension, or dismissal from a program or a combination of these. In the case of suspension or dismissal from a program, the suspension or dismissal may be recorded on the student’s academic record and transcript with a statement that these Standards have been breached.

With respect to undergraduate students, appeals against decisions under this policy may be made according to the guidelines for such appeals within the relevant Faculty.

In the case of graduate students, the procedures for academic appeals established in the School of Graduate Studies shall apply. Recommendation to terminate registration in a graduate program must be approved by the School of Graduate Studies. Decisions to terminate registration in a graduate program may be appealed directly to the School of Graduate Studies Graduate Academic Appeals Board (GAAB) in accordance with its practises and procedures.

In cases where the allegations of behaviour are serious, and if proven, could constitute a significant disruption to the program or the training site or a health and safety risk to other students, members of the University community, or patient/clients, the Dean of the Faculty responsible for the program or course is authorized to impose such interim conditions upon the student, including removal from the training site, as the Dean may consider appropriate.

In urgent situations, such as those involving serious threats or violent behaviour, a student may be removed from the University in accordance with the procedures set out in the Student Code of Conduct.
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>
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<tr>
<td>Demonstrates sensitivity to patients’ and others’ needs</td>
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<tr>
<td>Takes time and effort to explain information to patients and others</td>
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<td>Takes time and effort to comfort others in difficulty</td>
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<tr>
<td>Listens with empathy to patients’ and others’ concerns</td>
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<tr>
<td>Gives priority to patients’ interests</td>
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<tr>
<td>Shows respect for patients’ confidentiality</td>
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</table>

**Duty: Reliability and Responsibility**

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<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>
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<tr>
<td>Usually completes assigned tasks</td>
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<tr>
<td>Fulfills obligations</td>
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<tr>
<td>Takes on appropriate share of team assignments</td>
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<tr>
<td>Informs supervisor/course director when faced with a conflict of interest</td>
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</table>

**Excellence: Self Improvement and Adaptability**

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<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>
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<tbody>
<tr>
<td>Accepts constructive feedback</td>
<td></td>
<td></td>
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<tr>
<td>Recognizes own limits and seeks appropriate help</td>
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<tr>
<td>Incorporates feedback to make changes in behaviour</td>
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<tr>
<td>Comes prepared to academic and clinical encounters</td>
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<tr>
<td>Prioritizes rounds, seminars and other learning events appropriately</td>
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</table>

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

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<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>
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<td></td>
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<tr>
<td>Relates well to fellow students in a learning environment</td>
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<tr>
<td>Relates well to faculty in a learning environment</td>
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<tr>
<td>Relates well to other health care professionals in a learning environment</td>
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</table>
## Honour and Integrity: Upholding Student and Professional Code of Conduct

<table>
<thead>
<tr>
<th>Item</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>
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<tr>
<td>Resolves conflicts in a manner that respects the dignity of those involved</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<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>
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<tr>
<td>Dresses in an appropriate professional manner (context specific)</td>
<td>☐</td>
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**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 PAEDIATRICS FORM**

**PART 1 FORMATIVE FEEDBACK CHECKLIST**

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

Please use the following scale: A= Not done; B= Inadequate; C= Adequate; Select N/A when an answer is not applicable

<table>
<thead>
<tr>
<th>Identifying Data</th>
<th>Not Done</th>
<th>Inadequate</th>
<th>Adequate</th>
<th>N/A</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Identifies the patient in appropriate terms. Notes patient's age, sex, and any relevant social or demographic data.</td>
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<tr>
<td>2. Correctly identifies main problem(s) or reason for visit; clear brief statement of symptom and duration</td>
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**Chief Complaint**

<table>
<thead>
<tr>
<th>History of Present Illness</th>
<th>Not Done</th>
<th>Inadequate</th>
<th>Adequate</th>
<th>N/A</th>
<th>Comments</th>
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<tbody>
<tr>
<td>3. Describes and characterizes symptoms clearly, onset, duration, frequency, location, intensity, exacerbating &amp; alleviating factors</td>
<td>☐</td>
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<td>4. Presents the history in an organized temporal fashion (tells the &quot;story&quot; well)</td>
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<td>5. Notes important systemic features of complaint/associated symptoms</td>
<td>☐</td>
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<td>6. Describes progression</td>
<td>☐</td>
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<tr>
<td>7. Describes impact of illness on daily/social activities where applicable</td>
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<td>☐</td>
<td>☐</td>
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<td></td>
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<tr>
<td>8. Describes treatment, response to treatment where applicable</td>
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<tr>
<td>9. Mentions complications of disease or treatment</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>10. Mentions pertinent negatives</td>
<td>☐</td>
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<tr>
<td>11. Mentions important risk factors</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
</tbody>
</table>

**Medications**

<table>
<thead>
<tr>
<th>Medications</th>
<th>Not Done</th>
<th>Inadequate</th>
<th>Adequate</th>
<th>N/A</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>12. Notes medications and therapies (prescription and non-prescription)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
</tbody>
</table>

**Allergies**

<table>
<thead>
<tr>
<th>Allergies</th>
<th>Not Done</th>
<th>Inadequate</th>
<th>Adequate</th>
<th>N/A</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>13. Type of reaction noted if relevant</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
</tbody>
</table>

**Past Medical History**

<table>
<thead>
<tr>
<th>Past Medical History</th>
<th>Not Done</th>
<th>Inadequate</th>
<th>Adequate</th>
<th>N/A</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>14. 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)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
</tbody>
</table>

**For Paediatric Histories ONLY and CONTEXT SPECIFIC**

<table>
<thead>
<tr>
<th>For Paediatric Histories ONLY and CONTEXT SPECIFIC</th>
<th>Not Done</th>
<th>Inadequate</th>
<th>Adequate</th>
<th>N/A</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>15. Pertinent prenatal and neonatal history</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>16. Immunizations</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
</tbody>
</table>
17. Developmental History

18. Diet/feeding history

Family History

19. Notes relevant family history

Social History

20. Notes important relationships, occupation, lifestyle and environmental factors

21. Notes use of alcohol, smoking, illicit drugs

Functional Inquiry

22. Very brief mention of any other major symptoms that cannot be related to the HPI or PMH

**PHYSICAL EXAMINATION (CONTEXT SPECIFIC)**

23. 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)

24. Comments on general appearance of the patient

25. Vital signs

26. Head and neck examination

27. Respiratory

28. Cardiovascular

29. Abdominal

30. Genitourinary/Pubertal staging/Breast exam (where applicable)

31. Musculoskeletal system (appropriate to context)

32. Mental status and Neurological (appropriate to context)

33. Developmental (where applicable and appropriate to context)

34. Functional assessment (where applicable and appropriate to context)

**SUMMARY**

35. Summarizes the encounter in 2-3 sentences pointing out the most pertinent historical and physical findings.

36. 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**

37. Presents in an appropriate length of time given the context and complexity of the patient

38. Presents smoothly and without unnecessary repetition

---

**Part 2: Oral Presentation or Written Case Report Evaluation Form**

Tutor: Please remember to fill in all applicable boxes. This generates a mark for the student.

1 = Unsatisfactory; 2 = Borderline; 3 = Pass, meets expectations; 4 = Exceeds expectations; 5 = Far exceeds expectations.

<table>
<thead>
<tr>
<th>Student obtains insufficient information to identify the major problem, or is on the wrong track</th>
<th>Obtains sufficient information to identify the major problem</th>
<th>Obtains complete information including psychosocial context of individual patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

1. Data Collection
### 2. Approach to Clinical Problem

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Misses the problem. Lack of understanding</td>
</tr>
<tr>
<td>2</td>
<td>Incomplete or simplistic approach</td>
</tr>
<tr>
<td>3</td>
<td>Recognizes and addresses the problem</td>
</tr>
<tr>
<td>4</td>
<td>Addresses the problem precisely and perceptively</td>
</tr>
</tbody>
</table>

- **Little or no thinking about the issues; Tangential**
- **Descriptive, repetitious, superficial**
- **Some focus and organization of data; Minimal depth**
- **Focused, coherent, organized; Shows clarity and depth**

### 3. Degree of focus and Organization

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Lack of content knowledge interferes with understanding of clinical problem</td>
</tr>
<tr>
<td>2</td>
<td>Sufficient content knowledge to interpret clinical problem</td>
</tr>
<tr>
<td>3</td>
<td>Substantial content knowledge allows complex in-depth approach</td>
</tr>
</tbody>
</table>

- **Lack of content knowledge**
- **Minimal depth**
- **Focused, coherent, organized; Shows clarity and depth**

### 4. Content Knowledge

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Errors of expressions interfere with understanding</td>
</tr>
<tr>
<td>2</td>
<td>Some errors of expression or language</td>
</tr>
<tr>
<td>3</td>
<td>Exhibits command of language and terminology</td>
</tr>
</tbody>
</table>

- **Errors of expression interferes with understanding**
- **Some errors of expression or language**
- **Exhibits command of language and terminology**

### 5. Language

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Unable to establish rapport with patient and family</td>
</tr>
<tr>
<td>2</td>
<td>Establishes rapport with patient and family</td>
</tr>
<tr>
<td>3</td>
<td>Sophisticated communication and interaction with patient and family</td>
</tr>
</tbody>
</table>

- **Unable to establish rapport with patient and family**
- **Establishes rapport with patient and family**
- **Sophisticated communication and interaction with patient and family**

### 6. Interpersonal Skills

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Incomplete history and physical exam, disorganized presentations and approach to clinical problem</td>
</tr>
<tr>
<td>2</td>
<td>Complete history and physical exam with succinct presentations and approach</td>
</tr>
<tr>
<td>3</td>
<td>Sophisticated synthesis of history and physical exam, emerging ability to apply information</td>
</tr>
</tbody>
</table>

- **Incomplete history and physical exam, disorganized presentations and approach to clinical problem**
- **Complete history and physical exam with succinct presentations and approach**
- **Sophisticated synthesis of history and physical exam, emerging ability to apply information**

### 7. Global Clinical Skills

**Comments:**

---

**APPENDIX 3**
ASCM Teaching Tips

Clinical skills can be taught and learned in a variety of ways and as such ASCM employs the use of many teaching methodologies. In a given session you may be responsible for a large group session, small group facilitation, or 1:1 teaching. This resource is meant to provide some general tips as you begin to plan your sessions.

Plan ahead:

How many students? How many tutors?
What would you like the students to know ahead of time? (assign homework)
What are the Learning Objectives for the session?
What teaching methods will you use to achieve the learning outcomes?
How will you arrange the agenda?
What equipment will you need?
What seating arrangement will best facilitate the session?

Setting the Tone:

Students are expected to come prepared for ASCM and they share responsibility for their learning in each session. We suggest assigning specific teaching and learning tasks to the students each week. This will help them master the material and will generate meaningful engagement in each session.

Timing is Everything:

Set an agenda and stick to it!! Be generous with time slots to allow for unforeseen delays (e.g. Computer problems). Be prepared to omit non-essential elements of the lesson if necessary in order to stay on time. Post the agenda at the beginning of the session; the students will help you to stay on time!

They are always watching!

ASCM is often the first clinical contact with practicing physicians for medical students. They will be interested in how we perceive the profession and will keenly observe our behaviours. We must be mindful of hidden curriculum so as to avoid perpetuation of stereotypes, biases, and cynasism. Their keen observation also presents an opportunity to model reflective learning and professionalism. It is a chance to show our own enthusiasm for the profession.
Medium and Large Group Sessions:

At times an ASCM session may begin by guiding a lesson for more than 6 students. Large groups tend to function a little differently than small groups. Students are less likely to speak-up voluntarily as they tend to prepare themselves for a didactic presentation. Didactic presentations have gotten a bad wrap in recent years however when done in an engaging way they remain powerful knowledge transfer tools. Part of preparing for a large group session is including opportunities for mutual engagement.

<table>
<thead>
<tr>
<th>Tools</th>
<th>Description</th>
<th>Tips</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>PowerPoint/Prezi</td>
<td>Visual aid</td>
<td>Avoid simply reading your slides. Max 6 lines per slide.</td>
<td>*see resource below</td>
</tr>
<tr>
<td>Flip Charts</td>
<td>Visual aid</td>
<td>Record ideas/thoughts from your audience. Promotes active involvement.</td>
<td>List cardinal symptoms from a system. Record ideas from Think Pair Share Activity</td>
</tr>
<tr>
<td>Audio/Video Clips</td>
<td>Provide opportunity for students to reflect on what they see, consolidate what they are hearing, and generate conversation.</td>
<td>Keep the clips short (2-5 minutes)</td>
<td>Listening to heart sounds together. Movie clips (biopsychosocial session)</td>
</tr>
<tr>
<td>Diagrams</td>
<td>Visually demonstrate a key concept.</td>
<td>Look for simple and clear diagrams</td>
<td>Image of the ideal position of patient and cuff for taking the blood pressure.</td>
</tr>
<tr>
<td>Think Pair Share</td>
<td></td>
<td>Plan for 1 or 2 think pair shares per session. Schedule 5 min for pairing up and 5-10 min for discussion.</td>
<td>“Based on the video you have just seen, work with a partner to describe the biopsychosocial context for the patient in the clip” Then, have each pair share some of their ideas with the larger group.</td>
</tr>
<tr>
<td>Dialogue and Narratives</td>
<td>Generate opportunities for conversation with students. Narratives or Stories from your experience are powerful learning tools if kept brief. (This is also a method of modeling reflection)</td>
<td>Poll the audience Ask Questions – start simple – let all the hands go up! Prime students ahead of time so they are prepared to participate. Set a time frame – time flies! E.g. 10 min</td>
<td>Priming: “for next week’s session, reflect on a time when you either saw or experienced empathy. What techniques might you use to show empathy?”</td>
</tr>
<tr>
<td>Case Based Learning</td>
<td>The use of cases gives the content some clinical context.</td>
<td>See portal for “Mr. GB content” Generate a case to serve your teaching agenda for the session.</td>
<td>Mr. GB CHF content Ms. X. is a 62yr Female presenting with a cough. Allow the case to unfold as the students generate the history and exam</td>
</tr>
<tr>
<td>Question breaks</td>
<td>Pose or receive questions. An opportunity to check in on your students’ understanding.</td>
<td>Schedule time for questions. This allows the students to have questions answered but also allows you to stay on time.</td>
<td>Can insert a slide at a content transition point that reminds you to pause for questions.</td>
</tr>
<tr>
<td>Students as Teachers</td>
<td>When prepared, students enjoy sharing their knowledge.</td>
<td>Pre-assign a task to the students and have them demonstrate to the larger group.</td>
<td>Next week you will explain and demonstrate the ideal positioning of the patient for taking the blood pressure.</td>
</tr>
</tbody>
</table>
**Small Group Sessions:**

Following the large group session, often the group breaks into groups of 6 to practice their clinical skills. In these more intimate groups there is time for direct application of materials discussed in the large group sessions. It is an opportunity for students to practice, refine skills, and clarify questions.

---

**Key Opportunities engendered by Small Group Learning in ASCM**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Benefits</th>
<th>Drawbacks</th>
</tr>
</thead>
</table>
| Direct Observation             | - allows tracking of student progress  
                                | - provides student with ample opportunity for questions  
                                | - assesses communication and clinical skills                      | Some students may feel anxious or intimidated.  
                                | Tip: Students appreciate being able to directly observe skill before they attempt it themselves. Show them how you perform the given skill! | Tip: offer unsupervised practice occasionally and allow the students to teach each other. |
| Real-time feedback             | Providing immediate reinforcing and corrective feedback helps students to master clinical skills |                                                                                   |
| Relationship building and mentoring | As the term progresses tutors and students begin to know one another. Much as in clinical medicine, the relationship between student and teacher serves as a platform for the student's professional growth. |                                                                                   |

---

**In your small groups, students should be the primary contributors. If this is not happening, take a step back to diagnose the problem.**

**Problems to be cognizant of:**
1. A teacher dominates the discussion
2. A single student dominates the session
3. Lack of student engagement or preparedness
Giving Feedback:

Providing feedback, whether formal or informal, should be part of every session. Feedback occurs informally, formally, and out of necessity (a critical incident). The small group sessions provide regular opportunities for direct observation and informal corrective feedback. This real-time feedback allows students an opportunity to correct and re-attempt a skill before bad habits take hold. Formal feedback tends to be scheduled ahead of time with time allotted to each student. It should be done privately. In ASCM formal feedback occurs at midterm and end of term. It allows the tutor and students to reflect on overall progress in the course and develop learning plans to address deficiencies.

There are many ways to structure feedback and some will feel more comfortable to you or the situation than others. Below is an example that allows for quick, specific and corrective feedback. Please see the attached resources for other examples.

<table>
<thead>
<tr>
<th>Continue</th>
<th>Start to do more</th>
</tr>
</thead>
<tbody>
<tr>
<td>- What was effective?</td>
<td>- What does the learner know how to do but have not applied yet?</td>
</tr>
<tr>
<td></td>
<td>- What are they doing that they could do more often?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Consider</th>
<th>Stop or do less</th>
</tr>
</thead>
<tbody>
<tr>
<td>- What are the next steps for this learner to progress to the next level</td>
<td>-What actions were not helpful?</td>
</tr>
<tr>
<td></td>
<td>- What actions may have been harmful?</td>
</tr>
<tr>
<td></td>
<td>- Describe possible impact of the actions</td>
</tr>
</tbody>
</table>

Tips for effective feedback:

1. Be specific (if it’s too general, the student may not realize what areas need improvement)
2. Be concise (focus on 1-2 items rather than a laundry list).
3. Provide feedback close in time to the events stimulating the feedback.
4. Seek privacy when feedback is sensitive
5. Focus on elements that are within a learner's locus of control.
6. Be descriptive – “The patient winced when your were palpating the abdomen; try to observe the patient’s face during palpation so that you can pick up on signs of pain early”
7. Ask the student for their self-assessment to identify gaps between perceived and actual performance
8. Provide feedback on positive encounters – they may not realize their own strengths
9. Take notes – will help to provide detailed and valuable feedback to students and is useful when reflecting on a student’s progress over the term.
10. Close feedback by negotiating a learning plan to further enhance skill development.
Learner in difficulty:

- Discuss performance with the student privately
- Get second opinions from other tutors
- Generate and document a clear and specific action plan
- Agree on a time for the next observation and feedback
- Inform site coordinator or course director if concerns persist

Resources:

Large Group Sessions:

- tips on planning and delivering lectures


Small Groups:


General:
