LSU School of Medicine: Pre-clerkship Education

The students on your clerkship have been taught a number of clinical skills throughout the first 2 years of medical school, including a clerkship preparation course immediately preceding the clerkships. They should continue to hone these skills throughout their 3rd year. Students have also attended several Internal Medicine morning reports and rounds. They have had a radiology and clinical pathology thread throughout their 2nd year systems courses. In addition to these, there has been significant clinical integration into their basic science courses, with many of their lectures being delivered by clinicians.

They have taken the following courses prior to the clerkships:

Year 1:

- Gross and developmental anatomy
- Biochemistry
- Clinical skills integration 100
- Physiology
- Cell biology and anatomy
- Immunology
- Medical genetics
- Human behavior and development
- Foundations of population medicine and health systems

Year 2:

- Foundations of disease and therapy
- Diseases and therapy of the neuropsychiatric system
- Diseases and therapy of the musculoskeletal and dermatologic systems
- Diseases and therapy of the hematologic system
- Diseases and therapy of the respiratory system
- Diseases and therapy of the cardiovascular system
- Diseases and therapy of the genitourinary system
- Diseases and therapy of the endocrine and reproductive systems
- Diseases and therapy of the gastrointestinal system
- Clinical skills integration 200
- Clerkship preparation

The experiences required of all students are listed below.

- Approximately 5-7 history taking role plays
- Teaching, practice, and observation of the physical examination:
    - Musculoskeletal
    - HEENT
    - Heart and lung
    - Abdomen
    - Neurologic
- Basic ultrasound skills
- Clinical skills labs:
    - Universal precautions
    - Vital signs
    - Emergency assessment
    - EKG interpretation
    - Pulse ox/pulmonary function test interpretation
    - IV/venipuncture
    - Lumbar puncture
    - Heart sounds and murmurs
    - Arrhythmias
    - Airway management
    - Foley catheter placement
    - Breast, pelvic, and rectal examination
    - Suturing
- Completion of 14 virtual patient history and physicals
- Discussions of cultural competency and medical ethics
- Presentation of one journal club article
- Completion of several quality improvement modules
- Participation in one motivational interviewing exercise
- 3 History of Present Illness write-ups
- 3 History and Physical Examination write-ups
- 1 SOAP note write-up
- Completion of 1 web-based oral presentation module
- Basic life support certification
- CITI Research ethics training
- Prescription writing and proper abbreviations

The students have been taught the following regarding history taking and clinical reasoning:

History of Present Illness mnemonic: DOC CLARA PPP (developed this way because timing of a symptom is so important to the differential diagnosis)

- **D**uration
- **O**nset
- **C**ourse
- **C**haracterization
- **L**ocation (if applicable)
- **A**ggravating factors
- **R**elieving factors
- **A**ssociation symptoms
- **P**ertinent risk factors/past medical history
- **P**revious evaluation for complaint
- **P**atient perspective

Past Medical History mnemonic: MASS IAM

- **M**edical problems
- **A**ccidents or injuries
- **S**urgeries and hospitalizations
- **S**creening procedures
- **I**mmunizations
- **A**llergies
- **M**edications

Family medical history

Social history

Review of systems

The following pages contain a document that the students are given regarding writing a SOAP note. They have not yet been taught how to alter this format for particular specialties.

SOAP Note

This is a well-accepted format in which to document your patient's status as well as your plan for further evaluation and management. The length and exact content of the note will vary depending on your patient's problems and the clerkship. However, these general rules apply to all. For inpatients, make sure your note is labeled with your status (e.g. L3), the date, and the time. It is helpful to include hospital day, post-procedure day, or post-op day in the heading. Ensure proper use of abbreviations. Your note should be a representation of your thought process – it is not merely paperwork.

Before you see the patient, take a minute to think about their problem representation:

What is their diagnosis?

If no definitive diagnosis, what are the main complaints or problems?

If no definitive diagnosis, what diagnoses/hypotheses should I and/or the team consider?

Knowing these will help guide your search for information, which you will document in the SOAP note. It will help you know what questions to ask and what objective information to seek.

SUBJECTIVE

This is your investigation of your patient's symptoms. Think about this in the context of the 3 questions you asked yourself before you saw the patient:

What is their diagnosis?

Asking if their symptoms are better or worse helps you monitor response to treatment.

What are the main complaints or problems?

Symptom progression or relief may move some diagnoses up or down in likelihood.

What differential diagnosis is being considered?

Asking about symptoms that relate to other diagnoses helps you refine your differential diagnosis.

SO……

Subjective investigation involves asking about the symptoms your patient had on presentation, whether their symptom is better or worse, and whether new symptoms have developed. It involves asking about other things that are related to their diagnosis/ problem or their functioning in general e.g. appetite and oral intake, urine output, stool production, mental status, overall feeling of wellbeing. It also involves asking about any procedures that were recently done and how they were tolerated by the patient. For children, this information may be received from the parent or caregiver.

Subjective documentation does NOT include anything regarding physical examination or laboratory findings. It does NOT include your assessment or any component of your plan for management.

OBJECTIVE

This is your investigation of your patient's physical examination signs and laboratory/radiologic results. You should also think about this with respect to the same 3 questions:

What is their diagnosis?

Checking to see if physical exam signs are better or worse helps you monitor response to treatment.

What are the main complaints or problems?

Improvement or worsening in physical exam signs may move some diagnoses up or down in likelihood.

What differential diagnosis is being considered?

Eliciting physical exam signs that relate to other diagnoses helps you refine your differential.

SO……

Objective investigation involves looking for the signs your patient had on presentation, whether that is better or worse, and whether new signs have developed. It involves checking for other signs that could indicate their status in general e.g. overall appearance, orientation, hydration status. It also includes vital signs:

Note the range of vital signs noted by nursing overnight

Also note your own observations – your own HR, RR – especially if different than overnight

Remember that the medical language regarding subjective and objective findings may be somewhat different.

Symptom (history) = pain

Sign (examination) = tenderness to palpation/appears in pain

A complete PE may not be necessary every single day for a patient in the hospital. It should be focused on the pertinent findings. It is important to not document any physical examination finding that you did not personally witness or perform. This is documentation of YOUR findings, so if it is written, it is assumed that you did it.

Laboratory values go in this section. You should report new labs, and it's helpful to provide the date the lab was done, especially if serial labs are being done e.g. Blood cx 6/14 negative.

Radiologic values go in this section. The final impression given by the radiologist should be reported, not all of the notes that the radiologist dictates about the film itself.

Some people choose to put the patient's medication list and IVF in this section.

ASSESSMENT/PLAN

This is the part of the note that tells the reader what you think is going on and what the plan of care is. Because this section is based on your subjective and objective findings, you should not write this section first, no matter the length of time your patient has been in the hospital or the stasis of his/her condition. Things can change overnight, even for chronic patients, and your assessment and plan would need to reflect that. For hospitalized patients, this usually includes some mention of progress e.g. better or worse.

There are 2 approaches to writing this section. The service you are on, your attending physician preference, and the patient's condition and problems could affect which you take. Ask your supervising residents and attending physician what style works best for their service.

SYSTEMS APPROACH

This works well for complex patients and for patients in the ICU. In this approach, the assessment is a one-liner sentence that describes the patient's problems or lists the diagnoses. The plan then follows by systems e.g.:

Assessment: 23 year old female with pancreatitis and new onset shortness of breath.

Plan: CV/Resp: Obtain CXR to evaluate for pleural effusion

FEN/GI: Re-establish IV access and continue NPO status secondary to continued pain

Heme/ID: Follow CBC to evaluate WBC trend and anemia

Neuro/Psych: Follow up with CAGE questionnaire today to assess alcohol risk

Disposition: Discharge once tolerating po intake, pain well controlled, and etiology identified

PROBLEM-FOCUSED APPROACH

This works well for simple problems that don't involve multiple systems. In this approach, the assessment and plan are presented together. Individual problems are listed, immediately followed by the plan to address the problem. You still need to still think about all systems e.g. FEN to ensure thorough consideration of all problems:

Assessment/Plan:

1. *Acute pancreatitis with risk for alcohol and GB disease as etiologies: Continue current pain medication and obtain abdominal U/S to rule out GB disease. Obtain CAGE questionnaire to establish alcohol risk. Follow serial CBC to assess for anemia.*
2. *New onset SOB: Obtain CXR to rule out pleural effusion – if normal, consider other causes of shortness of breath.*
3. *Fluid status: Continue NPO status, restart IVF at maintenance. Follow serial electrolytes.*