utmb Health

Introducing You To The Pediatric Clinical Experience

Gayani Silva, M.D.
Clerkship Director

Valli Annamalai, M.D.
Austin Clerkship Director

Tiffany Swain
Pediatric Student Coordinator

Table of Contents

		Page
I.	**Disclaimer**	**4**
II.	**Orientation**	**4**
III.	**Goal of the Pediatric Clinical Experience**	**4**
IV.	**Opportunities to Develop an Understanding of the Basic Principles of Pediatric Medicine**	**4-7**
	A. Pediatric Primary Care Experience	4-5
	B. Secondary / Tertiary Care	5
	C. Mandatory Learning Opportunities	5-6
	D. Optional Learning Opportunities	6
	E. Recommended and Supplementary References	6-7
	F. Useful Websites	7
V.	**Evaluations**	**7-9**
	A. How am I evaluated	7
	B. Absences	7-8
	C. Observed History & Physical and Newborn Nursery Exam	8
	D. Design-A-Case	8
	E. Morning Report	8
	F. Final Exam	8
	G. How is my grade computed?	8-9
	H. Final Clerkship Grade and Assigning of Honors, High Pass, Pass & Fail	9
	I. How do I evaluate the Pediatric Clinical Experience?	9
VI.	**Student Awards**	**9-10**
VII.	**SOM Absence Policy**	**10-11**
VIII.	**Holidays**	**11**
IX.	**Honor Pledge**	**11**
X.	**Code of Conduct**	**11-13**
	A. What is the Definition of Medical Professional Conduct?	11-12
	B. What Principles Govern Student-Faculty Professional Conduct?	12-13
XI.	**Who is in charge of the Year III Pediatric Curriculum?**	**13**

Appendixes

	Page
Appendix A	
Goals and Objectives of the Pediatric Clerkship	14-18
Pediatric Curriculum	19-22
Pediatric Clerkship Checklist	23
How to Enter Case Logs	24
Case Logger Table	25-27
Format for History and Physical	28-29
Sample History and Physical	29-31
Oral Presentation Rating Tool	32
Ward Responsibilities	33-34
Appendix B	
Goals and Objectives for the Newborn Nursery Clerkship	35-36
Nursery Clerkship	37
What Students Do in the Morning	37-42
Discharge Papers	38
Presenting Your Babies on Rounds with the Attending	38-40
What to Ask During the Mother Visit	40-41
More on Discharges	41
Admissions and Miscellaneous Stuff	42
Dress Code for Newborn Nursery & ISCU	43
Other Pertinent Information	43-44
Nursery Forms	45-48
Appendix C	
Evaluation Forms	
Observed History & Physical Form	49-53
Evaluation of Newborn Physical Exam Skills	54
Evaluation of Clinical Performance on Service	55-57
Pediatrics Ambulatory Clerkship Evaluation of Clinical Performance	58-59
Appendix D	
Morning Report Presentation	60-61
Design-A-Case	62
Appendix E	
Department of Pediatrics Electives	63-64

I. Disclaimer

This syllabus represents curriculum planning at the time of posting and is subject to change. Should changes occur, every effort will be made to notify students as soon as possible via e-mail and this web based document. Students are responsible for checking Blackboard or the Department of Pediatrics website (http://www.utmb.edu/pedi/education/ume/ume_main.html) and their e-mail for such notifications.

II. Orientation to the Pediatric Clerkship

Orientation sessions to the Pediatric Clerkships will occur on the first Monday of each eight-week Pediatric block.*These sessions are designed to review your clinical responsibilities and assignments prior to beginning a new segment of your pediatric training. These meetings are held at:

Department of Pediatrics
Research Building 6 (old Children's Hospital)
Room 2.312 (Second Floor)
First day of block at 0830

* Students assigned to Austin should report to the Dell Children's Medical Center of Central Texas (www.dellchildrens.net) on their first day. An orientation will be conducted by the Austin Clerkship Director on the first day of the rotation. Orientation information will be sent via email to students prior to their clerkships. Additional information may be obtained by contacting the Office of Regional Medical Education - Austin at (512) 324-0165. Your schedule will be discussed at length during orientation.

ORIENTATION IS MANDATORY FOR EVERYONE

Students who are scheduled to do 2 weeks of inpatient at Driscoll Children's Hospital (Corpus Christie) and Newborn Nursery (1 week)/Subspecialty (2 weeks) segments at St. Joseph Medical Center (Houston) will receive additional orientation material specific to those sites at the start of the respective segments.

III. Goal of the Pediatric Clinical Experience

The goal of the pediatric clinical experience is to provide an opportunity for each student to develop the basic skills required to provide medical care for infants, children, and adolescents, and to provide a foundation for further training in pediatrics. In Pediatrics you will learn to appreciate the influence of growth and development in children, by experiencing first-hand how the maturation process affects the diagnosis and management of illness and how it influences general well being. Since children are not responsible for their own health care, you will also learn how to evaluate the family unit, parenting skills and the home environment as part of the child's total health evaluation.

IV. Opportunities to Develop and Understand the Basic Principles of Pediatrics Throughout the Clerkship

A. Pediatric Primary Care Experience
This includes 3 weeks in a community preceptor's office and a week in the newborn nursery.

1. ***Newborn Nursery***
You will be assigned to full time duty in the newborn unit for one week during your primary care experience. This experience will include examination of newborns, rounds with residents and faculty, and related readings. (See **Appendix B** and be familiar with its contents prior to starting.) Those students in Austin for their clerkship block will also take their newborn nursery in Austin. Houston based students will do their newborn nursery at St. Joseph Hospital. All other students will stay at or return to UTMB Galveston for their newborn nursery rotation. During the

newborn nursery week, you will be working either Saturday or Sunday (those travelling to a non-commutable ambulatory site or Corpus Christi, should work on Saturday, so they can travel on Sunday).

2. ***Ambulatory Pediatrics***
   You will spend 4.5 days / week for 3 weeks assigned to a community based preceptor, either locally or at a distant site. The outpatient experience involves both health maintenance and the care of acutely ill children and adolescents in a primary care community setting under the supervision of a general pediatrician. All students should call their ambulatory preceptor to determine what time to report on the first day of the rotation. If you are scheduled to begin this rotation on the first day of the clerkship, you should call immediately following orientation. Those assigned to commutable sites on the first day of the clerkship are expected to start the afternoon of orientation. If you are assigned to a distant site (more than 3 hours driving distance away), you will be expected to report to your preceptor at a time decided by them on Tuesday morning. If you are scheduled to begin the rotation immediately following your nursery week, and you are assigned to a distant site, Sunday will be considered a travel day for you. All students are expected to work a full day on the last Wednesday of the rotation. Students assigned to inpatient, subspecialty, newborn nursery and commutable sites will be expected to work a half a day on the last Thursday of the Clerkship. Those in non -commutable sites and Corpus Christi will use the last Thursday of the Clerkship as a driving day. The Shelf Examination will be held on the last Friday of the Clerkship. Students are not expected to participate in any clinical activities on the last weekend of the Clerkship after the Shelf examination.

B. Pediatric Secondary/Tertiary Care Experience

This experience involves management of hospitalized sick children or outpatients with complex / chronic conditions under the supervision of a Resident/Faculty team. Patients are assigned in numbers sufficient to provide experience, yet restricted enough to permit thorough study. The student should use the history and physical findings as a basis for self-selected readings in textbooks and journals. The Faculty and housestaff expect the student to bring to rounds a formulation of the patient's potential problem and a diagnostic or therapeutic plan.

1. ***Inpatient Team***
   All pediatric admissions
2. ***Subspecialty Rotations***
   Infant Special Care Unit (Galveston & St. Joseph's), Nephrology, Hematology/Oncology, Infectious Disease, Cardiology, Endocrinology and Adolescent Medicine.
3. ***Galveston:***
   Students taking the secondary / tertiary care portion of their clerkship in Galveston will spend two weeks on the Inpatient team (either in Galveston or Corpus Christi), and two weeks on a subspecialty service.
4. ***Austin***
   In Austin, students spend four weeks on the inpatient service.
5. ***Houston***
   Houston based students will spend two weeks on the inpatient team in Galveston or Corpus Christi. They will be assigned to either St. Joseph's Neonatal Intensive Care Unit or one of the other UTMB clinics listed in #2 for subspecialty. These clinics will be in our Bay Colony clinic location primarily.

C. Mandatory Learning Opportunities (*attendance required)

During the course of your clerkship, there will be a number of different learning opportunities. Their value is largely dependent upon your willingness to participate through active preparation and critical thought.

1. ****Common Pediatric Skills and Knowledge Conferences (Galveston and Houston Students)***
   These didactic conferences generally occur on Tuesday or Thursday from 1:00 to 5:00 p.m. during the secondary /tertiary portion of the clerkship in room 3.300A. Exceptions may occur due to holidays and unavoidable conflicts in the schedule. The purpose of these conferences is to cover common issues in pediatrics and clinical skills. As these sessions include hands-on skills practice and work with standardized patients, Houston students are expected to attend in person. The list of topics include the following:

   Lectures:

   Pediatric History and Physical Skills
   Delivering Bad News
   Common Infectious Disease Problems
   Common Pediatric Cardiology Issues
   Fluids and Electrolytes
   Pediatric Emergencies

Practice of communication skills (with standardized patients):
- Delivering bad news
- Interviewing a teenager
- 2 month well visit with translators
- Care of a child with a chronic medical condition

Procedural skills sessions:
- Performing a lumbar puncture
- Insertion of intravenous lines in a pediatric patient
- Giving subcutaneous and intramuscular injections
- Use of inhalers with spacers,
- Insertion of gastrostomy tubes and care of tracheostomy tubes

In Austin, rather than the Common Pediatric Skills and Knowledge Conferences, noon conferences are held each day to address common pediatric problems. Galveston Conferences will be videoconferenced to students during the time they are rotating in Corpus Christi.

2. **** Morning Report Presentation***
You and your team are assigned to present a case at Morning Report. Your team assignments will be given at orientation. Student cases are presented on Wednesdays and are worth 5% of your grade; Morning Report is held Tuesday through Thursday from 8 to 8:30 AM in 3.300A Research Building 6. Students are to choose a case which is interesting, but not too esoteric - you want to use the case as a springboard to review information of use to you as you learn Pediatrics. Check with your residents as you select your case - you don't want to duplicate a presentation they have planned, and they may have good advice for you. (See Appendix D for details).

3. **** Design-A-Case***
All students are required to complete 12 cases online. The cases can be found at http://www.designacase.org/. (See **Appendix E** for instructions).

4. **** Observed History and Physical Exam and Observed Newborn Physical Exam***
Students are required to do an observed history and physical examination during the inpatient part of the clerkship. They are also required to do an observed newborn physical examination during the newborn nursery part of the Clerkship (See **Appendix C** for details). Each of these activities will count for 7.5% of your grade.

D. Optional Learning Opportunities

Grand Rounds (Attendance highly recommended)
This conference lasts from 0800 to 0900 each Friday, in Room 2.312 Research Building 6. Attendance is not required while you are assigned to the Newborn Nursery. Once per month, Faculty meetings will be held instead of Grand Rounds, and students are not expected to attend, so check the schedule. Grand Rounds is videoconferenced to our clinic in Bay Colony.

In Austin, Grand Rounds take place on Fridays from 0730 to 0830 in the Signe Auditorium of Dell Children's. Students on the ambulatory and nursery experiences are not required to attend. Information will be distributed at orientation.

E. Recommended and Supplementary References

1. ***Recommended References:***
   a. *Core Concepts of Pediatrics* is a web-resource available to all UTMB medical students. This is a set of e-chapters covering the content areas of pediatrics to which you will be exposed to during the clerkship and for what you will be evaluated on at your end-of-clerkship evaluation. The resource is available through the departmental website, under education. Here is the link: http://www.utmb.edu/pedi_ed/CORE/index.htm

   b. *Nelson: Essentials of Pediatrics, 6th edition*. Robert M. Kliegman, Karen Marcdante, Hal B. Jenson, & Richard E. Behrman. WB Saunders Co., 2010. ISBN: 978-1-4377-0643-7.
2. ***Other Recommended Texts:***
   a. *Nelson Textbook of Pediatrics, 19th edition*. Robert M. Kliegman, MD, Richard E. Behrman, MD, Hal B. Jenson, MD, Bonita F. Stanton, MD, Basil J. Zitelli, MD & Holly W. Davis, MD. WB Saunders Co., 2011. ISBN: 978-1-4377-0755-7. This comprehensive text is available online through the UTMB library in the MD Consult collection, under Kliegman.

b. *Rudolph's Pediatrics, 22nd edition*. Rudolph AM. editor. McGraw Hill, New York, 2009. ISBN: 978-0071497237. This comprehensive text is available online through the UTMB library in the Stat!Ref collection.

c. *Case Files Pediatrics, 4th edition.* Eugene C. Toy, Robert J. Yetman, Mark Hormann, Margaret McNeese, Mark Jason Sanders, Sheela Lahoti, & Abby M. Geltemeyer. McGraw-Hill Medical, 2012. ISBN: 978-0071766982.

3. ***Supplemental References:***
   a. *Red Book: 2012 Report of the Committee on Infectious Diseases. 29th edition.* Larry Pickering. American Academy of Pediatrics, 2012. ISBN: 978-1581107036.

   b. *Harriett Lane Handbook, 19th edition.* John Hopkins Hospital, Kristin Arcara & Megan Tschudy. Mosby, 2011. ISBN: 978-0323079426.

F. Useful Websites

1. ***Design-A Case*** - http://www.designacase.org/
2. ***Online Resources (Home grown) - Available through the departmental website*** - http://www.utmb.edu/pedi/education/ume/ume_main.html
   a. Syllabus
   b. Austin supplemental manual
   c. Core Concepts of Pediatrics
   d. Outpatient supplement
   e. Otitis Media - A great review of otitis media with photographs –http://www.utmb.edu/pedi_ed/AOM-Otitis/default.htm
3. ***Home-Grown, not departmental website***
   Otolaryngology/Grand Rounds, with lots of Pediatric topics www.utmb.edu/otoref/grnds/grndsindex.html
4. ***Further A field***
   a. The Electric Airway, with audio clips of stridor, etc. – http://www.virtualpediatrichospital.org/providers/ElectricAirway/ElectricAirway.shtml
   b. Pediatric Education, a case-based collection of resources –www.pediatriceducation.org
   c. National Network for Immunization Information - http://www.immunizationinfo.org/
   d. Vaccine Education Center, Children's Hospital of Philadelphia http://www.chop.edu/service/vaccine-education-center/home.html

V. Evaluations

A. How am I evaluated?

The purpose of the Pediatric clerkship is to help you develop an understanding of pediatric medicine and the skills necessary for the care of infants and children. We wish to avoid overemphasis on evaluation, since excessive testing can distract from this more important purpose. However, we do have the responsibility of affirming to our students and to the school that you are competent in basic pediatric skills and knowledge. We are also required to provide information on your competencies to the university, the state and licensing authorities so as to meet their established requirements. The methods used to develop your clerkship grades are described below.

We, the faculty, recognize the subjectivity of evaluation methods, thus all clinical evaluations are subject to review by the Pediatric Undergraduate Medical Education Committee before they become final. Clinical evaluations (inpatient, subspecialty, newborn nursery and ambulatory) comprise 60% of your final grade. All failing evaluations are reviewed by the committee, which may affirm or overrule the evaluation. The committee also reserves the right to issue a failing grade based on the student's overall performance whether or not any specific component of the course has been failed. All failing grades may be appealed to the Undergraduate Medical Education Committee.

B. Absences

Planned absences require prior approval from the clerkship director and, depending on your service at the time, your faculty attending. If you are ill, notify the Clerkship Coordinator (772-5286) and your faculty attending. In Austin, please notify the Office of Regional Medical Education-Austin (512-324-7860) and your faculty attending. Missed night or weekend calls must be made up. If a student has four or more absences in a block, the student will be required to repeat the entire block. This is not intended to be punitive, but to reflect the Undergraduate Medical Education Committee's concern that this many absences substantially disrupts the educational process; simply making up four or more days would not be adequate. The occurrence of any absence without prior notification of the faculty to whom the student is responsible and to the clerkship director or course coordinator will be considered an unexcused absence. Faculty are asked to report unexcused absences to the Clerkship Coordinator by written memo. **Absences that remain**

unexcused will result in failure of the course. (See University of Texas Medical Branch Policy on Student Absence on page 12.)

C. Observed History and Physical Exam and Observed Newborn Physical Exam

The observed history and physical is designed to assess the student's ability to obtain a complete history and perform a thorough physical examination, synthesize an assessment and management plan, orally present this information and justify and defend the assessment and management plan. During the secondary / tertiary portion of your clerkship you will be observed performing a history and physical examination on a patient, and will be evaluated on that performance. You will have 24 hours to prepare your assessment and management plan. You will then be scheduled to orally present the history and physical, as well as the assessment and management plan to a faculty or upper level resident evaluator, to justify and defend the appropriateness of your assessment and management plan. It is the responsibility of the student to schedule this exercise with the faculty attending or senior resident (3rd or 4th year residents only) during their ward portion of the clerkship. During your nursery week, you will be observed performing a physical examination (including gestational age assessment) on a newborn. This examination will be observed by one of the housestaff or faculty (including nurse practitioners, who may be clinical faculty). These two evaluations will comprise 15% of your overall clerkship grade. **Failure of the Observed History & Physical will result in an incomplete grade for the Clerkship and will require repeating the exercise until it is completed successfully.**

D. Design-A-Case

You are required to complete 12 online cases. There are optional quizzes associate with some of the cases. See Appendix E for details. Non completion of the required number of cases can result in lowering of your final grade and/or up to failure of the clerkship.

E. Morning report presentations:

This group presentation will be evaluated by the audience and a peer evaluation process will determine your individual grade. It will comprise 5% of your final grade. Failure of this component will not result in failure of the clerkship, but students will only be eligible for an overall grade of *pass* in the clerkship.

F. Final Exam

Students will take a written final examination (NBME shelf exam) at the end of the eight-week clerkship rotation. All students will be off by noon on the last Thursday of the rotation. Students who are in non-commutable sites and Corpus Christi will use this last Thursday as a driving day. The Shelf Exam will be administered Friday morning. Students will be released after the Shelf Exam. Failure of the Shelf Exam will result in a grade of "PC" and the student will be required to retake the exam at a later date. (See UTMB grading policy for details.) The final exam grade will count 20% towards your final grade for the Pediatric Clerkship.

G. How is my grade computed?

Clinical grades are developed by averaging grades assigned by faculty and senior residents during the various valuable components of the clerkship. Evaluations submitted by community preceptors will be reviewed by the Executive Committee of the Undergraduate Medical Education Committee for grade assignment. The evaluation of your clinical performance depends upon visible and audible evidence of your competency and skills to collect data, solve problems, and establish relationships with patients and fellow professionals. Failure of any of these components constitutes failure for the applicable portion of the clerkship, regardless of your overall grade average. The shelf examination will be considered failed if your score falls below the 5th percentile nationally for the quarter in which you are taking it. The Undergraduate Medical Education Committee reserves the right to issue a failing grade for the Clerkship on the basis of the student's overall performance whether or not any specific component of the course has been failed. Specifically, documented repeated and/or egregious episodes of unprofessional behavior will be seriously considered as grounds for failure of the entire Clerkship.

The weights assigned to each component of the Pediatric Rotation:

Clinical Performance: (60%)

Secondary / Tertiary:

General Ward	15% (30% for Austin)
Subspecialty Block	15% (NA for Austin)

Primary Care:

Office Based Practice	22.5%
Nursery Service	7.5%

Observed Clinical Evaluation Exercise (15%)

Observed history and Physical	7.5%
Observed newborn physical	7.5%

Morning Report Presentation (5%)

National Pediatric Shelf Exam (20%)

Total = 100%

***Additional required activities:**

- Completion of 12 web cases on Design-A-Case web authoring platform
- Two written History and Physical with feedback during the inpatient block (3 in Austin)
- One written History and Physical with feedback during subspecialty block (NA for Austin)

H. Final Clerkship Grade and assigning of Honors, High Pass, Pass and Fail:

All the clerkship evaluations will be converted to a numeric grade and the sum of each component weighted grade will be the final Clerkship grade.

Honors: Equal or above 89.5
(* if Design-A-Case case web cases are not completed by the assigned date, grade will be lowered to a high pass)

High Pass: Equal or above 86. 5
(* if Design-A-Case case web cases are not completed by the assigned date, grade will be lowered to a pass)

Pass: Equal or above 70

Fail: Below 70
Failure of any clinical components
Non completion of Design-A-Case web cases
Professionalism concerns
Failure of shelf exam (will result in a PC)

I. How do I evaluate the Pediatric Clinical Experience?

You will be provided an opportunity to evaluate your pediatric learning experience at the conclusion of your clerkship. To recognize the contribution of the Pediatric housestaff to your educational experience, we will also ask you to participate in selecting the recipient of our annual housestaff teaching award at the conclusion of each Clerkship block.

VI. Student Awards

The Department of Pediatrics offers two awards for students.

The Pediatric Distinguished Student Award

This award is designed to honor a Senior Medical Student who intends to enter a pediatric residency and has demonstrated superior performance in his or her activities as a medical student in the Department of Pediatrics. Pediatrics evolved as a specialty because children have unique physiologic, biochemical and psychosocial needs which reflect dynamics of change during growth and development. The recipient of the Pediatric Distinguished Student Award should demonstrate a sound grasp of these concepts as well as skill in applying them to the care of children. Awardees should have completed their year three pediatric clerkship rotation with honors and demonstrated exceptional ability and potential for future contributions to the specialty of pediatrics.

The Tonya Johnson Memorial Award
In July of 1991, thirteen-year-old Tonya DeSha Johnson died in an accidental shooting in Galveston. Tonya was a bright, sensitive and giving child with a promising future. From an early age, Tonya's dream was to become a pediatrician. Tonya's mother, a pediatric cardiology technician in the Department of Pediatrics, along with various relatives and friends of Tonya have established a memorial fund in Tonya's honor to transform her loss into a positive, life-affirming symbol. The purpose of the Tonya Johnson Memorial Award is to recognize and reward a graduating medical student that intends to enter a pediatric residency and has shown evidence of community service to improve the health and welfare of children who are members of underserved populations. Examples of this type of involvement include, among others, volunteer work at The Ronald McDonald House, the Special Olympics, Children's Diabetic Camps, and special tutoring or literacy volunteer organizations.

A list of nominees for these awards will be issued annually in April by the Clerkship Director. The Pediatric Undergraduate Medical Education Committee will vote on the nominees and the student receiving the majority of the votes from those voting members present will be selected as the award recipients with the approval of the Department Chair. Both awards will be presented by the Department of Pediatrics at the Generational Cup Challenge held each May.

VII. School of Medicine Absence Policy for year 1-4

Absence Definitions
Students are expected to attend all required activities. Each course and clerkship ("course") publishes its required activities. An absence is any instance when a student is not physically present at an activity. Students should not assume they are allowed any absences at their discretion or for their personal convenience. Absences are considered acceptable only when unavoidable, which include two types of circumstances:

A. When unavoidable and **anticipated**, as in a residency interview or presentation at a professional meeting. Students are strongly encouraged to schedule interviews during vacation periods to avoid conflict with scheduled courses.

B. When unavoidable and **unanticipated**, as in personal illness or family tragedy.

Actions Required by the Student
In the event of any of these absences, students must (in advance when anticipated, and as soon as possible when unanticipated):

A. Notify their course/clerkship coordinator and/or director; and

B. Notify their supervising faculty (e.g. facilitator, clinical attending, or preceptor)

Consequences of Absences

A. Absences (for approved reasons listed above) that total no more than three days in a single course are a matter between the student and the course director. For the Practice of Medicine courses, this is defined as three days of absences for the entire academic year. In all cases, the student is responsible for the material missed while absent. At the discretion of the course director, the student may be required to provide documentation of the reason for absence, and be required to complete supplementary assignments to make up for missed activities, but the course is not required to provide repeat or make-up opportunities for missed assignments.

B. Absences for reasons other than those listed above, or failure to report an absence as described above is considered unprofessional behavior and will be reflected in the student's evaluation and may be grounds for failure of the course.

C. Absences (for approved reasons listed above) in any course that exceed three days are a matter that require consultation with the Associate Dean for Student Affairs (ADSA). In the event of excess absences, the ADSA will either:

1. determine that a student must withdraw from the course, which will result in the course assigning a permanent transcript grade of "Withdraw", "Withdraw Passing" or "Withdraw Failing" (any of which requires the student to repeat the course in its entirety); or
2. defer action to the course director who will then either:
    a. require the student to make-up the missed time prior to the end of the course, if feasible;
    b. assign a temporary grade of "Incomplete" (which requires the student to complete remaining course requirements), or

c. assign a grade of "F" (Fail) for the course. A course failure based on excessive absences results in a requirement that the student complete a Professionalism Remediation Program as in addition to repeating the course.

3. Student absences will be tracked longitudinally. The name of any student demonstrating a pattern of multiple absences per course will be forwarded to the Office of the ADSA, who will contact the student and schedule an appointment to discuss the nature of the recurring absences.

Special Circumstances

A. ***Examinations:*** Because of the difficulty in rescheduling examinations, permission to be excused from high-stakes (e.g. mid-term, final, clinical skills) examinations must be obtained in advance from the ADSA, and is limited to reasons of health, personal tragedy, religious holy days (see below), or presentation at a national professional meeting. Although requests for exceptions will be considered on a case-by-case basis, residency interviews, family events and personal travel generally are not considered reasons for missing an examination. A student with an unapproved absence from any examination will receive a grade of zero for the examination**.**

B. ***Other Curricular Requirements:*** It may occasionally be necessary for students to complete curricular requirements while enrolled in another course. Participation in the Year 4 Integrated Curriculum Evaluation Exercise and any other school-based required activities will not be considered a course absence. Other absences, including those for USMLE licensing examinations will count toward the limits specified above.

C. ***Religious Holy Days:*** The Texas Education Code, Section 51.911 provides that students may be absent from class for the observation of a religious holy day. Absences for religious holy days must be excused in advance by the ADSA. The student will be allowed to take a make-up examination or complete assignments from which the student is excused within a reasonable time after the absence as determined by the course director. Such absences will not count toward the limits specified above.

VIII. Holidays

Per UTMB policy, students are guaranteed at least one day off per a holiday weekend, but not necessarily the actual holiday. Thanksgiving is the one exception - Students are excused Thursday through Sunday. The schedule will be distributed at orientation. Medical Students are expected to resume their normal working hours following a holiday, i.e., ascertain who their patients are and prepare to present for morning rounds.

IX. Honor Pledge

"On my honor, as a member of the UTMB community, I pledge to act with integrity, compassion and respect in all my academic and professional endeavors."

X. Code of Conduct

A. What is the Definition of Medical Professional Conduct?

The professional:

1. ***DISPLAYS CONCERN FOR THE WELFARE OF PATIENTS***. e.g., is thoughtful and professional in performing the history and physical examinations; avoids offensive language or gestures; treats patients with respect and dignity.
2. ***DEMONSTRATES CONCERN FOR THE RIGHTS OF OTHERS***. e.g., deals with other members of the health care team in a spirit of cooperation; acts with an egalitarian spirit toward all persons --- encountered in a professional capacity regardless of race, religion, sex, handicap, or national origin.
3. ***IS RESPONSIBLE***. e.g., assumes an appropriate and equitable share of duties among his/her peers; perseveres; is punctual; monitors patients' progress regularly and cares for them with appropriate supervision; responds to emergencies; is immediately available when on duty.

4. ***MAINTAINS PROFESSIONAL INTEGRITY***. e.g., is intellectually honest in communication with others; establishes priorities; recognizes when supervision or advice is needed; maintains confidentiality of information.
5. ***PRESENTS A PROFESSIONAL DEMEANOR***. Maintains a neat professional appearance at all times while on duty; maintains equilibrium under pressures of fatigue, professional stress or personal problems; avoids the use of alcohol while on duty, or the abuse of drugs at all times.

B. What Principles Govern Student-Faculty Professional Conduct?

The Honor Education Council, a student organization promoting awareness and discussion of professional behavior among students and faculty, has prepared the following Statement of Principles Governing Professional Conduct. "As a student at the University of Texas Medical Branch, School of Medicine, I understand that it is a great privilege to study medicine. Over the course of my training, I will assume extraordinary responsibility for the health and well-being of others. This undertaking requires that I uphold the highest standards of ethical, compassionate, and professional behavior. Accordingly, I have adopted the following principles to guide me throughout my academic, clinical, and research work. I will strive to uphold both the spirit and the letter of this Statement of Principles in my years at UTMB and throughout my medical career."

HONOR

- I will maintain the highest standards of academic honesty.
- I will neither give nor receive aid in examinations or assignments unless such cooperation is expressly permitted by the instructor.
- I will be truthful with patients and will report and record accurately all historical and physical findings, test results, and other information pertinent to the care of the patient.
- I will never seek, by action or implication, to create an incorrect impression of my abilities or to create an unfair advantage over my colleagues during evaluations or other procedures.
- I will conduct research in an unbiased manner, report results truthfully, and credit ideas developed and work done by others.

CONFIDENTIALITY

- I will regard confidentiality as a central obligation of patient care.
- I will limit discussions of patients to members of the health care team in settings removed from the public ear.
- I will uphold a classroom atmosphere conducive to learning.
- I will treat patients and their families with respect and dignity both in their presence and in discussions with other members of the health care team.
- I will interact with patients in a way that ensures their privacy and respects their modesty.
- I will interact with all members of the health care team in a considerate and cooperative manner.
- I will neither practice nor tolerate discrimination on the basis of race, gender, religion, sexual orientation, age, disability, or socioeconomic status.
- I will judge my colleagues fairly and attempt to resolve conflicts in a manner that respects the dignity of every person involved.

RESPONSIBILITY

- I will set patient care as my highest priority in the clinical setting.
- I will recognize my own limitations and will seek help when my level of experience is inadequate to handle a situation on my own.
- I will conduct myself professionally—in my demeanor, use of language, and appearance—in the presence of patients, in the classroom, and in health care settings.
- I will not use alcohol or drugs in any way that could interfere with my clinical responsibilities.
- I will not use my professional position to engage in romantic or sexual relationships with patients or members of their families.

INTERACTION WITH FACULTY, RESIDENTS, AND FELLOWS

- I will seek clear guidelines regarding assignments and examinations as well as testing environments that are conductive to academic honesty.
- I will seek prompt, frequent, and constructive feedback from housestaff and attending physicians in order to facilitate my training in medicine.
- I will not be compelled to perform procedures or examinations that are unethical or beyond the level of my training.
- I have the right not to be sexually harassed by those who are supervising my work.
- I have the right to be challenged to learn without abuse or humiliation.

XI. Who is in charge of the Year III Pediatric Curriculum?

Members of the Pediatric Undergraduate Medical Education Committee:

Name	**Extension**
Gayani Silva, M.D., Clerkship Director	21444
Judith Rowen, M.D., Committee Chair	70267
Michael Malloy, M.D.	25283
Richard Rupp, M.D.	22355
Ashraf Aly, M.D.	72821
Shavivah Balachandra, M.D.	20422
William Mize, M.D.	22355
Kwabena Sarpong, M.D.	21444
Valli Annamalai, M.D. Austin Clerkship Director, Dell Children's Medical Center	(512) 324-0165
John Luk, M.D. Assistant Dean for Regional Medical Education	(512) 324-7860

Ex Officio members

Name	**Extension**
Tiffany Swain, Coordinator II	25286
Brian Sullivan, Administrative Coordinator, OCE	70265
Sharon Sanchez, M.D., Chief Resident	22254

Pediatric Clerkship Curriculum

Goals and Objectives of the Pediatric Clerkship

The third year Pediatrics clerkship is designed to complete the students' introduction to Pediatrics by acquainting them with childhood and adolescent diseases and by exposing them to a much greater variety of clinical pediatric problems.

Goals

The goals of the pediatric core curriculum are to foster:

- Acquisition of a basic knowledge of normal growth and development (physical, physiologic and psychosocial) and clinical application of this knowledge in patients of all ages from birth through adolescence.
- Development of communication skills that facilitate the primary care physician's clinical interaction with children, adolescents and their families and thus ensure that complete, accurate historical data is obtained.
- Development of competency in the physical examination of infants, children and adolescents.
- Acquisition of the knowledge necessary for the diagnosis and initial management of common, acute and chronic pediatric illnesses.
- Development of clinical problem-solving skills applicable to all branches of health care.
- An understanding of the influence of family, community and society on the child, both in health and disease.
- Development of strategies for effective health promotion as well as for disease and injury prevention.
- Development of attitudes and professional behaviors appropriate for patient care.
- An understanding of the pediatrician's approach to the health care and overall well being of children and adolescents.

Objectives

At the completion of their Pediatric Clerkship training, third year medical students will be able to:

- demonstrate a basic comprehension of common childhood and adolescent diseases, their diagnosis and treatment;
- demonstrate a basic knowledge of the most frequent clinical, laboratory, roentgenologic and pathologic manifestations of common pediatric diseases;
- understand the normal process of growth and development in children and adolescents and to recognize substantial deviations they are from;
- perform a reasonable and complete, age appropriate history and physical examination in children of all ages;
- have a basic understanding of the more common principles of pediatric health maintenance;
- demonstrate a basic knowledge about common risk factors that contributes to the development of pediatric disease and injury;
- utilize common disease and injury prevention practices, including patient and family education, in reducing the incidence of pediatric disease and injury;
- communicate effectively with pediatric and adolescent patients as well as with their parents or guardians;
- demonstrate a basic knowledge on the more common principles of cost effective pediatric health care management;
- demonstrate compassion and empathy in caring for pediatric patients;
- demonstrate respect for the privacy of pediatric patients and for their dignity as people;
- demonstrate integrity and honesty in all personal and professional activities.

Knowledge

Objectives: By studying the suggested reference texts, viewing online resources, or through clinical contact and interaction with the faculty and housestaff, upon completion of the clerkship the student should be able to demonstrate knowledge of the following areas:

A. ***Well Child Care*** - knowledge shall be demonstrated by being able to:

- Discuss the standard immunization schedule and major contraindications and complications of the various vaccines.
- Discuss the necessary health maintenance procedures at various ages, e.g., hearing screening and vision screening, TB screening, lead screening, etc.

- Discuss the significance of deviations in recorded growth from the standard growth curves.
- Discuss common parental concerns at specific ages including feeding problems, colic, temper tantrums, constipation, and the risk factors for sudden infant death syndrome (SIDS).
- Discuss and create a health and safety plan for the child and family.
- Discuss how to recognize variations in development that require further or continuing attention.
- Identify common dermatological conditions encountered in well child care.

Knowledge in this area may be enhanced by encountering any of the following problems during the clerkship: incomplete immunizations, growth failure, diaper dermatitis, or developmental delay.

B. ***Assessment of Behavior and Development*** - knowledge shall be demonstrated by being able to:

- Recognize the importance in clinical care of the following developmental issues:
  - Infant – changes in reflexes, tone and posture; cephalocaudal progression of motor milestones during the first year; stranger anxiety.
  - Toddler / child – separation and autonomy in two to three-year olds; concept of school readiness
  - Adolescent – sequence of physical maturation and sexual maturity rating (Tanner); stages of emotional development.
- Identify the early signs of mental retardation and cerebral palsy.
- Perform developmental screening as part of the health maintenance visit or inpatient evaluation.
- Summarize the main developmental changes of adolescence that are important to discuss with parents and adolescents.
- Elicit age-appropriate behavioral concerns during the health supervision visit.
- Identify behavioral and psychosocial problems through the medical history and physical examination.
- Discuss the typical presentation of common behavioral problems at various ages and developmental stages (e.g. infant: sleep problems; toddler/preschooler: temper tantrums, toilet training, eating problems; elementary school age: enuresis, attention deficit disorder; middle school/high school: conduct disorders, eating disorders, risk taking behaviors).
- Recognize that somatic complaints may represent underlying psychosocial problems (e.g. recurrent abdominal pain or headaches, chronic fatigue, and neurological complaints).
- Recognize the various situations where pathology in the family contributes to childhood behavior problems (e.g. alcoholism, domestic violence, depression).
- Distinguish between age-appropriate "normative" behavior and significantly "deviant" behavior or psychiatric illness.

Knowledge in this area may be enhanced by encountering any of the following problems during the clerkship: mental retardation, attention-deficit or other learning disorders or delayed language or motor skills.

C. ***Assessment of Growth*** – knowledge shall be demonstrated by being able to:

- Recognize and define short stature.
- Discuss the meaning of primary and secondary growth disturbances.
- Discuss specific growth patterns in children with short stature.
- Discuss the evaluation of infants / children with growth failure.
- Discuss the evaluation of children with precocious or delayed puberty, including menarche.
- Perform and describe the Tanner sexual maturity rating.

Knowledge in this area may be enhanced by encountering any of the following problems during the clerkship: short child, or early/late maturer.

D. ***Assessment of Nutrition*** – knowledge shall be demonstrated by being able to:

- State the calories/kg per day needed for normal growth in infants and small children.
- Identify the major differences between human milk and the various commonly available infant formulas.
- Describe the advantages of breast feeding and recognize potential common difficulties experienced by breast-feeding mothers.
- Recognize factors that contribute to the development of failure to thrive and obesity in childhood.
- Recognize that chronically ill children may have special nutritional needs requiring unique diets, supplements, or feeding methods, and identify ways that these special diets can be an essential aspect of patient treatment.
- Advise families about the dietary prevention and treatment of common pediatric mineral (e.g. iron, fluoride, calcium) and vitamin deficiencies.
- Obtain routine diet histories on infants that include:
  - the type of feeding (breast vs. formula) with amount and frequency,
  - the types and approximate amounts of solids, and
  - the diet supplements given (vitamins, fluoride, iron).

Knowledge in this area may be enhanced by encountering any of the following problems during the clerkship: obesity and failure to thrive.

E. ***Care of the Febrile Child*** - knowledge shall be demonstrated by being able to:

- Describe historical information that is important in the evaluation of a febrile child.
- Describe physical exam findings that are important in the evaluation of a febrile child.
- Describe the clinical conditions that may be potentially life threatening in a febrile child and know how to differentiate them from other less threatening conditions.
- Provide indications for the symptomatic management of fever.

Knowledge in this area may be enhanced by encountering any of the following problems during the clerkship: febrile child or febrile seizure.

F. ***Assessment of the Child with a Severe Infection*** – knowledge shall be demonstrated by being able to:

- Recognize the signs and symptoms of sepsis and meningitis.
- List the primary organisms associated with sepsis and meningitis during the neonatal and the post neonatal period.
- Recognize the signs and symptoms of other severe infections during childhood including septicarthritis, respiratory infections, and urinary tract infections.
- Recognize the signs and symptoms associated with streptococcal, staphylococcal, mycoplasma, chlamydial, and tuberculosis infections.
- Recognize the signs and symptoms associated with the major viral pathogens of childhood including adenovirus, enterovirus, parvovirus, herpes virus, cytomegalovirus, varicella zoster virus, influenza viruses, rubeola, rubella, mumps, Epstein-Barr virus, human herpesvirus 6 (roseola), parainfluenza, and respiratory syncytial viruses.
- Recognize the signs and symptoms associated with pelvic inflammatory disease and other sexually transmitted diseases in adolescents and be able to manage them.
- Recognize the history and physical findings that would cause you to suspect an underlying immunodeficiency.

Knowledge in this area may be enhanced by encountering any of the following problems during the clerkship: Neonatal fever, viral exanthema or vaginal/penile discharge.

G. ***Care of the Child with Acute Respiratory Symptoms*** – knowledge shall be demonstrated by being able to:

- Recognize the signs and symptoms associated with croup and epiglottitis.
- Discuss the common causes of pneumonia in normal infants and children as well as those that occur in the immunocompromised child.
- Recognize the signs and symptoms of common respiratory conditions, e.g., rhinitis, otitis media, croup, epiglottitis, bronchiolitis and asthma, and know the approach to treatment of these problems.
- Identify symptoms and physical findings that suggest allergic disease.

- Discuss the basis and application of therapeutic measures used in specific allergic diseases.

Knowledge in this area may be enhanced by encountering any of the following problems during the clerkship: viral URI, streptococcal pharyngitis, acute otitis media, bronchiolitis, asthma, or pneumonia.

H. ***Assessment of the Child with Cardiovascular Disease*** – knowledge shall be demonstrated by being able to:
- Describe the clinical features that point to the presence of a congenital heart malformation.
- Understand the anatomy and physiology of common congenital cardiac defects.
- Understand the etiology, symptoms and diagnosis of acute rheumatic fever.
- Describe the criteria for establishing a diagnosis of hypertension in a child.
- List the causes of hypertension during infancy and childhood.

Knowledge in this area may be enhanced by encountering any of the following problems during the clerkship: heart murmur or high blood pressure.

I. ***Assessment of the Child with a Suspected Endocrine Disorder*** – knowledge shall be demonstrated by being able to:
- Recognize and discuss the symptoms, diagnosis, and management of type I and II diabetes.
- Recognize and discuss the symptoms and diagnosis of thyroid disease in children.
- Recognize and discuss the symptoms and diagnosis of pituitary disease in children.
- Recognize the presentation and laboratory abnormalities of congenital adrenal disorders.

Knowledge in this area may be enhanced by encountering any of the following problems during the clerkship: diabetes, goiter or pituitary mass.

J. ***Assessment of the Child with Acute Abdominal Pain and/or Diarrhea*** – knowledge shall be demonstrated by being able to :
- Describe the initial information necessary to categorize the severity of the problem and the urgency of response.
- List an age appropriate differential diagnosis that reflects the degree of acuity.
- Describe the criteria for establishing a diagnosis of diarrhea.
- Explain the major risks associated with diarrhea and identify the signs and symptoms that indicate high risk to the patient.
- Select laboratory tests that complement patient management.

Knowledge in this area may be enhanced by encountering any of the following problems during the clerkship: diarrhea or abdominal pain.

K. ***Assessment of the Child with Suspected Genito-Urinary System Disease*** – knowledge shall be demonstrated by being able to:
- Identify clinical features that suggest renal or urinary tract disease.
- Relate historical, physical, and laboratory findings to common renal pathology, including thenephrotic syndrome and glomerulonephritis.
- Recognize clinical situations that mandate urgent intervention or consultation.
- Develop an appropriate management plan for common renal or urinary system problems.
- Recognize the clinical signs and symptoms of sexually transmitted disease among males and females.
- Be able to differentiate normal from abnormal findings on a pelvic exam.

Knowledge in this area may be enhanced by encountering any of the following problems during the clerkship: urinary tract infection, sexually transmitted diseases, proteinuria or hematuria.

L. ***Assessment of the Child with a Suspected Neurologic Disorder*** – knowledge shall be demonstrated by being able to:
- Describe the features of the history and physical examination important to the evaluation of a child with a nervous system complaint.
- Describe the common causes of altered consciousness, weakness, and ataxia in children.

- Describe the clinical features obtained from the history and physical examination that indicate the need for immediate intervention or early consultation for a neurological condition.
- Describe the different types of seizure disorders in children.

Knowledge in this area may be enhanced by encountering any of the following problems during the clerkship: headache complaint or seizure disorder.

M. ***Assessment of the Child with a Fluid and/or Electrolyte Disorder*** – knowledge shall be demonstrated by being able to:

- Describe the physiologic processes that maintain fluid and electrolyte homeostasis.
- Identify the clinical signs and symptoms that suggest abnormalities of fluid and electrolyte balance.
- Select the laboratory procedures appropriate to clarify the clinical findings.
- Recognize clinical situations that mandate urgent intervention or consultation.
- Apply physiologic principles to the development of a fluid and/or electrolyte management plan.
- Describe a monitoring plan for assessing the efficacy of treatment plan.

Knowledge in this area may be enhanced by encountering any of the following problems during the clerkship: oral rehydration, edema or dehydration.

N. ***Assessment of the Child with a Suspected Hematologic / Oncologic Disorder*** – knowledge shall be demonstrated by being able to:

- Describe the findings from the history, physical exam and blood count that suggest a hematologic disorder.
- Describe the laboratory findings associated with various types of anemia.
- Recognize the historical, physical and laboratory findings associated with a bleeding disorder.
- Describe the findings from the history and physical exam that suggest malignant disease.
- Select procedures that assist in the diagnosis of a malignancy.

Knowledge in this area may be enhanced by encountering any of the following problems during the clerkship: anemia or leukemia.

O. ***Assessment of the Child with Suspected Acute Poisoning*** – knowledge shall be demonstrated by being able to:

- Describe the history and physical examination findings in common childhood poisonings.
- Describe management measures essential to sustaining a child during a diagnostic evaluation for acute poisoning.

Knowledge in this area may be enhanced by encountering any of the following problems during the clerkship: patient with ingestion or contact with the Poison Control Center.

P. ***Care of the Child with an Abusive Home Situation or an Emotional Disorder*** – competency shall be demonstrated by being able to:

- Discuss the clinical findings associated with psychosocial deprivation and/or physical abuse.
- Recognize the historical information and clinical signs that may indicate an abusive home situation.
- Provide information to families on community resources available for evaluating abusive home situations.
- Discuss common behavioral problems including attention deficit-hyperactivity disorder, school phobias, illicit drug use, drinking alcohol, smoking, and adolescent sexual activity that may occur among children from an abusive home situation.

Knowledge in this area may be enhanced by encountering any of the following problems during the clerkship: physical abuse or neglect.

Q. Care for the Child in Pain or with a Terminal Illness – competency shall be demonstrated by being able to:

- Prescribe age appropriate and situation appropriate medications for an infant or child experiencing pain.
- Counsel families on the common stages of grief associated with the impending or accomplished death of an infant or child.

Knowledge in this area may be enhanced by encountering any of the following problems during the clerkship: hospice care or chronic pain.

Pediatric General Curriculum

(See Appendix B for Newborn Nursery Core Curriculum)

Skills:
The development of competent clinical skills depends and builds upon prerequisite knowledge and skills acquired during the preclinical years which 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.
- Basic clinical organization and problem solving skills.

This basic knowledge will be refined in five general skill areas that will be introduced and reinforced during the pediatric clerkship: conducting an interview, performing a physical exam, communicating information, identifying and solving clinical problems, and developing an initial diagnosis and therapeutic plan. These are fundamental competencies and will be taught in some form in all the third year clerkships. Aspects of these skills that are unique to pediatrics are identified in the curriculum. The development of competent clinical skills requires practice and supervision with feedback.

Skill Objectives:

A. ***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 and 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. Initially, 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, noting the increased reliability of obtaining information directly 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 a relevant history that is unique to pediatrics in addition to the standard medical history.
   a. Past History:
      1. 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 prematurity, respiratory distress, jaundice and infections.
      2. Immunizations
      3. Development, noting the importance of assessing developmental milestones in evaluating the health of the child.
      4. Diet, noting the importance of assessing the amount, type, and method of infant feeding.
   b. Family History:
      Number and ages of siblings; consanguinity, known genetic disorders, early childhood deaths, cardiovascular disease, depression and alcohol abuse.
   c. Social History:
      Assessment of the home environment, school and peer relationships.
   d. Review of Systems:
      1. The relevant items are limited, but expand as the patient's age increases.
      2. 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, and adolescent.

B. ***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. Use developmental assessment as part of the physical examination for all ages.
7. Observe how normal behaviors, such as stranger anxiety, affect the ability of the examiner to perform the examination, and develop strategies for improving rapport.
8. Identify the physical changes of puberty and be able to conduct Tanner staging
9. Observe and demonstrate physical exam findings unique to the pediatric age group, and understand how findings have different clinical significance depending on the age of the child. Some examples are:
   a. Appearance –
      1. recognize signs of acute illness in an infant 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, including behavior, development, body habitus (height, weight, body fat), relationship to parents and examiners, and general condition.
   b. 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.
   c. Measurements –
      1. accurately measure height, weight and head circumference;
      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.
   d. HEENT –
      1. identify the anterior and posterior fontanels and assess them for fullness or turgor;
      2. recognize the need for careful observation of the head size and shape, symmetry, facial features, ear size and hair whole as part of the examination for dysmorphic features;
      3. recognize the red reflex and strabismus;
      4. assess hydration of the mucous membranes; and
      5. examine the tympanic membrane using pneumatic otoscopy.
   e. Neck –
      1. palpate lymph nodes, know what anatomic areas they drain;
      2. know that lymph nodes are more prominent during childhood; and
      3. recognize and demonstrate maneuvers that test for nuchal rigidity.
   f. Chest –
      1. recognize how the rate and pattern of respirations change with age, and that abdominal respirations are normal in infants;
      2. observe the rate and effort of breathing as a measure of respiratory distress;
      3. recognize stridor, wheezing and rales and be able to distinguish between inspiratory and expiratory obstruction; and
      4. interpret less serious respiratory sounds such as transmitted upper airway sounds.
   g. Cardiovascular –
      palpate pulses in the upper and lower extremities and auscultate the heart for rhythm, rate, quality of the heart sounds and murmurs.
   h. Abdomen –
      1. understand that the liver edge, spleen tip and kidneys may be palpable in the normal newborn;
      2. examine the umbilical cord for signs of infection;

3. examine the abdomen for distention, 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; and
4. be able to do a rectal examination and recognize when it is indicated.

i. Genitalia –
1. recognize the appearance of normal male and female genitalia in the newborn;
2. recognize abnormalities, including cryptorchidism, hypospadias, testicular mass in the male;
3. be able to examine the external genitalia of a female patient, and
4. recognize the need for privacy at all ages.

j. Extremities –
1. examine the hips of a newborn for dysplasia;
2. recognize arthritis; and
3. evaluate gait and limp.

k. Back –
know how to test for scoliosis.

l. Neurologic examination –
1. elicit primitive reflexes;
2. assess tone, gait, strength and reflexes, recognizing the importance of symmetry;
3. assess development milestones; and
4. recognize that much of the neurologic examination of infants and children is accomplished through observation alone.

m. Skin –
1. 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;
2. recognize common skin findings associated with child abuse; and
3. assess skin turgor.

C. *Communication*

1. Communication with the patient and/or family.
   a. Establish rapport with the patient and family.
   b. Identify the primary concerns of the patient and/or family.
   c. 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.
   d. Provide anticipatory guidance during health maintenance visits, including the newborn nursery visit.
   e. Recognize the important role of patient education in management of acute and chronic illnesses.

2. Written communication skills
   a. Write a complete summary of the history and physical examination in a timely manner which is suitable to place in the patient's chart.
   b. Outline the different formats for documenting the history and physical examination which may be used in different clinical settings.
   c. Write admission orders for a hospitalized patient.
   d. Write a prescription.

3. Oral communication skills
   a. Present a complete well organized summary of the findings of the patient's history and physical examination, modifying the presentation to fit the situation.
   b. Communicate effectively with other health care workers, including consultants, nurses and social workers.
   c. Explain the thought process that led to the diagnostic and therapeutic plan.
   d. Use precise descriptions of physical findings and avoid vague terms and jargon, such as "clear" and "WNL".

D. ***Clinical Problem-Solving***

1. Develop a complete problem list and a differential diagnosis for each problem; combine problems where appropriate to develop a differential diagnosis for the patient's unique combination of symptoms.
2. Use knowledge of key signs and symptoms and the frequency and prevalence of diseases at different ages when developing a differential diagnosis.
3. Formulate an initial diagnostic and therapeutic plan, considering the cost, risks, benefits and limitations of laboratory tests, imaging studies, medications, consultations, hospitalization, and more conservative measures such as observation.
4. Interpret the results of commonly ordered laboratory tests, such as the CBC urinalysis, and serum electrolytes, and recognize that the normal values of some tests may vary with the age of the patient.
5. Use the pediatric literature to research the diagnosis and management of clinical problems.
6. Develop critical thinking skills and the ability to use scientific evidence in making clinical decisions.
7. Recognize that physicians work in collaboration with other care providers in both the medical center and the community, including the schools. Public Health Department, social service agencies and the Child Protective Service.

Pediatric Clerkship Checklist

Guidelines for the use of the checklist:

A. This checklist provides the student with a list of skills that should be accomplished or observed during the clerkship. An (*) beside the skill indicates that this skill is a required task that must be accomplished during the clerkship.

____ *Observed History & Physical Exam by Faculty or PGY-3 resident
____ *Observed Newborn Physical Exam (during nursery week)
____ *Written H&P with assessment, plan and feedback #1
____ *Written H&P with assessment, plan and feedback #2
____ *Written H&P with assessment, plan and feedback #3

Two of the written H&Ps should be completed while on the Inpatient Team and one while on your subspecialty rotation (Austin students will complete all 3 on inpatient). Written H&Ps are used by the attendings as part of their assessment of you. ***Give them to your attending promptly. They must be given to your attending before the end of your secondary/tertiary block.*** Your attending (NOT your resident) should provide written feedback, and all 3 H&P's need to be turned in to the clerkship coordinator.

__ Dubowitz exam 1	__Newborn Physical exam 1	__Intraut growth plot 1
__ Dubowitz exam 2	__Newborn Physical exam 2	__Intraut growth plot 2
__ Dubowitz exam 3	__Newborn Physical exam 3	__Intraut growth plot 3
__ Dubowitz exam 4	__Newborn Physical exam 4	__Intraut growth plot 4
__ Dubowitz exam 5	__Newborn Physical exam 5	__Intraut growth plot 5
__ Dubowitz exam 6	__Newborn Physical exam 6	__Intraut growth plot 6
__ Dubowitz exam 7	__Newborn Physical exam 7	__Intraut growth plot 7
__ Dubowitz exam 8	__Newborn Physical exam 8	__Intraut growth plot 8
__ Dubowitz exam 9	__Newborn Physical exam 9	__Intraut growth plot 9
__ Dubowitz exam 10	__Newborn Physical exam 10	__Intraut growth plot 10

__ Written fluid orders
__Observe IV being started or start IV in an older child
__ Drawing blood (Pt > 10 yrs.)
__Observe Urinary Catheterization
__ Observe lumbar puncture

B. The written history and physicals, web cases (Design-A-Case), morning report peer evaluation, observed history and physical exam and newborn physical exam must be completed by the end of the rotation. Failure to complete these requirements in a timely manner will result in an incomplete and possibly failure of the course unless arrangements are discussed with the clerkship director **before** the end of the rotation.

C. The Liaison Committee on Medical Education (LCME) wants us to insure and document that all students see a minimum number of a variety of patient problems. Therefore, you are required to complete the Case Logger in New Innovations. The table associated with the log reflects a consensus on the type of patients a student should see, the setting, and level of student involvement during the clerkship experience.

HOW TO ENTER CASE LOGS

A. Go to **Main > Case Logger > Add Case Logs**

B. Select the **rotation** name. Procedures and diagnoses displayed are based on the **rotation requirements**, if any.

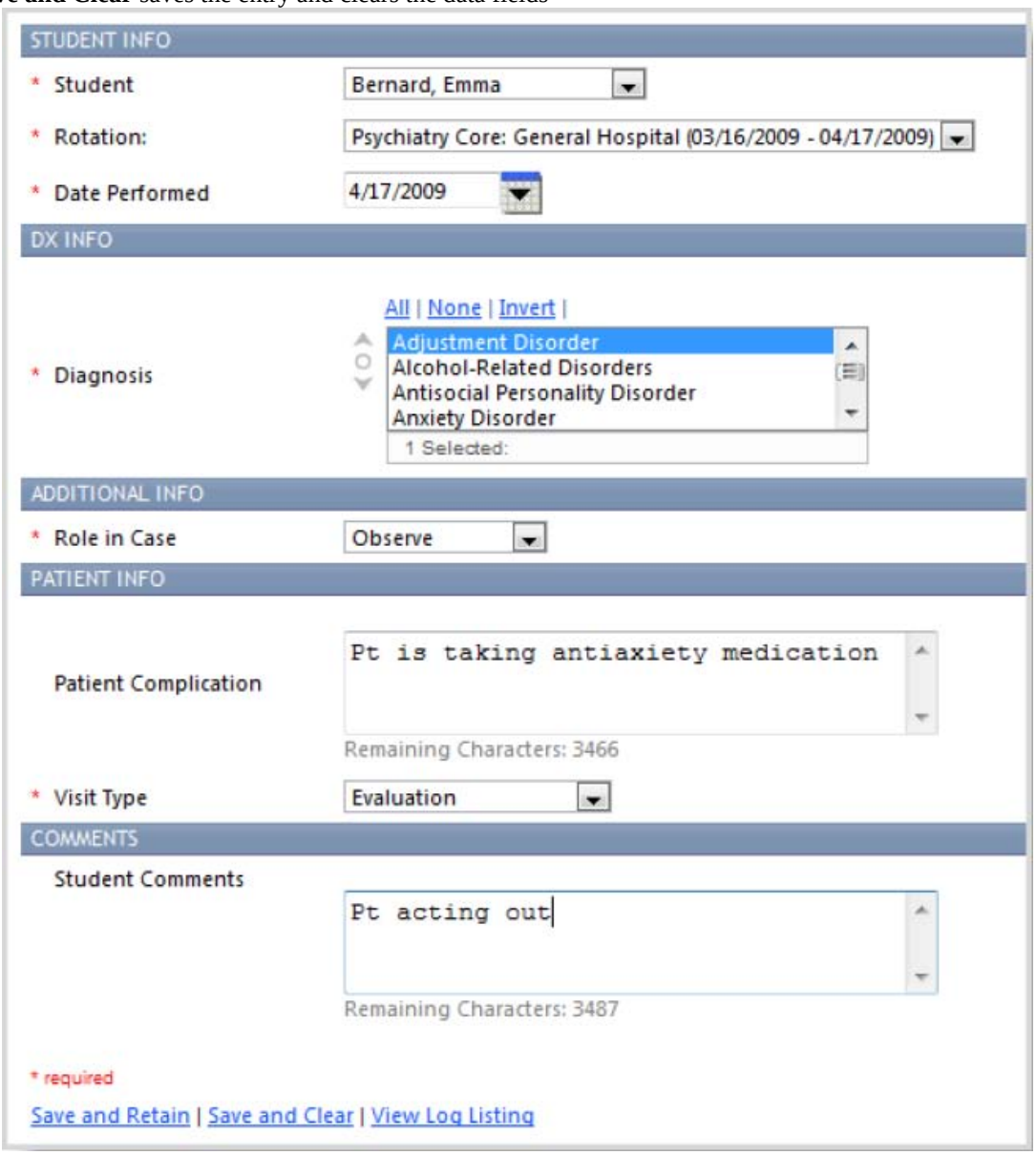
C. Enter the **date** the procedure was performed

D. Continue to complete each field provided on the page. This may vary from clerkship to clerkship depending on the data that is to be collected. *Required fields are designated with the red asterisk.*

E. Procedures and diagnoses may have a **Target number and requirements** configured.

F. Choose a save method at the bottom of the page

1. **Save and Retain** saves the entry and retains the data entered in each field so the user can continue to enter logs for this patient encounter
2. **Save and Clear** saves the entry and clears the data fields



Case Logger Information Table

This table reflects the consensus on the type of patients a student should see, the setting, and level of student involvement during the clerkship experience.

Table Key: Level of Participation
OB = Observation (Clinical Reasoning Only)
PP = Partial Participation (Hx or PE)
FP = Full Participation

Table Key: Clinical Setting
O = Outpatient
I = Inpatient
N = Nursery

Domain-patient type /core condition	Symptom, sign, or concern	Examples of diagnosis or issue addressed	# Of Pts. Required	Level of participation	Clinical Setting
Health Maintenance	Well Child Care	Newborn (0-1 month)	10	PP, FP	O, N
	Well Child Care	Infant (1-12 months)	10	PP, FP	O
	Well Child Care	Toddler (12-60 months)	10	PP, FP	O
	Well Child Care	School age (5-12 yrs.)	5	PP, FP	O
	Well Child Care	Adolescent (13-19 yrs.)	2	OB, PP, FP	O
Growth	Parental concern or abnormalities related to the domain.	* FTT * poor weight gain * short stature * microcephaly/ macrocephaly * constitutional delay * small/ large for gestational age	2	PP, FP	O, I
Nutrition	Parental concerns or abnormalities related to the domain	* FTT * breast vs. formula feeding * questions about switching to formula * when to add solids * beginning cow's milk * diet	10	PP, FP	O, I
Development	Parental concerns or abnormalities related to the domain	* delayed or possibly delayed language * gross motor skills * fine motor skills * social adaptive skills	2	OB, PP, FP	O, I
Behavior	Parental concerns or abnormalities related to the domain	* sleep problems * temper tantrums * feeding problems * ADHD * autistic spectrum disorder * poor school performance * colic * toilet training * enuresis * encopresis * eating disorders * head banging	10	PP, FP	O, I

Table Key: Level of Participation
OB = Observation (Clinical Reasoning Only)
PP = Partial Participation (Hx or PE)
FP = Full Participation

Table Key: Clinical Setting
O = Outpatient
I = Inpatient
N = Nursery

Upper Respiratory Tract	Sore throat, difficulty swallowing, otalgia	* pharyngitis * viral URI * peritonsillar abscess * otitis media * otitis externa * strep throat * herpangina * common cold * allergic rhinitis * sinusitis	5	FP	O, I
Lower Respiratory Tract	Cough, wheeze, shortness of breath	* bronchiolitis * pneumonia * asthma * bronchitis * aspiration * bronchiectasis	5	OB, PP, FP	O, I
Gastrointestinal Tract	Nausea, vomiting, diarrhea, abdominal pain.	* gastroenteritis * pyloric stenosis * HSP * gastroesophogeal reflux disease * giardiasis * appendicitis * peptic ulcer disease	2	PP, FP	O, I
Dermatologic System	Rash, pallor	* viral rash * eczema * contact dermatitis * thrush * seborrheic dermatitis * scarlatina * urticaria * toxic shock * atopic dermatitis * acne * anemia	5	PP, FP	O, I
Central Nervous System	Lethargy, irritability, fussiness, headache	* meningitis * seizures * closed head injury * concussion * ataxia * headache	1	OB, PP, FP	O, I
Emergent Clinical Problem	Respiratory distress, shock, ataxia, seizures, airway obstruction, apnea, proptosis, suicidal ideation, trauma, cyanosis	* meningitis * testicular tortion * SIDS * congestive heart failure * status asthmaticus * encephalitis * shock * DKA * (ALTE) acute life threatening event *burns * status epilepticus * child abuse	1	OB, PP, FP	O, I
Chronic Medical Problem		* seasonal allergies * cerebral palsy * diabetes mellitus * epilepsy * obesity * malignancy * asthma * cystic fibrosis * sickle cell disease * atopic dermatitis * HIV /AIDS * sensory impairment	5	PP, FP	O, I

Table Key: Level of Participation
OB = Observation (Clinical Reasoning Only)
PP = Partial Participation (Hx or PE)
FP = Full Participation

Table Key: Clinical Setting
O = Outpatient
I = Inpatient
N = Nursery

Unique Condition: fever w/o localizing findings	Fever	* rule out sepsis * urinary tract infection * systemic viral infection (e.g. EBV) * autoimmune diseases	2	OB, PP, FP	O, I
Unique Condition: neonatal jaundice	jaundice	* jaundice	2	OB, PP, FP	O, I, N
Musculo-skeletal complaint	Limp, pain, limitation of motion, stiffness.	* trauma * infection * inflammation * overuse	1	PP, FP	O, I

Format for History and Physical

(See example at end of Appendix A)

CHIEF COMPLAINT:

INFORMANT:
Child, mother, foster parent, etc.

REFERRING PHYSICIAN:

HISTORY OF PRESENT ILLNESS:
Begin with identifying data: age, race, sex, hometown. Then discuss the illness: symptoms, duration, sequence, previous treatment (including dosages), etc.

PAST MEDICAL HISTORY:

Prenatal problems with pregnancy - Was it a planned pregnancy? ETOH, tobacco, other drugs, illnesses, complications.

Birth history - Type of delivery, complications, duration of labor, birth weight, problems in nursery, age baby went home.

Immunizations – "Up to Date" isn't sufficient information; list those given and indicate if the actual immunization record was reviewed. Ask about specific immunizations, such as yearly flu shots, Pneumovax in susceptible populations, etc.

Allergies – indicate reactions

Serious illnesses, hospitalizations, surgeries

DEVELOPMENTAL HISTORY AND CURRENT DEVELOPMENTAL LEVEL:
"Appropriate" isn't enough information – list what the child can and cannot do if you have inquired about these skills.

FAMILY HISTORY:
Get history of miscarriages, stillbirths, early deaths, any congenital diseases (bleeding disorders, mental retardation, etc.).

SOCIAL HISTORY:
Remember that children exist as part of a family.

Who lives in the home?

Who is the primary caretaker for the children?

Where does the money come from to support the family?

If school-aged, include their level, type of classes they are in, any problems, friends, outside activities, etc.

If adolescent, include risk-taking behaviors such as sexual activity, drug use, seat belt use, etc.

REVIEW OF SYSTEMS:
Appropriate for the age of the child.

PHYSICAL EXAMINATION:
Begin with general appearance, hydration status if appropriate, activity, etc.

Vital signs - normal for age?

Height, weight, head circumference with percentile for age. Consider BMI and BMI percentile in older children and any child with an apparent growth disturbance (failure to thrive or obesity).

Be sure to plot growth parameters on appropriate chart.

ASSESSMENT:
List and discuss the patient's problems. Don't forget to address social and developmental issues.

PLAN:

Discuss how you plan to approach the diagnosis and treatment of the patient.

NOTE THAT THE ASSESSMENT AND PLAN ARE TWO SEPARATE PARTS OF THE RECORDED H & P.

Sample History and Physical

S:

CC: painful nodular rash on lower legs, fever of unknown origin

INFORMANT: Self and Mother of child

PCP: Dr. Smith

HPI: 14 y/o Vietnamese female was admitted from the UTMB ED secondary to fever of unknown origin and nodular leg rash on anterior tibia that is unresponsive to PO Abx. The rash began approximately 3 weeks ago at the ankles then progressed to the knees up the front of the legs. The patient described the rash as tender to the touch and red but not painful enough to limit her normal daily activity, except during martial arts class. During the first few days of the rash, the patient describes having a headache and nausea (without vomiting) that resolved by the fourth or fifth day and has not recurred. Approximately one week after the rash began, the patient began having fevers in the afternoons that would resolve by 9pm in the evening with a max temperature of 101.8°F. The patient began taking Tylenol for the fevers every 4 hours. The patient did not take anything for the rash until 8 days ago when she went to her Family practitioner who prescribed Gatifloxacin 400 mg QD (now on day #8/12). The patient describes some improvement over the first few days of the Abx but it since has returned. The patient denies recent sx of URI including cough, runny nose, sore throat, or congestion. The patient also denies other symptoms of abdominal pain, diarrhea, vomiting, joint pain, musculoskeletal pain, dysuria, hematuria, vaginal discharge, bleeding, easy bruising, or other problems. Patient did note that her urine is darker yellow than usual and smells different. The patient denies sick contacts, contact with tuberculosis, or recent travel. She did mention that her parents traveled to Vietnam last summer, but neither have ever had prolonged cough, or treatment for tuberculosis or lung infection to her knowledge. Everyone in her household currently has been well recently. The patient denies trauma. She denies sexual activity, reached menarche at 12 y/o and her LMP began on 10/12/01. The patient denies OCP use. The patient denies any previous episodes of the rash and does not know of anyone with similar symptoms. The patient has not had contact recently with any pets including kittens or puppies or experienced bug bites or exposure to insects.

BIRTHHX: SVD born FT in Vietnam, hospital name not known. The mother reports (by telephone interview) that she had no problems during pregnancy including no infections, gestational diabetes or other notable problems. The baby went home with the mother and experienced no difficulties post-partum.

PMH: Hospitalization at UTMB at 8 y/o for vaginal trauma 2° to injury sustained falling on a headboard. Patient has not had recurrent problems from the incident. Patient reports no other hospitalizations or major illnesses. Patient denies lung infections, UTI's, or other problems.

PSH: Denies any surgical history

MEDS: Gatifloxacin 400mg PO QD x 12 days (currently day 8/12)
Tylenol q4° prn for fever

ALLERGIES: NKDA

IMMUNIZATIONS: Up to date per child and mother, had last booster doses this year

DEVELOPMENTAL HX: Developmentally appropriate – in appropriate grade at school, communicates well, is active in sports, and does well in school

SH: Patient lives in _____ with mother, father, 4 sisters (age 19, 12, 9, and 5) and one brother (age 8). The oldest sister recently (1 week ago) was hospitalized for drug OD. Parents help a relative run a small grocery store. The patient is in the 9th grade and has not missed any grades. She does well in school (straight A's) and is active in tennis and martial arts. The patient denies sexual activity, alcohol use, tobacco use, or illicit drug use. There are no pets in the home. One sister smokes in the household, but she has recently been hospitalized

DIET: The patient eats foods from all 4 food groups.

FH: Pat gma- DM type 2; sister – heart murmur; no history of lung disease, rheumatic disease, other infectious diseases, cancer, or other problems.

ROS: per HPI, normal bowel movements daily with occasional constipation and no diarrhea

O:
T: 35.5 °C PO **HR:** 67 **BP:** 95/59 right arm, sitting **RR:** 18
Weight: 52.6kg (60%ile) **Height:** 170 cm (92%ile)

Gen: AxOx3, NAD, pleasant and cooperative

Skin: erythematous nodular rash on anterior tibial aspects with approximately 1 dozen raised erythematous, tender, not sharply marginated 1-3 cm in diameter each per leg (bilateral but not uniform) with some diffuse raised erythematous areas around the ankles; one raised area on the left arm dorsally approximately ½ way down the forearm that measures ½ cm in diameter

HEENT: NCAT. MMM. No pharyngeal erythema or petechaie. No aphthous ulcers. Good dentition. TM clear bilaterally with no fluid, bulging, erythema or indications of infection, good landmarks. Nares patent without erythema or d/c. PERRL and EOMI.

Neck: supple. FROM. One 1cm right anterior chain lymph node TTP at angle of mandible that is firm but mobile; no other LAD detected; no other masses or thyromegaly. No meningeal signs.

CV: RRR without M/G/R. Normal S1 and physiologic split of S2.

Pulm: CTA bilaterally without W/R/R

Abd: + bowel sounds in all quadrants, soft, NT/ND. No HSM or masses. No CVA tenderness noted.

GU: Tanner stage IV, no genital sores or rashes.

Ext: Bilaterally lower extremity erythematous nodules as described under skin. Normal strength 5/5 in all extremities. 2+ pulses x4. No C/C/E. Capillary refill <2 seconds.

Neuro: CN II-XII intact. Normal reflexes.

LABS/TESTS:CBC: wbc: 8.5/ hbd: 11.8/ hct: 37.4/ plt 408 ⇑⇑⇑⇑⇑ MCV=82

ESR: 113 ⇑

Total bili: 0.3Albumin: 3.5
LFT's: wnl except GGT 39 ⇑ (slight)
Rapid strep test: negative. Cx- pending
CXR- lungs clear. Heart nl size. Dextroscoliosis of the mid thoracic spine noted.
ASO titer: pending

A/P:
ASSESSMENT: 14 y/o Vietnamese female with no significant PMH or recent infections is admitted from the ED with bilateral anterior tibial nodular erythematous rash and periodic daily fevers. The rash is suspicious for erythema nodosum of unknown origin x 3 weeks and periodic fever x 2 weeks. Patient also has one tender lymph node TTP on anterior cervical pain.

For the most unique presenting feature, erythema nodosum, the list of causes include viral (EBV, HBV), bacterial (Group A Strep, 1° TB, Yersinia, and cat-scratch disease caused by Bartonella henselae, lymphogranuloma venereum), fungal (coccidiomycosis, histoplasmosis), other (sarcoidosis, inflammatory bowel disease, SLE, Behcet's disease, spondyloarthropathy), drugs (estrogen containing OC's, sulfonamides, phenytoin), or other unknown causes oridiopathic (up to 40%). Given the child's history the GAS, cat scratch, and lymphogranuloma venereum are unlikely because the child has

no recent pharyngitis or URI, no exposure to pets or scratches by any animals and is not sexually active or have any physical signs or symptoms for GU exam. Both fungal causes are less likely due to the child's lack of respiratory symptoms, location, lack of travel and normal chest x-ray. The other causes, including sarcoidosis, are unlikely given history and normal chest x-ray. IBD is less likely due to history of no GI complaints other than occasional constipation and no diarrhea and no family history of bowel disease, although this cannot be ruled out as a cause. SLE is less likely and at the current time does not meet adequate diagnostic criteria. Given the history lacking joint complaints, photosensitivity, oral ulcers, malar rash, discoid rash or any of the other complaints consistent with lupus, this diagnosis is less likely. Labs should be ordered including ANA (as a general screen, + in >95% with SLE) to consider this further. Spondyloarthropathies are less likely due to lack of joint involvement based on history and physical exam.

Drug causes are highly unlikely since the child and parent report no history of the child using these medications. Viral causes and idiopathic causes are still high on the list, although HBV is less likely due to immunization, reported lack of exposure, normal LFT's, and lack of physical signs of liver involvement. EBV cannot yet be ruled out and titers should be ordered. Additionally idiopathic causes are a big possibility if no other source is found. Most cases of erythemanodosum, depending on the cause, will resolve spontaneously in approximately 6 weeks.

The differential diagnosis for the fever is likely smaller given the concurrent onset of the erythema nodosum- since they are likely due to a related cause. Even still a general search for some of the causes of fever of unknown origin including CBC, blood culture, and UA with culture should be explored to look for general signs of viral and bacterial etiologies of the fever. The patient has no meningeal signs and no signs of URI and only some vague complaints of concentrated urine recently. LP is not warranted in this child at this time and the work-up for erythema nodosum should be explored first to discern the source of the fevers.

The lymphadenopathy (unilateral) in the anterior cervical chain is most likely also related to the cause of the erythemanodosum. The differential for this includes many of the same causes such as EBV, HBV, CMV, cat scratch, group A streppharyngitis, SLE, rheumatoid arthritis, sarcoidosis, Kawasaki disease, leukemia or lymphoma, and other much less common causes. Again the work-up should begin with a search for the sources of those causes related to the erythemanodosum and then progress to the less common and less likely causes.

PLAN: Admit to inpatient service:

1. Erythematous rash –
   - Ice to lower extremities bilaterally prn
   - Throat cx
   - Monospot
   - EBV titer
   - Chem. 7/60
   - Rheumatoid factor
   - ANA (look for titer >=1:80)
   - Rheumatology consult
   - Ibuprofen 600 mg q6° for control of inflammation
2. Fever-
   - continue Ibuprofen 600 mg q 6° (for fever as well)
   - monitor for change in neuro status
   - vitals q4 hours
   - UA and cx (clean catch)
   - Encourage fluid intake
   - Monitor I/O's
3. Anterior cervical lymphadenopathy-
   - see work-up for erythema nodosum

This H&P was adapted with very minor changes from one completed by Kari Gillenwater, MSIII in 2001.

Oral Presentation Rating Scale

The following oral presentation rating tool will be used throughout the clerkship to evaluate student's oral presentations. Students are encouraged to use this tool for self evaluation and peer evaluation.

ORAL CASE PRESENTATION RATING SCALE (Adapted from a form from the University of Maryland)

ORAL CASE PRESENTATION RATING SCALE

STUDENT NAME:	EVALUATOR	DATE:

1. History: Introductory statement (IS) includes patient's age, sex, and chief complaint or reason for admission in one sentence without extra information

1	2	3	4	5	Questions/Comments
No IS or CC		Included IS, CC and most relevant information		Painted a clear picture of patient	

2. HPI is organized so that chronology of important events is clear

1	2	3	4	5	Questions/Comments
Sequence unclear		Major events sequenced		All events sequenced	

3. The PMH, FH, SH, and ROS include only elements related to active medical problems

1	2	3	4	5	Questions/Comments
Information not clearly connected to problems		Active medical problems adequately described		Active problems completely & concisely described	

4. Physical Exam begins with a general statement (GS), vital signs (VS) and growth parameters

1	2	3	4	5	Questions/Comments
GS poor or missing/ VS incomplete		Mostly clear GS/ VS mostly complete		Succinct GS/ VS appropriately given	

5. Includes a targeted physical exam stating the positive/ negative findings that distinguish the diagnoses under consideration and any other abnormal findings

1	2	3	4	5	Questions/Comments
Too much or too little information given		Most important information is given		All important elements of PE given	

6. LAB data: Organizes lab data and results of other diagnostic tests to distinguish between possible diagnoses

1	2	3	4	5	Questions/Comments
Irrelevant test results presented or significant results omitted		Either minor omissions or a few extra results included		All relevant results relevant presented	Check here if no labs/tests available: ☐

7. Provides an appropriate differential diagnosis (DDX) for each problem, appropriately prioritizes problems

1	2	3	4	5	Questions/Comments
No DDX given and/or focuses on trivial problems		DDX given with several possibilities / most important problems are prioritized		Extensive DDX given, problems all appropriately prioritized	

8. States the diagnostic/therapeutic plan that targets each problem

1	2	3	4	5	Questions/Comments
plan not related to the problem list		Plan addresses most important issues / may omit active but lower priority problems		Plan is complete, relates directly to problem list; all active issues included	

9. At the end of the presentation I had a clear picture of this patient's situation

1	2	3	4	5	Questions/Comments
Much ambiguity remained		The picture was clear for the major issue(s)		The picture was complete and all issues were clear	

10. Speaking style

1	2	3	4	5	Questions/Comments
Difficult to understand		Mostly understandable		Understandable and engaging	

11. Able to answer questions during and immediately following presentation

1	2	3	4	5	Questions/Comments
Unable to answer		Moderately able to answer		Answers questions fully/responsively	

12. Overall assessment of presentation

1	2	3	4	5
Needs significant help	Needs some help	Mostly on target	Above expectations	Well above expectations

May 2011. J Rowen, MD, G Silva, MD and Clerkship Directors, Univ. Texas Medical Branch. Adapted from work of Linda Lewin MD, , Univ. Maryland School of Medicine.

Additional Comments:

Ward Responsibilities

Students assigned to the pediatric hospital units are expected to follow each patient assigned to them and to be involved in the care, management and decision-making process. Each student should also be familiar with all other patients on the team.

Duties include

- Examining each of your patients prior to morning rounds.
- Checking the patient's chart and being aware of any overnight problems.
- Determining, where appropriate, intake, output, calories.
- Checking any outstanding lab reports prior to morning rounds.
- Presenting succinctly on morning rounds, including an opening sentence that gives the patient's age, sex and diagnosis; overnight problems and decisions; pertinent physical examination; pertinent laboratory results; assessment of current problems; plan for the day.
- Being available to care for your patients, and making sure your resident team leader knows where to find you.
- Examining your patient prior to afternoon rounds.
- Being ready to succinctly present your patients (including new patients) in afternoon rounds.
- Checking out with the student on call for your team any anticipated problems or labs that need to be done that night.
- Not leaving for the day until you have checked out with the residents on your team for any work that needs to be done for your patients.

Evening Work

In Galveston, between duties, the on-call student may relax in the team room or residents' lounge. Students must remain on campus and available during evening duties. Students may exchange evenings within the same service, but not across services. For example, a student on the Inpatient Service with ward duties on Friday night may exchange with another student on the Inpatient Service who has ward duties on a Tuesday night. The student could not exchange with a student who has call on the Nursery Service. Students complete evening duties at 10 pm. The student on evening duty needs to write "on-call" notes in the progress note section of the charts of patients he/she is called to see at night. Be sure to identify the resident on call with you, and be sure he/she can reach you. Call/evening work in Austin is handled similarly. Austin students will receive more information about the call schedule at orientation.

Scrubs

Scrubs must be worn in the newborn nursery and ISCU. You must wear street clothes in and change into your scrubs once in the newborn nursery and ISCU. You must change back into street clothes if you are leaving the building for any reason and back into scrubs when you return.

Evening Activities Include

- Participation in the afternoon checkout as an observer, making note of work that must be followed upon through the evening
- Participation in initial evaluation (history and physical, formulation of differential diagnosis, development of plan for evaluation/management) of patients admitted during evenings on duty
- Taking "first call" with intern for all floor problems
- Assisting with all procedures
- Facilitating communication between lab, x-ray and floor
- Providing ongoing assessment of all floor patients in conjunction with the intern
- Assisting in gathering all information that has been checked out by the team

Educational benefits include

- Participation in initial assessment of all admissions to become familiar with information gathering and decision making
- Participation in order writing
- Participation in all discussions about the patient that occur, to become conversant with areas for discussion in rounds and to direct areas of further reading

Progress Notes

Patients should have a daily progress note written by a medical student. Acutely ill patients may need more than one note per day. These should be concise, and contain pertinent information about the care of the patient.

New Patients

New patients are assigned to students on a rotating basis. The student who will take the admission needs to be readily available. The teams usually write the names of new patients on the blackboard in their conference room. Check this frequently since a team may get several admissions in a short time. A complete history and physical examination should be recorded within 24 hours.

Useful Room/Phone Numbers

Room Number	***Phone***
Inpatient Unit - J10A	22070
Morning Report - 3.300A (CH)	73992
Grand Rounds - 2.312 (CH)	
Pediatric Academic Resource Center - 3.302-Library (CH)	

Goals and Objectives for the Newborn Nursery Clerkship

Goal

The goals of the newborn Nursery Clerkship are:

- to provide the student with the opportunity to master the newborn history and physical exam;
- to offer the student the opportunity to gain a greater understanding of the biological basis of common problems observed in the newborn period, as well as how to diagnose and manage those problems.

Skill Objectives

Through patient contact, use of patient models, viewing of instructional videos, and interaction with and observation of preceptors, upon completion of the Newborn Nursery portion of the Clerkship, the third year medical student will be able to:

- gather historical information relating to the infant's pregnancy, labor, and delivery;
- perform a Ballard exam for gestational age assessment on a newborn;
- accurately plot an intrauterine growth curve;
- perform a physical exam on a newborn emphasizing those specific areas unique to the newborn, (i.e., umbilical cord exam; assessment for dislocated hip; examination of the head for molding, caput or cephalohematoma; red reflex eye exam);
- learn basic newborn resuscitation techniques.

Knowledge Objectives

By patient contact, studying the suggested reference texts, through interaction with preceptors, and through case studies, upon completion of the Newborn Nursery portion of the Clerkship the student should demonstrate knowledge in the following areas:

A. *General Care of the Newborn* – knowledge shall be demonstrated by being able to:

- recognize factors in the maternal history that may adversely affect the fetus or newborn;
- identify characteristics of a normal newborn physical examination and its acceptable variations;
- recognize the appearance of normal male and female genitalia in the newborn;
- identify preventive and screening practices used in the newborn period;
- recommend an appropriate diet for a newborn and know the underlying basis for their commendation;
- provide anticipatory guidance to parents for the period from birth to 2 months of age;
- discuss the changes in cardiovascular and respiratory systems physiology that occur at birth.

B. *Common Problems Encountered in the Newborn* – knowledge shall be demonstrated by being able to:

- develop a differential diagnosis for jaundice occurring in the newborn period;
- discuss the common causes of respiratory distress encountered in the newborn period;
- discuss the possible causes of cyanosis in the newborn period;
- identify the possible causes of vomiting in the newborn period;
- recognize the causes of hypoglycemia in the newborn period;
- recognize the signs and symptoms of sepsis in the newborn and discuss the common causes of neonatal infection and the approach to therapy;
- recognize the signs and symptoms of neonatal asphyxia and list the steps required for resuscitation.

C. *Congenital Malformations and Genetics*—knowledge shall be demonstrated by being able to:

- discuss physical exam findings, and the clinical implications they are from, associated with the diagnosis of common:
  - chromosomal abnormalities (e.g. Trisomy 21);
  - sex chromosome abnormalities (e.g. Turner's syndrome, Klinefelter's syndrome, Fragile X syndrome);
  - other genetic disorders (e.g. Cystic Fibrosis, Sickle Cell Disease); and
  - congenital malformations (e.g. spina bifida).

- identify commonly used prenatal diagnostic techniques and the accepted indications for their use, e.g. alpha-fetoprotein, amniocentesis;
- discuss the effects of commonly recognized teratogenic agents such as alcohol, hydantoin, maternal tobacco smoking and illicit drug use;
- to collect relevant information, via an appropriate history and physical exam, to evaluate a genetic disorder or congenital defect.

Procedures

Understand the indications for procedures such as a lumbar puncture, parenteral fluids including intravenous and emergency procedures such as intubation. Observe how to provide emotional support for patients undergoing procedures. The technical aspects of doing procedures should be introduced, although there is no expectation of mastery at the third year student level.

Competencies

A. Evaluate newborn 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.

B. Prepare a complete written summary of the history and physical and orally present the case in a focused and chronological manner.

C. Identify clinical problems and outline an initial diagnostic and therapeutic plan.

D. Know what hospitalization and diagnostic tests are indicated.

E. Select the diagnostic tests which are most likely to be useful and be aware of their costs and limitations.

F. Effectively communicate information about the diagnosis and treatment to the patient and caregiver.

G. Obtain updated information relevant to the diagnosis and treatment to the patient, performing a literature search and critical review of the literature.

Nursery Clerkship

On the first day:

- Meet in the Nursery (JSH Towers 3 A/B) at 0630. Bring your pen (black ink) and stethoscope (ideally, with pediatric size bell attachment).
- Students must have a Valid ID card with a dolphin insignia on it to work in the nurseries. Otherwise pick up the phone at the Entrance and request permission to enter. Do not just go through the doors or it will trigger an alarm
- Change into scrubs. Ask the unit clerk or one of the nurses for the location of appropriate change rooms and where to store your personal belongings. (See page 41 for a statement of the dress code for Newborn and ISCU Units.)
- Remove watches and jewelry and perform a 1 minute scrub, washing to the elbows.
- A review of the Chapter in Bates and Nelson Essentials on How to Examine an Infant is strongly suggested before beginning in the Nursery.

This service has the largest patient volume in the entire hospital, with 6000 admissions per year, sometimes 20 per day, it is a really fun, and sometimes chaotic place. You are valued members of our team, and we need you.

Before you are actually allowed to run amok among these wee ones, you will be oriented by the nurse practitioner and/or the nursery chief resident (PL2), on how to examine new/transitioning babies and how to tame the myriad of paperwork. For optimal learning and minimal heartburn, please familiarize yourself with all of the contents of the Nursery Survival Guide, a manual which is found in the Newborn Nursery and in Transition Nursery. The Nursery Survival Guide includes all of the routine paperwork, with examples and other useful information. Examples of this paperwork are also in the Medical Student syllabus. Most of the time the examples are identical, but, if not, follow the Nursery Survival Guide, because it is more frequently updated.

PLEASE READ CAREFULLY AND HEED THE FOLLOWING WISDOM ABOUT THE NURSERY ROUTINE

What Students Do In the Morning

In brief, this includes your personal baby exams, rounds with the attending, and discharging babies from the nursery.

When you arrive in the morning (0630 every day), follow this sequence to examine babies and prepare for rounds:

1. Change into scrubs, making sure to prominently display your UTMB ID badge, even if you *hate* that picture of yourself. *You must go to campus police before starting the newborn nursery rotation for a dolphin badge to access the nurseries and transport babies.*
2. Wash your hands.
3. Contact the NNP or resident to determine which babies you should examine.
4. Examine the assigned baby, taking care to limit the time the baby is unbundled; since he has been incubating at mother's 98.6 for the past 9 months, he gets chilly easily. Measure the head circumference (abbreviated FOC for frontal-occipital circumference) every day using the baby's own paper measuring tape; this will save time when you do the discharges.
5. Change the diaper if needed and rebundle (like a burrito). If you don't know how to change or rebundle, cordially ask a nurse or doctor for instruction. They will be more than happy to teach you.
6. Check the computer for the labs on the mother and the baby and write them into your daily Medical Student EPIC note.
7. Place the infant's paper chart **under** the plastic crib and then move on to the next baby. A resident or nurse practitioner will check your work later and move the chart to an upright position at the foot of the crib to show that the baby is ready for rounds.
8. Wash your hands (we do this a lot) or scrub with gel, wipe your stethoscope with an alcohol prep and begin the sequence with another baby.

Handy tip: A yellow name tag on the chart spine means a vaginal delivery (usual maternal discharge in 24–48 hours). A blue tag means a C-section (usual maternal discharge in 48-72 hours).

Each day (Tuesday—Friday) 1-2 students will be assigned to transition nursery for the day, to work up new babies. If transition is not busy, they should help with the other nursery work.

All of the babies must be seen and examined, all daily notes written and all labs checked so that **attending rounds can start at 0900**. This is to allow the babies to be out to their mothers for feeding by 1000. *Therefore, the factor determining your arrival time in the morning is the workload in the nursery*. The PL2 will tell you what time to show up if it is different from 0630.

Discharge Papers

Students may assist NNPs or PL1's in preparing the Discharge Summary by gathering information, but are not responsible for filling out the EPIC template.

If you finish the daily notes before 0900, there are a few things you can do to lessen the work for you later:

- Begin preparing the discharge papers for the babies whose mothers are "up for discharge," information which is available as a list from the clerk or a resident. Then, after rounds, the charts will need only to be flagged and 2day f/u visit appointments made.
- Update the master computer list:
  - Look up needed information (on Mom and Baby) according to the list
  - Annotate on the chart
  - Annotate on list
  - If name of Baby and Mom is not on the list, acquire all the needed information, especially UH numbers of each and add them to the list.
- Do some "Mommy Visits" (see 4. on the following pages for exciting details).

Presenting Your Babies on Rounds with the Attending

A. You are allowed to read your note straight from EPIC, but present only pertinent findings. Each presentation should take less than <u>one minute</u>.

"What to say on rounds"

S - Day of life (the birth day is day 1, and add one for each subsequent day), and Hour of life # (age in hours of the baby when you write your note- very important to calculate unless the baby is over ~100 hours) Term or Preterm AGA, SGA or LGA male or female…Problems over the past 24 h

O - Vital signs are stable (if not, what parameter is unstable?) Current weight and change from BW. Feeding breast or bottle or both and how much and how well. Physical exam: mention only pertinent findings such as hematoma, murmur, jaundice Labs: I.e. Mom and Baby blood types, DAT, etc (see 1. on the following pages for more exciting details on labs).

A - TAGA…. male or female, plus restate significant physical findings and all diagnoses, both old and new.

P - Follow the printed format and submit your plan, which must include whether the baby can go home, under what conditions, and recap what discharge requirements are pending. *A major reason for "blessing the fleet" with the attending is to decide if a baby will be allowed to go home that day and under what conditions. So this should be clearly documented in the note (Plan).*

B. <u>**NEVER**</u> (see below**) discharge a baby

- Who is <24 hours old
- Who is <48 hours old and DAT positive

- Who is < 48 hours old if mother is Group B strep positive & inadequately treated
- Whose bilirubin is >13 mg/dl
- Whose maternal RPR at delivery is unknown
- Whose maternal Hepatitis B status is unknown (either prenatal or peripartum will suffice), unless the baby has received both Hepatitis B vaccine and HBIG
- Whose maternal HIV status is unknown

****Unless the attending physician approves on a case-by-case basis.** (They get paid bigger bucks to make these decisions.)

C. If a consult is part of the discharge plan, make sure that it gets ordered on EPIC or called in by phone (sometimes the FAX goes haywire). If you have not seen nor heard from the consultant by 1300 please call the associated clinic and find out when they will be coming so that the baby will be present in the nursery at that time.

D. If a baby should be held for 48 hours and is a <u>vaginal</u> birth, mark "48 h d/c" on the chart spine tag (C/S will be held anyway because of the mother), but <u>do not</u> write prolifically on the chart spine.

BEFORE A BABY CAN BE DISCHARGED, DOCUMENTATION OF SPECIFIC LABS, HEARING SCREEN, THE MOTHER VISIT AND HEPATITIS B VACCINATION MUST BE COMPLETED.

Details on these tasks are as follows (1-4):

1. <u>Documentation of maternal labs</u>, which includes blood type, and peripartum RPR, Hepatitis B surface antigen and HIV (if done). Texas State Law requires that RPR and HBsAg be done twice, and HIV testing be offered, during both the prenatal and peripartum periods. <u>Please note these tedious but important rules about labs</u>:

   - A current RPR (obtained in the peripartum period and usually less than 7 days before delivery) on the mother must be available before the baby can be discharged, unless approved by the attending. If the mother is positive, obtain and document in the baby's chart the following information:
     - Maternal history of previous RPRs, including titers and dates
     - Treatment for syphilis, including antibiotic and dates
     - Maternal testing for Treponemal antibody, i.e., MHATp

     An RPR is required on the baby. Further work-up of the baby should be discussed with the attending and may include CSF for VDRL, liver function tests, CBC and long bone films. The RPR tests are run by serology every day, usually early in the morning. Specimens which arrive after 0600 are not done until the next day. Results are usually on the computer by mid- morning.

   - **<u>Hepatitis B surface antigen (HBsAg)</u>** If the mom is HBsAg negative in prenatal testing, the baby is given Hepatitis B vaccine after mother's consent is obtained by nursing staff. If the mom's status is unknown, the baby is given Hepatitis B vaccine immediately, and the baby is given Hepatitis B Immune Globulin (HBIG) if the mother is still unknown at the time of discharge (HBIG has efficacy for up to one week after exposure). If the mother is HBsAg positive, the baby is given both vaccine and HBIG ASAP. Babies whose mothers are positive or unknown should have Hep B vaccine #2 at one month, and Hepatitis B testing at 6-9 months. The maternal HBsAg test results are available <u>on the computer</u> **between 1500-1530** every day except Sunday. Do not call the lab: this not only annoys the techs, but answering the phone keeps them from doing their important work-which happens to be running the HepB tests that we want.

   - HIV testing is done only if the mother consents. The screening test, which is an ELISA, must be positive twice, and then confirmed by Western blot, before the mother is reported as positive. This takes several days. Many mothers do not get peripartum testing if previously negative. If the mother is HIV positive, the baby receives Zidovudine

(AZT) at 2 mg/kg p.o. q 6h for 6 weeks, beginning within 6-8 hours after birth. Infectious Diseases is consulted and blood is obtained for HIV testing and CBC. (Please see the practice guideline about HIV.) If the mother was diagnosed before or during pregnancy, the ID service is usually familiar with her case.

- The baby's blood type is tested from cord blood if the mother is type O or Rh negative. If the baby is type A or B with a type O mother, or Rh positive with an Rh negative mother, a DAT (Direct Coomb's) is automatically done. If the DAT is positive, the baby has ABO or Rh incompatibility with the potential for hemolytic disease and needs to be kept in hospital for 48h. (Note: When Rh negative mothers are given Rhogam during pregnancy, the baby sometimes has a false positive DAT, so should not be labeled as having hemolytic disease unless he is symptomatic.)

- If any test on the mother or baby is still pending at discharge, make a note in the chart and in the Pending Lab Book. All pending labs should be in that book, located in the nursery, and checked the next day or until the result is available. Notify the attending if a result is positive.

2. Screening test for the baby's hearing. Another State Law. This test, an otoacoustic emission screen, or OAE, which is performed by dedicated audiologists, seems to magically happen sometime during the birth hospitalization.

   Handy Hint: A green or red dot on the crib name card indicates the baby has completed the OAE. Green means passed. Red means failed. All failed OAE's will and must be repeated prior to discharge. If OAE#2 is failed, make sure follow-up plans are made with the mother (Audiology usually does this).

3. Administration of Hepatitis B vaccine #1, if the mother consents, to start the childhood immunization schedule.

4. Visiting the mother. Mommy visits must be done in person, not over the phone, hence, the word visit. These should be done no more than 24 hours after the baby is born. The mommy visit is a courtesy call to see if she has questions, and an opportunity to educate the mothers on SIDS, car seat use, and 2-day and 2-week follow up plans. To improve parent satisfaction and save us a lot of trouble, inform the mother ASAP if her baby is ineligible for 24 hour discharge, especially if she delivered vaginally and may be sent home at 24 hours. Mothers do not like to leave without their babies!

   Be sure to summarize your conversation with the mother in the pre-printed note used for this purpose.

What to ask during the "mother visit"

"Where do you plan to do your baby's follow up visit?"
Cual va ser la clinica que va a escoger para el seguimient medico del bebe?

If they are being discharged prior to 36 hours after birth, they will need a 2-day follow-up appointment **made by us** at the clinic of their choice. The Pasadena clinic and a few others do not have 2 day follow-up so they must return here to PCG or somewhere else closer to where they live.
They need to be informed that whether or not they need a 2 day follow-up, the baby will need a two-week follow-up and that they will be responsible for scheduling those appointments, at the clinic of their choice.

Make sure to provide them with the phone numbers they need to help them with compliance issues they may or may not have.

"Do you plan to breast or bottle-feed or both?"
Usted va a dar el pecho o botella al bebe?
If bottle: 2-3 ounces every 4 hours by three days of age

If breast: On demand for 10-15 minutes per breast. The patient may allow the baby to suckle longer, but they should monitor for their own safety issues (drying, cracking, or decreased milk in one breast relative to another). The mother usually can tell when she needs to switch, but 10 minutes is a good time to start them with.

"Do you have a car seat for your baby?"
Usted tiene la silla del bebe para el carro?
If so, are you aware of the proper placement of the car seat in the car and how to place baby in the car seat? Make sure baby and car seat are facing the rear of the car behind one of the front seats with baby and car seat buckled in.

Debe de colocarla en el asiento de atras del carro, el bebe mirando hace atras.

"Have you been educated about SIDS?"
If not, tell them that the baby should be placed on its back or side on a firm mattress without pillows when sleeping. The baby should not sleep on pillows or with the parents.
"El bebe debe de dormir en su espalda o de lado o boca aribe."

The baby should not be exposed to cigarette smoke.

The baby should not be taken to public places for one month.

If they don't understand be sure to get them a pamphlet from the nursery in their chosen language; hopefully it's English or Spanish.

STILL MORE ON DISCHARGES…….

Frequently used telephone numbers:

Blood Bank	21524
Hematology	22249
Microbiology	21738
Serology (RPR)	22349
Social Service	21541

- **24-hour discharges** cannot be done after **8 PM** unless approved by the attending physician. This means that if a baby is born after 8PM, he will not be eligible for discharge until morning rounds, two days later.

- **ALL** babies discharged at **24-36 hours need a two-day follow-up**.
  SOME babies discharged between **36-48 hours** need a two-day follow up.
  A FEW babies discharged after 48 hours need 2-3 day follow-up. Another "Attending thing," so ALWAYS make sure this is part of your plan in the progress note. Students help make the 2-day appointments (refer to the most current list of clinic numbers).

- Unless the baby is completely ready for discharge, do not put a signed chart at the clerk's desk. If the chart is signed but waiting for labs, social service clearance, etc., keep the chart at the residents' desk.

THE REST OF THE DAY, INCLUDING NEW ADMISSIONS AND MISC STUFF…

Admission work-up on all healthy newborns (see examples in the following pages) includes:

A. Physician's Record of Newborn Infant, a form which includes:
1. Complete history (see Perinatal Profile, which is the L&D record). The following should be documented:
   - The infant's weight in grams, gender, date and time of birth.
   - The Mothers age, gravidity, parity, blood type, RPR Hepatitis B status, HIV status, Group B strep status, description of pertinent medical history, description of pregnancy.
   - Labor details, including length and method of membrane rupture, character of fluid, complications
   - Delivery type, ie spontaneous or forceps-assisted vaginal, C-section and complications
   - Condition of baby at birth, Apgars, any resuscitative interventions
   - Procedures, labs or events in Transition Nursery
2. Physical examination including measurements of head and circumferences, and length. Wear gloves if the infant has not had a bath.

B. Ballard examination to determine gestational age (preprinted form).
C. Intrauterine Growth Chart (pre-printed)
D. Admission Orders (pre-printed)

After rounds
Continue where you left off with mommy visits, updating the labs and other pertinent information and finishing discharge paper work on the definite discharges. Do your 2-day follow up appointment scheduling. Divide the work so that 1-2 people do mommy visits and the rest can finish doing the paperwork/computer updating and discharges.

Important
Each student is required to spend one afternoon (Tues—Friday) in Transition Nursery (on the second floor) doing "fresh baby" history and physicals and going to the resuscitation stand. Divide the days up amongst yourselves on Monday.

When on call and covering the stand
Don't forget to consult the Departmental Student Call Schedule to determine the night you are assigned to the nursery. You will receive further instructions on call from the residents.

When to leave the nursery
Please hang out in the nursery at other times. This provides opportunities to work up new babies. Teaching rounds with the nursery faculty are usually from 11:00 to 12:00 or 1-2 PM Mon-Fri, and you are expected to be there. The time may change based on other commitments, so confirm the time with the attending every day.

As you know, you will arrive at 0630 every day. Once you are in the nursery, you may never want to leave, but we insist you do stay as follows:

Monday	Stay until at least 5 pm, or until the NNP or Faculty says you can leave.
Tues-Friday	Stay until 4 pm, or until the NNP or Faculty says you can leave.
Sat-Sunday	Stay until the NNP or Faculty says you can leave, which is usually by noon. (See a pattern here?)

You will work either Saturday or Sunday during the one week rotation in the nursery. The weekend day will be assigned by your attending. After you have been here a few days, you will see why we need you on the weekend. In a nutshell, the morning workload can be heavy and we're in a time crunch to get it done. At noon on the Thursday before your shelf, you are excused from any further clinical responsibility.

Dress Code for Newborn and ISCU Units

In order to look professional and to assure rigorous infection control practices, we observe the following standards for appearance and attire in the ISCU and Newborn Nursery Units.

Appropriate Attire:

- Employee identification badge and name tag designating name, job classification, and licensure status when applicable should be worn at eye/shoulder level.
- Hair longer than shoulder length (male and female) will be pulled back and contained in a suitable manner.
- Jewelry on the hands is limited to a single flat wedding band. Watches should be pinned to your clothing.
- Short sleeve T-shirts and turtlenecks may be worn as an undergarment only.
- White, single-colored or reserved-patterned scrub-style uniforms (dresses, pants, shirts, or uniform polo shirts) may be worn.
- Physicians and some allied health staff (Occupational Therapist, Social Service Worker, and Audiology personnel) may wear street clothes in the unit. A cover gown may be worn over clothing to protect from soiling while giving direct care.
- Fingernails must be trimmed (not to exceed 1/4 inch past the end of the finger) and neat and clean. Polish may be worn if neat and not chipped.

Inappropriate Attire:

- Leggings, tights, sweat pants
- All black scrubs
- T-shirts as primary top (including solid colors, theme or message T-shirts), or other casual-attire-style tops; sleeveless blouses
- Long-sleeved garments, such as sweat shirts or long-sleeved sweaters
- Mixtures of street attire and scrub clothing with the exception of a scrub shirt and regular pants or slacks.
- Multicolored nail polish and designer paints/decals on nails.
- Open-toed shoes.

Other Pertinent Information

General:

- A 3-minute scrub must be done upon entering the Nursery; then hands must be washed before and after touching each infant.
- Please ask the residents, nurses, or clerks if you are not sure of information or a procedure.
- If you are having trouble locating an infant:
  1. Infants for discharge may be out breast feeding or being fed by the Nursery staff in the Nursery.
  2. Check if the rooming-in list says the baby is in the mother's room (usually the crib will be gone also).
  3. Check to see if the baby is in the ISCU or Intermediate Nursery.
  4. Check to see if the baby's last name has been changed.
- NEVER leave a baby unattended, especially on the scale in an isolette with the door or portholes open, or on a radiant warmer with the sides down.
- Newborn flow sheets are not to be removed from the crib.
- Do not sit on the desks found in the discharge area. They were not designed to support your weight and will be pulled out of the wall.

- Eating and drinking are allowed in the lounge area only.
- Never transport an infant using the stairs. When an infant is being transported, take the emergency box with you. This provides emergency equipment in case the infant chokes or has a respiratory arrest.

Procedures:

Guidelines for placement of an infant in an isolette

- Preemie (< 35 weeks gestation)
- LBW/SGA, post-mature who has failed weaning to crib X 2
- Any infant who has had 2 episodes of low temp, below 97.0 degrees axillary
- Very depressed infants who require close observation
- Infant who requires isolation
- Infant who is tachypneic and requires close observation

Serum Glucoses (Accuchek)

Glucoses are routinely followed on preemies (<36 weeks), LGA, SGA, IDM infants, and breastfed infants (<37 weeks) during first 24-hour period. The normal range is 40–80 mg %.

Vital Signs - Normal Ranges

Temp	97.6–99.5 AX
Resp	40–60
HR	120–170
B/P	depends on infant size and weight

Nursery Forms

Audrey Sanders Fnp MIDLEVEL PROVIDER H&P 05/21/2010 06:

NEWBORN HISTORY & PHYSICAL

Date of Service: 5/21/2010

Date of Birth and Time: 5/21/2010 12:00 AM

Maternal History

Mother's Name: Jennifer Mccalla
UH# 635490Q

Age: 36yo Prenatal Care: yes. Where? UTMB Galveston clinic Now G 3, P 3, Ab 0, LC 3

Blood Type/IAT: O positive/IAT negative

Prenatal Labs/Dates:
RPR : non-reactive, date done 5/4/2010
Hep Bs Ag: negative, date done 10/9/2009
GBS: negative, date done 5/4/2010
HIV: negative, date done 5/4/2010
Other Infections: None

Social History: Smokes 1-2 Ciggs per day

Other pregnancy Problems: Diabetes gestational, controlled

AROM 2 hours prior to delivery with clear fluid.

Mode of Delivery: Vaginal

Apgar's: 1 minute 8, 5 minutes 9

Resuscitation: basic stimulation and basic suction

Transition: unremarkable

Newborn Physical Exam:
Birth Weight: **Last 6 Encounter Wt Readings:**

Date	Wt
05/21/2010	3490 g (123.1 oz) (47%)

Birth Length: **50.5** cm
Birth Head Circumference: **35.5CM**
Gestational Age: (Dates) Gestational Age: 39 weeks. (exam) TAGA Gestational Age: 39 weeks.

Vital signs stable unless noted here

General: active, in no distress
Skin: well perfused without rashes or hematomas, facial bruising and Petechiae

5/21/2010

Head and Neck: molding present, caput present, sutures open, fontanel soft, normal facies, palate intact
Eyes: red reflex intact bilaterally, no discharge
Chest/Lungs: symmetrical, breath sounds present and equal bilaterally
Heart: regular rate and rhythm, no murmur; pulses palpable
Abdomen: soft and round, no organomegaly or masses, bowel sounds heard
Cord: 3 vessels
Genitalia: normal male phallus, testes bilaterally descended
Extremities: no deformities, normal range of motion, hips stable, clavicles intact
Neurologic: positive moro and suck reflexes; normal tone
Back: no defect, anus patent and normally placed

Assessment:
Term liveborn male appropriate for gestational age
At risk for ABO incompatability
Facial bruising bilaterally
Infant of diabetic mother

Plan:
Routine nursery care: check maternal labs, Hepatitis B vaccine, & OAE
Cord blood type and DAT
Follow glucoses
Visit baby's mother

Cosigned by: Sunil Kumar Jain, MD. *[05/21/2010 0820]*
Original Note: Audrey Sanders Fnp *[05/21/2010 0617]*
Revision History Details

Date/Time	User
05/21/2010 0621	Audrey Sanders Fnp
05/21/2010 0617	Audrey Sanders Fnp

5/21/2010

Audrey Sanders Fnp MIDLEVEL PROVIDER
NEWBORN NURSERY DAILY NOTE

Progress Notes 05/21/2010 0554

DOL #: 3 / 33 hours

Birth: C-Section

Subjective:
Problems since birth: Placed in Isolette for size 2445gms

Objective:
Vital Signs within normal limits unless noted here
Weight (g)/change from birth weight: Bw: 2445gms; Current Wt: 2380gms(-65gms)
FOC (cm): 32.5cm
Feeding: 30 cc q 3 hours, formula and Breastfeeding minutes per breast
Voids x 8, Stools x 5, Glucoses none indicated today

Physical Exam:
General: active in no distress
Skin: no rashes, hematomas, or lesions, dermal melanocytosis on buttocks
Head/Neck: fontanelle soft, sutures open, no abnormalities
Eyes: no discharge, clear
Chest/Lungs: symmetrical, breath sounds present and equal bilaterally
Heart: regular rate and rhythm, no murmur; pulses palpable
Abdomen: soft and round, no organomegaly or masses, bowel sounds heard
Genitalia: normal external female genitalia
Extremities: no deformities, normal range of motion, Lt hip click
Neurologic: normal tone

Maternal Blood Type: O positive
Baby's Blood Type if mother is type O or Rh negative: O positive
DAT: Negative

Maternal Labs: (peripartum)
RPR: Negative, Date 5/19/2010
HepBsAg: Negative, Date 5/19/2010
HIV: Negative, Date 5/19/2010
GBS: Negative, Date 5/7/2010

Other Labs (Maternal or Newborn):
Transcutaneous Bilirubin: 6.6, time of test 2100, hour of life 24, risk zone high Risk

Assessment:
Preterm liveborn female appropriate for gestational age. Tw B (36 weeks)
Lt Hip click
Feeding skills are good .

Plan:
Continue newborn care
Complete discharge requirements:
Follow Lt hip click

5/21/2010

Continue Isolette Care, if she stays warm start wean in 24 hours
Maternal labs checked and recorded: yes
Mother visited: yes, Date 5/20/2010
Hearing Screen (OAE) done: yes, Failed , Date 5/20/2010 Rescreen Done 5/21/2010
Hepatitis B vaccine given: yes, Date 5/19/2010

Discharge Planned: Discharge not permitted today due to size of baby weaned from Isolette this am, Continue to monitor x 24 hours.

AUDREY SANDERS, FNP

Cosigned by: Sunil Kumar Jain, MD. *[05/21/2010 0921]*

5/21/2010

Evaluation Forms

Observed History and Physical Form

Goals

To offer an opportunity for faculty members to observe a student performing a history and physical examination and to provide critical feedback on the student's technique. (This goal should be attained by observing the performance of a complete history and physical exam unless otherwise instructed by the attending.)

INSTRUCTIONS TO FACULTY AND STUDENTS

- This evaluation form should be completed during and immediately after observing the student-patient encounter. Important points of the exercise and information to provide the student prior to the encounter include the following:
  1. The student has 45 minutes maximum to complete a comprehensive interview and an appropriate physical exam.
  2. Upon completion of the history and physical exam the evaluator should complete this portion of the evaluation form and review it with the student (approximately 15 minutes).
  3. The student may then have 24 to 48 hours to develop an Assessment and Management Plan, which should be presented to the evaluator in the following sequence:
     A. Case presentation (5 minutes)
     B. Assessment of Plan presentation, justification, and discussion (10 minutes)
     C. Evaluator completes Evaluation Form
     D. Evaluator reviews Evaluation with student
  4. The student and the Evaluator should sign the bottom of the last page of the Evaluation Form as an acknowledgment that the student's performance has been reviewed and discussed.
- While observing the student-patient encounter, the evaluator should:
  - rate the observable skills by marking the appropriate column on the form
  - assign a final rating at the conclusion of your observations
  - include narrative comments
- The objectives of this exercise are to offer the opportunity for the third year pediatric clerkship student to:
  1. be observed performing an interview and physical examination
  2. receive critical feedback on their skills
  3. be educated in areas where they appear deficient
  4. To develop an assessment and management plan upon which they also receive feedback
  5. To receive critical feedback on their presentation.

These objectives may be fulfilled through the use of inpatients or outpatients to which the responsible faculty has access. A focused interview and exam that provides enough insight to the evaluator of the student's capabilities is an acceptable alternative to a full history and physical exam.

RETURN SIGNED FORM TO TIFFANY SWAIN
RESEARCH BUILDING 6 (old Children's Hospital) ROOM 3.302
BY THE LAST FRIDAY OF THE INPATIENT / WARD ROTATION

Checklist for Observed History & Physical Exam

(Leave items blank if not applicable to case)

1 = Not Done
2 = Done Superficially
3 = Done Appropriately

(Please check one box for each applicable question)

COMMENTS	INTERVIEW SKILLS		1	2	3
	Chief Complaint and History of Present Illness				
	quality				
	location				
	severity				
	onset				
	duration				
	frequency				
	context				
	modifiers				
	associated symptoms				
	Defines present illness completely				
	Past Medical History				
	birth history				
	hospitalizations				
	surgeries/injuries				
	medical illnesses				
	disease/toxin exposures				
	health maintenance				
	immunizations				
	developmental history				
	MEDICATIONS				
	ALLERGIES				
	Social History:	Family environment			
		Diet/exercise			
		Drug usage			
	Family Medical History:	Mother (age, living with child, illnesses)			
		Father (age, living with child, illnesses)			
		Siblings (ages, illnesses)			
	ROS:	HEENT			
		Chest/heart/lungs			
		GI			
		GU			
		Immune			
		Neurological/musculoskeletal			
		Behavioral/psychiatric			
Patient Information	Greets child and parent, introduces self, establishes rapport				
	Asks questions appropriate to patient problem				
	Asks age appropriate questions				
	Demonstrates concern for patient				

EVALUATION CONTINUED ON THE BACK OF THIS DOCUMENT

1 = Not Done 2 = Done Superficially 3 = Done Appropriately

(Please check one box for each applicable question)

INTERVIEW EVALUATION (continued)		1	2	3
Question Style	Appropriate use of open-ended questions			
	Clarifies with focused questions			
	Clusters and sequences questions in sections			
	Maintains narrative thread			
	Summarizes and transitions between sections			
	Places emphasis on major problems			
	Level of detail appropriate for problems			

PHYSICAL EXAM CHECKLIST: The physical exam should be thorough; however, it should be directed toward the major problem areas. A complete neurological exam need not be done unless it is deemed important to the problem. An examination of the genitalia need not be done unless it is pertinent to the problem. Rectal and pelvic exams are not required. Leave items blank if you do not feel they are applicable to the case.

1 = Not Done 2 = Done Superficially 3 = Done Appropriately

(Please check one box for each applicable question)

PHYSICAL EXAM		1	2	3
Vital Signs	Pulse			
	Respiratory rate			
	Blood pressure			
	Growth measurements (may be obtained from the chart)			
General Appearance	Observed			
Head	Palpated anterior fontanel			
	Inspected general facial features for hyperterliorism, low set ears, asymmetry			
	Inspects conjunctiva, sclera, pupils			
	Assess pupil response to light			
	Inspects fundi			
	Inspects external auditory canals			
	Inspects tympanic membranes			
	Inspects nose			
	Inspects oral cavity and throat			
	Tests motor function of tongue			
	Palpates for lymph nodes in neck			
	Palpates thyroid			
Chest	Auscultates posterior lung fields			
	Auscultates anterior lung fields			
	Auscultates precordium appropriately			
Abdomen	Auscultates abdomen			
	Palpates for liver and spleen appropriately			
	Palpates inguinal lymph nodes			
	Palpates femoral pulses			
	Inspects umbilicus			
Genitalia	Inspects genitalia (not required)			
	Assesses testicular descent (not required)			
Skin	Inspects for rashes, lesions, nevi			
Extremities	Inspects for muscle development or asymmetry			

EVALUATION CONTINUED ON NEXT PAGE OF THIS DOCUMENT

1 = Not Done 2 = Done Superficially 3 = Done Appropriately

(Please check one box for each applicable question)

PHYSICAL EXAM CHECKLIST (continued)		1	2	3
Neurologic	Tests cranial nerves			
	Tests deep tendon reflexes			
	Assesses for presence of primitive reflexes			
	Assesses motor development appropriate for age			
	Assesses strength of upper and lower extremities			
	Assesses gait and tandem walking			
	Assesses cutaneous sensation			
Performance Skills	Washes hands prior to examination			
	Remains aware of patient comfort during exam			
	Exam complete for major problem			
	Exam correctly done			
	Elicits abnormal findings			

COMMENTS ON INTERVIEW AND PHYSICAL EXAM SKILLS:

PRESENTATION, PROBLEM SOLVING AND MANAGEMENT SKILLS:

Following an opportunity to review the case (12 - 48 hours) the student is expected to present the case to the evaluator and to justify and defend an assessment and management plan.

1 = Unacceptable **3 = Proficient**

2 = Below level of most students **4 = Outstanding**

(Please check one box for each applicable question)

	1	2	3	4
Presented an introductory statement with patients name, age, CC and reason for admission				
Presented a HPI with a clear chronology of events				
Presented a PE witch started with the child's general appearance and vital signs				
Presented a targeted PE which included positive/negative findings related to diagnoses under consideration				
Presented lab data/ labs that need to be done to distinguish between possible diagnoses				
Develops an appropriate assessment of major problems (includes problem list)				
Can provide more than one possible diagnosis for the major problem				
Able to appropriately prioritize likelihood of diagnoses				
Management plans appropriate for patient problem				
Management plans include patient education				
Can explain basis for management plans				

COMMENTS ON PRESENTATIN, PROBLEM SOLVING AND MANAGEMENT SKILLS

EVALUATION CONTINUED ON BACK OF THIS DOCUMENT

SUMMARY SCORE OF CLINICAL EVALUATION EXERCISE
(Please circle one number below)

Clearly unacceptable performance in one or more of major skill areas	**Acceptable performance, but performance below level of most students at this stage**	**Good, proficient, meets expectations for level of training, clinically competent**	**Excellent, consistently exceeds expectations, stands out as a role model**
1 1.5 2	**2.5 3**	**3.5 4**	

Competent students should receive a rating of 3.0. Higher or lower ratings should be awarded to students displaying significant, clearly identifiable strengths or weaknesses. The Undergraduate Education Committee must have meaningful narrative comments to understand a student's rating if it falls above or below 3.0.

COMMENTS ON STUDENT'S OVERALL PERFORMANCE ON OBSERVED HISTORY & PHYSICAL THAT WILL APPEAR ON THE DEAN'S LETTER:

STUDENT'S NAME:_____STUDENT ID#:_____
(PLEASE PRINT)

The student acknowledges that the results of the evaluation exercise have been reviewed with the faculty.

STUDENT'S SIGNATURE:_____DATE:_____

EVALUATOR'S NAME:_____
(PLEASE PRINT)

EVALUATOR'S SIGNATURE:_____ DATE:_____

Revised 05/3/2011

EVALUATION OF NEWBORN PHYSICAL EXAM SKILLS

1 = Not Done
2 = Done Inappropriately
3 = Done Appropriately

(Check one box for each question)

Student Name: _____
Rotation Dates: _____ to _____
Evaluator: _____ *(Please Print)*

Physical Exam Skills	**1**	**2**	**3**
Either measures or states what physical measurements should be taken, ie. FOC, chest, and length			
Remarks on presence or absence of skin lesions (nevi, e. toxicum , hemangiomas)			
Appropriately assesses the head for caput and cephalohematomas			
Indicates or actually performs check for red reflex			
Examines mouth			
Examines clavicles			
Auscultates heart and lungs appropriately			
Palpates for liver, spleen and kidneys			
Examines umbilical cord			
Examines genitalia, checks for anal patency and sacral dimples			
Performs Ortolani maneuver			
Checks for pulses in extremities			
Checks for Moro reflex and suck reflex			
Gestational Age Assessment Skills	**1**	**2**	**3**
Uses appropriate external characteristics to estimate gestational age (names a minimum of 4 characteristics)			
Uses appropriate neurological characteristics to estimate gestational age (names a minimum of 4 characteristics)			
Overall assessment of gestational age is appropriate			

Clearly unacceptable performance in one or more of major skill areas	Acceptable performance, but below level of most students at this stage of training	Good, proficient, meets expectations for level of training, clinically competent	Excellent, consistently exceeds expectations, limited to top 15% of students

1 1.5 2 2.5 3 3.5 4

Competent students should receive a rating of 3.0. Higher or lower ratings should be awarded to students displaying significant, clearly identifiable strengths or weaknesses. **The Undergraduate Medical Education Committee must have meaningful narrative comments to understand a student's rating if it falls above or below 3.0.**

COMMENTS ON STUDENT'S OVERALL PERFORMANCE THAT WILL APPEAR ON THE DEAN'S LETTER:

EVALUATOR'S SIGNATURE:_____DATE:_____

C:\ugme\pediclrkshp2003\Newbrn.Peskills.eval3_5_03.doc

EVALUATION OF CLINICAL PERFORMANCE

(Inpatient, Newborn Nursery & Subspecialty)

Pediatrics Clerkship Evaluation of Jane Doe

School Year: 2011-2012	Period: 1
Evaluator: Patty Smith	
Evaluator Capacity: Inpatient Attending	
Service: Inptatt	
Form Opens: 6/30/2011	Closes: 9/2/2011
Length of Contact: more than 14 days	

1.	HISTORY TAKING SKILLS
History Taking Skills: 4 - Outstanding	Consistently: ▪ asks questions in a logical sequence ▪ develops chief complaint fully ▪ explores sensitive information professionally ▪ data is accurate/correct
	Inconsistent performance of skills: ▪ History incomplete or inaccurate ▪ Misses key information or chronology unclear
Comments:	

2.	PHYSICAL EXAMINATION SKILLS
Physical Examination Skills: 3 - Competent, Satisfactory	Consistently: ▪ performs PE or MSE maneuvers appropriately ▪ able to perform complete exam for relevant area ▪ able to distinguish normal from abnormal findings
	Inconsistent performance of skills: ▪ cannot perform PE or MSE maneuvers correctly ▪ does not perform complete exam ▪ misses important abnormal findings
Comments:	

3.	COMMUNICATION SKILLS
Written Communication Skills: 3 - Competent, Satisfactory	Consistently: ▪ writes complete, thorough, well organized H&P ▪ incorporates pertinent positive/negative information ▪ daily notes are up to date, legible ▪ data is accurate/correct
	Inconsistent performance of skills: ▪ H&P disorganized, incomplete and/or missing important data ▪ data inaccurate ▪ does not update notes ▪ does not incorporate team thinking ▪ writing illegible

Verbal Communication Skills: **3 - Competent, Satisfactory**	Consistently: ▪ presents data in appropriate, logical sequence without commentary ▪ uses proper medical terminology ▪ focuses daily presentation to key info and tolerates interruptions w/o losing flow
	Inconsistent performance of skills: ▪ disorganized in presentation ▪ missing important data ▪ data inaccurate ▪ does not use proper medical terminology
Patient Education Communication Skills: **3 - Competent, Satisfactory**	Consistently: ▪ establishes rapport with even the most difficult patients/families ▪ changes and adapts communication style for individuals in distress, or with emotional impairment ▪ uses appropriate language for patient/family understanding
	Inconsistent performance of skills: ▪ ineffective communicating or establishing rapport with patients/family ▪ not easily understood by patient/family ▪ insensitive to patient/family emotional state
Comments:	

4.	PROBLEM-SOLVING SKILLS
Fund of Knowledge: **3 - Competent, Satisfactory**	Consistently: ▪ Demonstrates thorough knowledge of common medical problems ▪ understands basic pathophysiology ▪ able to suggest appropriate diagnostic and therapeutic plan for level of training ▪ shows evidence of outside reading
	Inconsistent performance of skills: ▪ fund of knowledge spotty/sparse ▪ demonstrates thorough knowledge of common medical problems ▪ spotty/sparse knowledge of broad Tx categories ▪ sparse knowledge of Dx tools ▪ no evidence of outside reading
Application/Problem-Solving: **3 - Competent, Satisfactory**	Consistently: ▪ appropriately interprets data to develop thorough, defensible assessments ▪ able to problem-solve in a logical fashion ▪ uses basic science principles in problem-solving ▪ able to understand and interpret the important elements of hx/pe ▪ appropriately prioritizes problems and DDx
	Inconsistent performance of skills: ▪ has difficulty developing assessments with appropriately broad and defensible DDx ▪ does not use a logical pattern to problem-solve ▪ can not apply basic science principles ▪ difficulty interpreting data ▪ has difficulty with prioritization of info
Comments:	

5.	PROFESSIONALISM
Professionalism: **4 - Outstanding**	Consistently: ▪ demonstrates responsibility for patients and learning activities ▪ seeks and accepts feedback ▪ actively participates in team activities ▪ demonstrates respect for patients, healthcare professionals, peers, and staff ▪ demonstrates honesty and integrity
	Inconsistent performance of skills: ▪ appears disinterested in learning ▪ chronically late ▪ demonstrates disrespect of patients, healthcare professionals, peers, and staff ▪ accepts constructive criticism/feedback poorly ▪ does not demonstrate interest in improving skills ▪ fabricates data ▪ does not know patients
Comments:	

6.	DEAN'S LETTER COMMENTS
	Ms. Doe did great on the inpatient rotation. She was always on time, a team player, and great asset to the team. She accepted feedback and worked well with the patients, faculty and staff. She will do well in any medical field she chooses.

7.		OVERALL PERFORMANCE
		Serious weaknesses noted in one or more areas. Student would clearly benefit from remediation.
		Some weaknesses noted. Performance is below that expected for a student at this level; student might benefit from remediation.
		Performance at expected level for training. Competence demonstrated in ALL skills areas necessary to pass clerkship objectives.
	✔	Performance above level of training in some areas. Excellence demonstrated in some skill areas, competency in all other areas.
		Performance consistently above that expected for this level. Excellence demonstrated in ALL skill areas.

Ambulatory Evaluation Form

Student Name: Jane Doe – ID# P000000000
Patty Smith, MD – Apple of My Eye Clinic
Periods 1 – 2, 2012-2013 (July 2 – August 24)

PEDIATRIC CLERKSHIP
EVALUATION OF CLINICAL PERFORMANCE

Skills: Use this list to identify and comment upon characteristics we hope the students will display during their rotation with you. In your comments please describe how well or poorly the student demonstrated these characteristics.

Characteristics Sought:	**Comments on Skills:** (For Grading Committee Purposes Only)
___ Interviews proceed in logical fashion	
___ Focuses history appropriate to patient problem	
___ Establishes rapport with patient/family	
___ Focuses physical exam appropriate to problem	
___ Uses appropriate physical exam technique	
___ Recognizes abnormal findings	
___ Oral presentations organized and sequential	**Evaluation on Performance of Skills:** (check one)
___ Notes organized in SOAP format	**___Honors ___High Pass ___Pass ___Failure**

Knowledge: Use this list to identify and comment upon characteristics we hope the students will display during their rotation with you. In your comments please describe how well or poorly the student demonstrated these characteristics.

Characteristics Sought:	**Comments on Knowledge:**(For Grading Committee Purposes Only)
___ Develops an appropriate assessment for major problems	
___ Can provide more than one possible diagnosis for a major problem	
___ Able to appropriately prioritize likelihood of diagnoses	
___ Demonstrates an adequate knowledge base	
___ Shows evidence of study and knowledge growth	
___ Management plans appropriate for patients problems	
___ Management plans include patient education on disease prevention and health promotion	
___ Can explain basis for management plans	
___ Demonstrates awareness of health cost issues	**Evaluation of Knowledge:** (check one)
___ Demonstrates awareness of community health issues	**___Honors ___High Pass ___Pass ___Failure**

Attitudes / Professional Behavior: Use this list to identify and comment upon characteristics we hope the students will display during their rotation with you. In your comments please describe how well or poorly the student demonstrated these characteristics.

Characteristics Sought:	**Comments on Professional Behavior:** (For Grading Committee Purposes Only)**:**
___ Arrives prepared and on time	
___ Professional appearance	
___ Demonstrates interest in learning	
___ Self-motivated learner	
___ Participates actively in rounds and conferences	
___ Demonstrates interest and/or participates in community activities	
___ Shows concern for patients and families	
___ Works collegially with staff and team	**Evaluation of Professionalism:** (Check one)
___ Seeks and accepts feedback	**___Honors ___High Pass ___Pass ___Failure**

EVALUATION CONTINUED ON BACK OF PAGE

SUMMARY EVALUATION OF STUDENT PERFORMANCE

(Please circle one number below)

Failure: Clearly unacceptable performance in one or more of major skill areas	**Pass:** Good, proficient, meets expectations for level of training, clinically competent. Lower grades indicate acceptable performance, but below level of most students at this stage of training	**High Pass:** Above average performance. Exceeds expectations.	**Honors:** Excellent, consistently exceeds expectations, stands out as a role model, **limited to top 10-15% of students**

1 1.5 2 2.5 **3** 3.5 4

Competent –good students should receive a rating of 3.0. Higher or lower ratings should be awarded students displaying significant, clearly identifiable strengths or weaknesses. The Pediatric Grading Committee must have meaningful narrative comments to understand a student's rating if it falls above or below 3.0. **Only the top 10 to 15% of the students should receive a rating of 4.**

COMMENTS ON STUDENT'S OVERALL PERFORMANCE (These comments will appear on the Dean's Letters for the students):

Total # of absences while assigned to your clinic: _____

COMMENTS FOR STUDENTS AND GRADING COMMITTEE CONCERNING AREAS TARGETED FOR FUTURE GROWTH OR IMPROVEMENTS (These comments will not appear on the Dean's letter):

EVALUATOR'S NAME: (PLEASE PRINT) _____

EVALUATOR'S SIGNATURE: _____ DATE: _____

STUDENT'S SIGNATURE:_____ DATE:_____

Morning Report Presentation

A team of students are assigned to present a case at Morning Report. Student cases are presented on Wednesdays; Morning Report is held Tuesday through Thursday from 8 to 8:30 AM in 3.300A Research Building 6 (old Children's Hospital). Choose a case which is interesting, but not too esoteric – you want to use the case as a springboard to review information of use to you as you learn Pediatrics. Check with your residents as you select your case – you don't want to duplicate a presentation they have planned, and they may have good advice for you.

You will have opportunity to see Morning Report before you are expected to present. The case is usually presented in pieces, with the audience asked to help the case unfold – for example, after the history is presented the audience may be asked if they have additional questions, and the audience may be asked to draft a differential diagnosis after the entire H&P or to request specific laboratory testing. Once the case is completed, present information relevant to the case from the literature – it is often very helpful to present a specific relevant journal article, or to review the pathophysiology or pharmacology relevant to the case.

Since you put a fair amount of effort into this presentation, it will account for 5% of your grade. The audience will be asked to evaluate your presentation and provide feedback. These evaluations will be collected and result in the base grade for this course component. We will ask each of you to rate your team members in terms of how much they contributed to the work of the team. You will be asked to divide 100 points among your team members. If each member contributed equally, you can divide the points equally. If some members contributed more than others, you can give greater numbers of points to those members who contributed to a greater degree, and lesser points to members who were lesser contributors. The points will be used to "multiply" by the base grade to come up with an "adjusted" grade for the Morning Report presentation.

To understand how the grade is adjusted, an example can be seen as follows.
If a student had a base grade of 90, and a peer evaluation grade of 100 points (average) the adjusted grade would be calculated as follows:

base=90 X Peer eval: 1.00 = Adjusted grade = 90

If that same student got an "above average" peer evaluation grade of 104, the adjusted grade would be as follows:

base = 90 X Peer eval 1.04 = Adjusted grade = 93.6

If a different student in the group received a "below average" peer evaluation score of 96, the adjusted grade would be as follows:

base = 90 X Peer eval .96 = Adjusted grade = 86.4

Many students are uncomfortable with the idea of peer evaluation, but we include it because it ensures a measure of accountability for all members of the team. With peer evaluation, students are given an opportunity to reward their team members who prepare and participate and therefore positively contribute to the team grades. Students who do not attend or who do not prepare can be provided with feedback about their lack of help with the team work. Peer evaluations will be sent to you by email and the completed copy will be filed anonymously.

Appendix D

Here is the form that will be used by the audience:

Morning Report Student Presentation Evaluation

The cases presented each week by the 3rd year medical students are important learning experiences for each student. Please provide appropriate feedback for the group that participated in the case presented this week. Complete this form and return it to the Pediatric Clerkship Coordinator, Tiffany Swain. Thank you.

DATE OF PRESENTATION: _____

CASE PRESENTED: _____

YOUR STATUS: (e.g., student, resident, faculty) _____

Please respond to the following statements by circling your assessment on a scale of 1-5:
1= strongly disagree, 2= disagree, 3=neutral, 4=agree, 5=strongly agree. Comments are welcome.

1. The case was presented in an appropriate, logical sequence 1 2 3 4 5
- history, PE findings, labs and/or studies presented
- case presented as patient presented upon admission or during hospitalization

2. The presentation focused on relevant key information 1 2 3 4 5

3. Audience questions and participation were handled appropriately 1 2 3 4 5

4. Knowledge about the case and/or medical problem was demonstrated 1 2 3 4 5
If relevant, the following may be discussed:
- presenting signs and/or symptoms
- diagnostic tests/studies
- differential diagnosis discussed
- pertinent pathophysiology
- treatment
- prognosis and/or complications

5. Evidence of researching relevant literature related to the case was shown 1 2 3 4 5
- background reading evident
- evidence-based medicine discussed
- list of references made available

Comments:

Design-A-Case Web Cases

Design-A-Case is a web-authoring platform created by UTMB's Family Medicine Department; it is used at many institutions in this country and others. During the Pediatrics rotation, you are **required** to complete 12 web cases. There are quizzes on some of the cases on BlackBoard and as you work through the cases, you can self assess with these quizzes. Your answers to the prompts on the cases are recorded. These are not graded, but may be audited to ensure that you have properly accessed and worked through the case. (Note: inappropriate language, inadequate responses or typing nonsensical character strings is considered unprofessional behavior).

You are required to complete cases 1-6 by the end of week 4 as these cases provide content for some of the didactic activities during the clerkship. You can choose the remaining 6 cases from a large number of cases that are available in the Pediatric Case Library. All cases must be completed by the last day of the Clerkship. To qualify for honors/high pass, you are required to complete the 6 cases listed below by the end of week 4and the remaining 6 cases by the last day of the Clerkship. Failure to complete the first 6 cases on time will result in your overall clerkship grade to be lowered by one letter grade. Failure to complete all 12 cases by the last day of the clerkship will result in a failure of this required component and failure of the clerkship.

Below are the instructions for accessing your web case assignment in Design A Case. If you have any problems logging in, please email support@designacase.org for help.

A. Retrieve Your Password

In a web browser, go to http://www.designacase.org
On the right hand side of the page, under the Logon button, click "Forgot password?"
Type your full school email address (username@utmb.edu) into the box and click Submit
Your password will be emailed to your school email address. Check your email account to retrieve the password.
You will use this password to login to Design A Case from now on.

B. Login to Design A Case and Begin Assignment

In a web browser, go to http://www.designacase.org
On the right hand side of the page, type in your full school email address (username@utmb.edu) and password
Check the box for "I agree to the Terms and Conditions" (check this every time you log in)
Click the "Logon" button.
Once logged in, click the course title you are enrolled in.
The list of web cases will be shown.
Click on the title of a case to start a case.
Within the case, click the Continue, Submit, and Faculty Response buttons to move forward.

All students must complete the following required cases by the end of week 4:

1. Child with a abnormal newborn screen
2. Neonatal Fever: Yesinia Rodriquez is a 16 day old baby with fever
3. New born WCC with teen parent and father not involved with cradle cap and diaper rash
4. Wheezing - Ian Cassidy is a 15 month old male with difficulty breathing for 12 hours.
5. Abdominal Pain - A 16-year-old female is brought to the Emergency Room by her mother complaining of fever, nausea, vomiting, and abdominal pain for 2 days.
6. Child Abuse - Randall Glen is a 3 month old male infant with the chief complaint of fussiness.

In addition to the above cases all students must complete 6 additional cases of your choice by the end of the Pediatric Clerkship. You are encouraged to complete all the cases in the Pediatric Library as it is a valuable learning tool.

Department of Pediatrics Electives

Clinical Electives

PEDU-4001	Acting Internship in Pediatrics-Inpatient
PEDU-4004	Pediatric Immunology/Allergy (Clinical)
PEDU-4005	Acting Internship in Pediatrics-Neonatology
PEDU-4007	Hematology-Oncology
PEDU-4010	Pediatric Cardiology
PEDU-4011	Pediatric Diabetic Camp
PEDU-4012	Pediatric Endocrinology
PEDU-4014	Pediatric Infectious Diseases
PEDU-4019	Adolescent and Behavioral Health
PEDU-4021	Pediatric Genetics
PEDU-4022	Pediatric Preceptorship
PEDU 4024	Acting Internship Chronic Care Rehab
PEDU-4027	Adolescent Medicine
PEDU-4032	Texas Pediatric Society Pediatric Preceptorship
PEDU-4039	Practice of Medicine Project
PEDU-4047	Acting Internship-Ambulatory Pediatrics
PEDU-4051	Pediatric Medical Summer Camp Experience
PEDU-4053	Acting Internship in Pediatric Hematology/Oncology
PEDU-4060	Foundations in Patient Safety & Healthcare Quality
PEDU-4061	Clinical Neonatology at St. Joe's
PEDU-4068	Pediatric Boot Camp
PEDU-4097	Community Elective in Neonatology
PEDU-4102	The Art of Healing
PEDU-4103	Pediatric Urgent Care in Galveston
PEDU-4104	Child Development and Behavior

Research Electives

PEDU-4067	Basic Science Issues in Pediatric Trauma

Medicine / Pediatrics Electives

MPEU-4036	Endocrinology Medicine/Pediatrics
MPEU-4037	Infectious Diseases Medicine / Pediatrics

Ambulatory Community Selectives

PEDU-4045	Pediatric Primary or Specialty Care Ambulatory Community Selective

Basic Science Humanities Selectives

PEDU-4035	Basic Science Issues in Pediatric Trauma (Austin)
PEDU-4054	Mystery Diagnosis and Case Discussion in Pediatrics
PEDU-4055	Literature Review in Hematology/Oncology
PEDU-4056	Energy Medicine
PEDU-4057	Developing Interactive Web-Based Clinical Cases with an Emphasis on Integration of Basic Science
PEDU-4101	The Art of Healing

Austin Electives / Dell Children's Medical Center of Central Texas

PEDU-4033	Pediatric Emergency Medicine
PEDU-4034	Acting Internship in Pediatrics - Inpatient
PEDU-4037	Acting Internship in Pediatrics - Pediatric Intensive Care Unit
PEDU-4042	Pediatric Infectious Diseases
PEDU-4043	Pediatric Pulmonary
PEDU-4044	Acting Internship in Pediatrics – Orthopedic Surgery

PEDU-4046	Pediatric Gastroenterology and Nutrition
PEDU-4049	Pediatric Hematology / Oncology
PEDU-4050	Pediatric Neurology
PEDU-4059	Pediatric Rheumatology
PEDU-4062	Pediatric Surgery
PEDU-4063	Acting Internship in Pediatric Neurosurgery
PEDU-4064	Pediatric Dermatology
PEDU-4065	Acting Internship in NICU at Dell
PEDU-4066	Acting Internship in NICU at Brackenridge
PEDU-4105	Transformative Teams in Healthcare: Dialogues in Interprofessional Practice

For further information, questions, or to check on availability of these electives, call the Office of Enrollment Services at (409) 772-1215. Austin Pediatric electives are also available through the Dell Children's Medical Center of Central Texas. For information contact Dr. Valli Annamalai at (512) 324-0165.