Pediatric Clerkship

Pediatrics
661

2008-2009

A comprehensive course of study which consists of faculty supervised responsibilities in ambulatory and Inpatient care. Broad clinical experiences are integrated with seminars and student centered learning.

Pediatrics 661

PEDIATRIC CLERKSHIP
2008-2009

SYLLABUS

University of Nevada
School of Medicine

DEPARTMENT OF PEDIATRICS

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Date: July 2008

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A comprehensive course of study which consists of faculty supervised responsibilities in ambulatory and inpatient care. Broad clinical experience are integrated with seminars and student centered learning.

UNIVERSITY OF NEVADA SCHOOL OF MEDICINE
PEDIATRIC DEPARTMENT

Address Form and Information

For the purpose of keeping your address updates, please complete this form at the beginning of the clerkship and return it to Sunshine Lackey Department Administrative Assistant.

Date: ______________________________

Name: ______________________________

Address: ______________________________

Telephone*: ____________________ Cell Phone*: ____________________

Pager*: ____________________

E-mail: ______________________________

Primary Medical Interest:

a. Primary Care Specialty ____________________

b. Subspecialty ____________________

c. Private Practice ____________________

d. Academic Career ____________________

e. Other ____________________

Current Class Standing: ____________________

e.g. Upper, middle, or lower 1/3 of class

USMLE Part I Score: ______________________________

*Please note the best way to contact you.

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PEDIATRIC CLERKSHIP

July 1, 2008

PREFACE

Pediatric Clerkship

The University of Nevada School of Medicine's Department of Pediatrics offers a third year medical student clerkship, consisting of a six week clinical rotation. Included during this time period are weekly didactic sessions, consisting of: a) lectures/seminars, and b) case discussions. The format for these sessions are Tuesday afternoons, as part of the 24 week "Clinical Reasoning in Medicine" course. The lecture/seminar is given by a faculty member, and case discussions are given by two students. These sessions will be graded by the faculty member as to oral presentation skills, use of problem solving skills, and use of informational science skills.

I. Yearly Schedule (starting dates)

July 7, 2008
August 18, 2008
September 29, 2008
November 10, 2008
January 5, 2009
February 16, 2009
April 6, 2009
May 18, 2009

II. Shelf Examination Dates

August 15, 2008
September 26, 2008
November 7, 2008
December 19, 2008
February 13, 2009
March 27, 2009
May 15, 2009
June 26, 2009

GOALS

COMSEP

The 2005, curriculum attempts to define a central body of pediatric knowledge, skills and attitudes which are fundamental for a general physician.

The goals of this core curriculum in Pediatrics are to foster:

- Acquisition of basic knowledge of growth and development (physical, physiologic and psychosocial) and of its clinical application from birth through adolescence.
- Acquisition of the knowledge necessary for the diagnosis and initial management of common pediatric acute and chronic illnesses.
- An understanding of the approach of pediatricians to the health care of children and adolescents.
- An understanding of the influence of family, community and society on the child in health and disease
- Development of communication skills that will facilitate the clinical interaction with children, adolescents and their families and thus ensure that complete, accurate data are obtained.
- Development of competency in the physical examination of infants, children and adolescents.
- Development of clinical problem-solving skills.
- Development of strategies for health promotion as well as disease and injury prevention.
- Development of the attitudes and professional behaviors appropriate for clinical practice.

The pediatric clerkship, in order to accomplish the above stated goals, has a number of objectives as defined below. These objectives are to be met during your six week clerkship rotation. It is necessary that you, where applicable request of your preceptor(s) an evaluation as to whether you are satisfactorily meeting these objectives.

OBJECTIVES

1. Upon completion of the basic clerkship, each student should be able to:

   A. Demonstrate skills in independent learning and critical thinking.

   B. Obtain and record clearly a complete medical history, conduct a complete physical examination, and,
   (1) Identify normal and abnormal patterns (physical, intellectual and social).
   (2) Identify and accurately record the patient's problems (physical, intellectual and social).
   (3) Assess the data in the context of the patient's status, formulate a problem list for both acute and long-term problems, and a provisional diagnostic and therapeutic plan.
   (4) Obtain necessary supplementary information and reassess the patient's status at appropriate intervals; and revise the problem list and plan utilizing the information noted under (3) above.
   (5) Present verbally at bedside or in conference, concise summary of the patient.

   C. Establish a relationship of mutual respect between the physician, patient and patient's family, and acquire the basic interpersonal skills which facilitate this relationship.

   D. Utilize community agencies, practicing physicians and community health care programs to facilitate optimal care.

E. Research a particular subject in depth and communicate this clearly and effectually in writing.

F. In carrying out the above, utilize appropriate learning resources including texts and literature, consultation with peers, senior colleagues and/or allied professionals.

G. Develop positive attributes which will serve as the basis for a successful professional career.

H. Develop study habits which will enhance lifelong learning.

2. These objectives and the goals of this clerkship are for the student to recognize that:

"Pediatrics is the specialty of medical science concerned with the physical, emotional, and social health of children from birth to young adulthood. Pediatric care encompasses a broad spectrum of health services ranging from preventive health care to the diagnosis and treatment of acute and chronic diseases."

"Pediatrics is a discipline that deals with biological, social, and environmental influences on the developing child and with the impact of disease and dysfunction on development. Children differ from adults anatomically, physiologically, immunologically, psychologically, developmentally, and metabolically."

3. Comments

A. None of these objectives can be regarded as an absolute. Students will usually be able to carry out many of the functions to varying extents even before beginning the clerkship. The intent of the student should be to continually develop the knowledge, skills and approaches needed to achieve these objectives in as satisfactory a manner as possible.

B. **No rigid rules can be laid down about how students should rank priorities in the use of their time to benefit the most from their clerkship; common sense and individual judgment must be exercised. In general, however, students should understand that the faculty regard a maturing sense of professional responsibility and an alacrity in seeking out opportunities to learn and participate in patient care, as favorable indicators for future professional quality. Progress in this regard is an important factor in performance evaluation.**

C. This survey course is designed to allow these goals to be achieved expeditiously. This course's value to you will be directly proportional to the effort you expend. You have both cognitive and performance responsibilities, which will be monitored and evaluated.

4. **Students are expected to uphold the principles of and abide by the following <u>Honor Pledge</u>:**

University of Nevada School of Medicine Honor Pledge

I will strive to maintain the highest standards of responsibility, integrity and professionalism during my education and throughout my professional career.

I will neither receive nor give unauthorized assistance on examinations or assignments and I will
approach my education with honesty and integrity.

I will respect and support my classmates, colleagues and teachers at all times.

I will strive to acknowledge my limitations, strive to learn from my mistakes and work to improve my skills to the benefit of my patients.

I will strive to commit myself to a lifetime of learning and teaching both the art and science of medicine.

I will strive to attend to all my patients with competence and compassion.

I will maintain patient confidentiality and be tactful in my words and actions.

I will honor the diversity of patients' experiences, cultures and beliefs.

I will recognize the privileges afforded to me as a physician and a physician-in-training and promise not to abuse them.

I will use my knowledge to improve the lives of others and never to harm. I make these promises
solemnly, freely and upon my honor.

REQUIREMENTS

1. Lecture/Seminar

   All Students are required to attend the Tuesday afternoon Clinical Reasoning in Medicine course. Please refer to the MED 651 Clinical Reasoning in Medicine syllabus for dates and topics. Students should prepare for the series by reviewing the knowledge base and clinical problems section of the COMSEP Curriculum in reference to the subject to be discussed, in addition to the module cases/tutorials provided.

2. Shelf Examination

   The Shelf Examination will be administered at the end of the family medicine/pediatric clinical rotations and must be passed (greater than or equal to the 5th percentile) to receive a passing grade for the Pediatric Clerkship.

3. Dress and behavior Code

   A. Your dress, cleanliness and behavior must be appropriate to your profession and acceptable to your attending physician or clinic director. Wear your name tag at all times. Please remember your white coat, stethoscope, otoscope, and opthalmoscope (battery charged).
   B. Fingernails must be trimmed short.
   C. Always introduce yourself as a student physician to the patient and the patient's family or friends. Never walk into a room and begin an examination or procedure without introducing yourself. If you know the patient and accompany a new student or physician into a room, introduce that person to the patient.

4. Faculty evaluation

   Evaluation of the clerkship, lectures and faculty will be performed utilizing the E*Value program. These evaluations **must** be complete by at the end of the rotation.

5. Absences

   A. **Absence due to illness**: If you become ill during the clerkship and are unable to carry on with your responsibilities for the Las Vegas students, call the Pediatric Department Office at (702)671-2231or for the Reno/Elko students call (775)784-6170 as soon as possible and report your illness. In addition, notify your assigned preceptor.
   B. **Absence Other Reasons:** No one but the Clerkship Coordinator can excuse your absence from the clerkship for reasons other than illness. Arrangements will have to be made at least one week in advance of your planned departure. As soon as you have the approval of the coordinator, you are to inform your preceptor of the dates of your absence.
   C. **Problems**: If you have any problems during the clerkship (people problems, school problems, personal problems, etc.), please discuss this with the chair or clerkship coordinator. Unresolved problems do affect clinical performance and how we function as professionals. We cannot help you with a problem we do not know about, so please take the responsibility to talk with someone when you have any kind of problem during this clerkship.

OPTIONAL STUDENT PAPER

It is essential for physicians to be able to communicate clearly and effectively in writing. If you would like to have this ability evaluated, you can prepare a brief five to six page, double spaced, typewritten paper on a pediatric topic of interest to you. A summary of a textbook or review of an article is not acceptable. However, part of the paper can be a general introduction and review, but evidence of journal article research is required. The report should be a **critical review** of a specific question, and encompass the concept of evidence based medicine and meta analysis. An alternative is to prepare a paper for publication. If you intend to prepare a paper, discuss this with the clerkship coordinator.

CORE COMPETENCY AREAS

The table below lists the areas of competency that residents are expected to have at the completion of their training. These areas are ones, that during your medical student education, you should be aware of and for which you will partially be evaluated during your 3rd and 4th year.

Core Competency Areas for Residency Training Approved by the ACGME*	
Patient Care	Provide care that is compassionate, appropriate, and effective. Communicate effectively and demonstrate caring, respectful behaviors. Perform competently all medical and invasive procedures considered essential for area of practice.
Medical Knowledge	Demonstrate an investigatory, analytical thinking approach to clinical situations. Know and apply the basic and clinically supportive sciences appropriate to the discipline.
Practice-based Learning and Improvement	Analyze practice experience and perform practice-based improvement activities using a systematic methodology. Facilitate the learning of students and other health Professionals.
Interpersonal and Communication Skills	Engage in effective information exchange and teaming with patients, their families, and professional associates. Work effectively with others as a member or leader of a health care team.
Professionalism	Demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to diverse patient population. Show respect, compassion, integrity, and be responsive to the needs of patients and society in a way that supercedes self-interest. Demonstrate a commitment to excellence and ongoing professional development
Systems-based Practice	Demonstrate an awareness of and responsiveness to the larger context and system of health care.

*From the Web site of the Accreditation Council for Graduate Medical Education, **www.ACGME.org**.

RESOURCES

Informational Science Resources:

Reading assignments and suggested references are as delineated in this syllabus. The UNSOM Library's web site is www.med.unr.edu/medlib. All necessary reading materials, journals, etc. are available, including audio visual materials.

GENERAL PEDIATRIC SOURCES, JOURNALS AND REFERENCES

Any of five major textbooks may be referenced from the library as a source of reading for your pediatric clerkship experience. These include: Avery and First's *Pediatric Medicine,* Hoekelman's *Primary Pediatric Care,* Nelson's *Textbook of Pediatrics*, Rudolph's *Pediatrics* and Oski's *Principles and Practice of Pediatrics.*

The following handbooks are attempts at a compromise between brief synopsis and expensive texts. The former (handbooks) are easily carried in a coat pocket and a quick ready reference in capsulized format. There are a variety of other pediatric handbooks available for use, each of which may be recommended by faculty members.

Handbooks

Behrman, et al.: *Nelson's Essentials of Pediatrics*, Saunders
Berkowitz: *Pediatrics, A Primary Care Approach*, Saunders
Bernstein and Schelov: *Pediatrics for Medical Students*, Lippincott, Williams and Wilkins
Rudolph, et al: *Rudolph's Fundamentals of Pediatrics*, McGraw Hill
Wood, et al.: *Pediatrics*, J.B. Lippincott Co.
Woodhead: *Pediatric Clerkship Guide,*Mosby

The following are very useful for understanding the approach to differential diagnosis of historical or physical examinations abnormalities.

Athreya and Silverman: *Pediatric Physical Diagnosis*, Appleton-Century Crofts.
Barness: *Manual of Pediatric Physical Diagnosis*, Year Book Medical Publications.
Daeschner, et al.: *Pediatrics: An Approach to Independent Learning,* Churchill Livingstone.
Green: *Pediatric Diagnosis*, Saunders.
Tunnesen: *Signs and Symptoms in Pediatrics*, Lippincott.
Zittelli and Davis *Atlas of Pediatric Physical Diagnosis*, C.V. Mosby Co.

Journals and monographs as sources for review articles include:

American Academy of Pediatric PREP
Advances in Pediatrics
American Journal of Diseases of Childhood
Behavioral Pediatrics
Current Problems in Pediatrics
Journal of Pediatrics
Major Problems in Clinical Pediatrics
Pediatrics
Pediatrics Clinic in North America
Pediatric Infectious Disease
Pediatrics in Review
Year Book of Pediatrics

For USMLE test question preparation

NMS (National Medical Series for Independent Study) *Pediatrics* by Dworkin
Pre Test "Pediatrics" by Yerman and Hormann

A Framework for Teaching Evidence-Based Medicine Across the Medical Curriculum

A short list of useful websites for EBM

1. The Oxford Centre for Evidence-Based Medicine – http://www.cebm.net/
2. Toronto's Centre for Evidence-Based Medicine – http://www.cebm.utotonto.ca/
3. The Centre for Health Evidence – http://cche.net/
4. The University of Alberta's EBM toolkit – http://med.ualberta.ca/ebm/ebm.htm
5. The EBM Resource Center in New York – http://www.ebmny.org/
6. The U Mass EBM site – http://library.umassmed.edu/EBM/
7. BMJ's EBM On-Line – http://ebm.bmjjournals.com/
8. Family Medicine's Evidence-Based Practice – http://www.ebponlline.net/
9. Best BETs – http://www.bestbets.org/
10. The McMaster Online Rating of Evidence – http://hiru.mcmaster.ca/MORE/
11. EBM Tools by Alan Schwartz – http://araw/mede/uic.edu/~alansz/tools.html
12. AHRQ Clinical Resource Pate – http://www.ahrq.gov/clinic/
13. The University of Sheffiled's Netting the Evidence – http://www.shf.ac.uk/scharr/ir/netting/
14. The society for Academic CME – http://www.sacme.org/Research/EBM_resources.htm
15. The JAMA Users' Guides – http://www.cche.net/usersguides/main.asp
16. The Cochrane Library – http://www.cochrane.org/
17. CATwalk – http://www.library.ualberta.ca/subject/healthsicences/catwalk/index.cfm
18. Entrez PubMed – http://www.ncbi.nlm.nih.gov/entrez

Methodology for the Use of Tests for Learning

Self testing as a review for determining your own database knowledge is a valuable tool. A simplified approach is outlined and requires the learner to spend as much time as needed to magnify the learning experience obtained from individual questions and answers. A major testbook (Nelson's) should be available before starting your self testing.

1. Read the question with the potential answer choices covered up.
2. Attempt to answer the question without uncovering the answers.
3. Uncover the first answer and ask yourself (the question) as to why or why not this is or is not the answer
4. If you don't think this is the answer then determine why it is not. This may require you to look this answer up in a textbook, which you should have readily available.
5. Proceed with the next answer in a similar fashion.

Most questions will take 5-10 minutes to analyze in this fashion, depending on your knowledge of the subject matter.

You may find it helpful to use this methodology with a study group and explore each topic or subject matter by finding out what you do or do not know about the items uncovered.

Examples:

1. The most common anomaly of the eyelid is:
   What do you think? Do you have any idea?
   (Perhaps you should look up common disorders of the eyelid.)
   A. Entropion — What is this?
   B. Congenital ptosis
   C. Ectropion — Should have uncovered what this is by looking up entropion.
   D. Palpebral coloboma
   E. Blepharophimosis — Are you sure you know what this is?

More difficult types of questions to use this methodology are the "except" type questions.

2. Polycythemia may be found in each of the following **except**

   A. Cyanotic heart disease
   B. Renal tumors
   C. Emphysema
   D. Bronchiectasis
   E. Juvenile diabetes

An obvious answer, but what is it you know about these diseases and their mechanism in causing cyanosis?

The "true/false" type questions are probably the most educational in that you need to know why the answer is false.

RECOMMENDED READING/VIEWING

During your third-year clerkship, in addition to the general reading assignments, to derive data base material for understanding the fundamentals of pediatrics, every effort should be made to formally review the following topics, either through lectures, reading material, videotapes and/or discussion groups. In some instances core lectures will be provided, whereas in other instances these areas may be discussed as part of the patient evaluative process in the clinic or ward situation. These topics are considered to be commonly encountered areas, some of which you should have gained an understanding for previously and some of which you should now gain a firm understanding (see table below). The COMSEP Curriculum is an excellent starting place.

	Yr I	Yr II	Yr III	Yr IV	By end of Yr III
1. Health Supervision	+	+	+	+	75% Level
2. Growth	+	+			100%
3. Development	+	+			100%
4. Behavior Problems	+	+			100%
5. Nutrition	+	+			100%
6. Prevention of Illness	+	+	+	+	75%
7. Issues Unique to Adolescents			+		100%
8. Issues Unique to Newborn			+		100%
9. Medical Genetics and Dysmorphology	+	+			100%
10. Common Acute Pediatric Illnesses			+	+	75%
11. Common Chronic Illnesses & Disability			+	+	75%
12. Therapeutics	+	+	+	+	75%
13. Fluid and Electrolyte Management			+	+	75%
14. Poisoning			+	+	50%
15. Pediatric Emergencies			+		100%
16. Child Abuse			+	+	75%
17. Child Advocacy			+	+	50%

As part of your basic reading, you will be given a copy, for your use during the clerkship, of Bernstein and Shelov's, *Pediatrics for Medical Students* paperback, including the CD. This copy is to be returned to the department upon completion of your six week clerkship rotation. A final grade will not be given if the copy is not returned promptly.

The guiding principles of reading and keeping current as stated by Sir William Olser, the father of academic medicine, is to:

> **"read with two objects (in mind), first to acquaint yourself with the current knowledge on a subject and the steps by which it has been reached, and secondly, and more important, read to understand and analyse your cases."**

General undirected reading helps the physician stay current with the state of the art, whereas reading about puzzling individual cases (or a series of cases seen in practice) has an immediate, specific, and practical purpose. Both types of reading, general and specific, will be more valuable if you have an objective in mind or can relate what you read to your clinical experience.

The importance of reading and seeing patients cannot be overemphasized. Again to quote Osler:

> **"To study the phenomena of disease without books is to sail on uncharted sea, while to study books without patients is not to go to sea at all."**

Computer-assisted learning in Pediatrics Project

CLIPP

Introduction

The Computer-assisted Learning in Pediatrics Project (CLIPP) is a series of 31 Web-based interactive virtual patient cases and related teaching resources that comprehensively teach the clerkship curriculum of the Council on Medical Student Education in Pediatrics (COMSEP). CLIPP was primarily developed for use by students during their Pediatrics Clerkship.

CLIPP Cases

CLIPP cases integrate knowledge into a clinical scenario and expose learners to clinical reasoning in primary care pediatrics, including newborn, health maintenance, acute and chronic conditions. Each case is designed to take a student learner approximately 45 minutes to complete. The cases feature significant use of multimedia (audio, video and still pictures), directed by hyperlinks to high-quality material on the Internet, and Key Teaching Points printable at the end of each case that succinctly summarize the important teaching points within the case.

Registering

Go to the CLIPP Home Page at www.clippcases.org. Click "Go to Cases" in the left column, and it will take you to the CLIPP Login page.

Click the "register" link, and on the User Data page, type in your name, institution and e-mail address. Click OK. The system will send you 2 e-mails with your Login and Password. When you get them, on the Login page:

Type in your Login and Password, then click "Login." The case selection page will appear. Click to open it.

Please make note of your Login and Password and use them whenever you access the cases.

One thing many users have not noticed is that there is a Clipboard button on the bottom navigation bar, which will give you a way to go back to cards in the case that you have already completed. It will not let you skip ahead! However, once you have completed a case, you can use the Clipboard button or the drop-down menu at the top of the card to go to any card in the completed session.

Changing Your Password: If you want to change your password, here are the directions for doing so: On the login page, type your login and your current password. Then click the Edit user data checkbox right below the password field. Click Login. A user profile page opens, and there are two fields to type your password. After you do this, click "ok"

Clinical Encounter Table

During your clerkship it is anticipated that you will have a variety of clinical encounters that will provide a minimum clinical data base in order to assure your gaining sufficient experiences to evaluate, diagnose and provide adequate treatment for the common pediatric disorders. Of the 14 domains listed eg. patient type/core conditions, there are selected CLIPP cases that will assist you with gaining fundamental knowledge in these areas and allow you to utilize your clinical problem skills. You are required to do a minimum of twelve cases which will be reviewed by your clerkship coordinator. These cases will not be graded except to be used as part of the subjective clinical evaluation form.

Domain	**CLIPP case number**
Health Maintenance	
Newborn	1
Infant	2
Toddler	3
School age	4
Adolescent	5,6
Growth	( )
Nutrition	( )
Development	28,29
Behavior	4
Upper respiratory tract	14
Lower respiratory tract	12,13
Gastrointestinal tract	15, 27
Dermatology	3,21
Central Nervous System	20,24,28
Emergent clinical problems	23,25
Chronic medical problems	30,31
Unique conditions (fever)	10
Neonatal jaundice	8

Cross Cultural Healthcare Case Studies

For those of you who have not had an opportunity to explore the cultural issues in medicine that present from people of diverse cultural backgrounds, the website listed below is an interactive self-study program, that consists of a series of five tutorials in cultural competence, designed to familiarize yourself with these common issues. I believe it would be worthwhile for you to review these and perhaps if appropriate prepare have a case conference around cultural diversity.

The web-site is http://ppc.mchtraining.net/.

PEDIATRIC CLERKSHIP AND CLINICAL REASONING IN MEDICINE COURSE

The pediatric case material and tutorial questions in the Clinical Reasoning in Medicine course should be viewed from the perspective of developing your critical thinking and clinical reasoning skills rather than gaining pediatric data base information. It is therefore necessary to maximize your pediatric clerkship experience by concentrating, not only on your clinical skills, but expanding your medical fund of knowledge in pediatrics that will enhance our understanding of the molecular biology and normal physiology of infants, children and adolescents, as well as the diseases and disorders that affect pediatric patients.

Critical thinking involves a series of elements including a degree of maturity, self-confidence, being open minded and a desire to seek the truth. This is accomplished by being inquisitive, systematic and analytic in approach to the problem to be answered or solved.

It is important to recognize that a considerable amount of time and energy must be devoted to gain a firm data base of information needed to refine your clinical judgment.

Suggestions for learning throughout the clerkship include reading daily both generic information as well as focused subject reading regarding your patients. At least two hours per day should be devoted to this activity. Read with a view as to what is the scientific or evidenced based information for statements being made. The clinical practice of medicine is frequently experienced based and it is important to understand the differences between clinical experience, evidenced based medicine and established or recommended practice guidelines. Web sites are available for practice based guidelines for many diseases and disorders.

PEDIATRIC ROTATIONS

Refer to your site specific syllabus for your individual rotation schedule.

LECTURES/SEMINARS/COMPUTER CASES

1. Student should prepare for the **Tuesday** (Clinical Reasoning in Medicine) series by pre-reading in your textbook and reviewing the knowledge base and clinical problems sections of the COMSEP Curriculum in reference to the subject to be discussed, in addition to the module cases/tutorials provided.

2. See Clinical Reasoning in Medicine course syllabus for more detailed information.

3. See CLIPP Clinical Encounter Table.

PEDIATRIC EVALUATION

Clinical Performance

The student's clinical performance in the clerkship will be evaluated in areas of content-scholarship, process-scholarship, motivation, interpersonal skills, performance skills and integrity. Each of these attributes has been defined in terms of specific criteria which, as a student, you are required to meet throughout your clinical clerkship (see E*value). We wish to encourage faculty and students to engage in an active dialogue concerning the student's clinical performance. The "Evaluation of Pediatric Student Clerkship Performance" form is the product of the faculty and identifies those attributes on which a student will be appraised during clerkship. Where more than one attending or preceptor fills out an evaluation, an attempt will be made to average these evaluations and weigh them according to depth and frequency of exposure.

Faculty Evaluation

The evaluation of the faculty by students must be completed at the end of the rotation. These evaluations, are completed online (E*Value program). Note that there are two different forms, one for faculty lectures and one for clinical teaching. Fill out the appropriate form(s) for each faculty member. The completed forms are confidential and only available to the Office of Medical Education.

Clerkship Evaluation

Students are required to complete on-line, a clerkship evaluation form prior to the end of the clerkship. This form is confidential and only available to the Office of Medical Education. The evaluations are extremely important feedback to those of us responsible for the pediatric clerkship. We use the information provided in addition to the exit interview, to modify the clerkship in such a way that enhances the student's educational experience.

Mid-Clerkship Evaluation

Students are to arrange to have a formal evaluation at the end of their 3rd week, with the clerkship director or his/her designee to discuss the student progress.

Final Evaluation

Both the mid-clerkship evaluation and the final evaluation, including the final grade, will be available on line (E*value) for the students review.

Third Year Pediatric Clerkship Exit Interviews

(to supplement the students confidential evaluation of clerkship forms)

1. Experience
   a. Average number of patients seen/day in outpatient___________________
      inpatient____________________
      nursery______________________

   b. Number and type of procedures performed _____________________
      ____
      ____

   c. On call activity
      Frequency _____________________
      Average number of patients evaluated _____________________

   d. Learning experience
      Average number of hours reading/day _____________________
      Total hours of reading 0-50hrs _____________________
      51-100hrs _____________________
      >100hrs _____________________

   e. Primary sources of reading _____________________
   f. Web site(s) _____________________
   g. Types of reprints _____________________
   h. CLIPP cases completed _____________________

2. Resident teaching experience:
   a. Type of teaching

   b. Resident level teaching

3. Comments regarding clerkship:
   a. Most important or best aspect

   b. Least important or worst aspect

Interviewer:_________________

Grading

Student grades will be HONORS, HIGH PASS, PASS, MARGINAL, or FAIL.

Final grades will be based on the pediatric shelf examination and the composite of the "Clinical Performance Evaluation" forms completed by the clinical preceptors.

Shelf examination scores will be recorded as a percentile and graded as HONORS (>70th percentile), HIGH PASS (50th to 69th percentile), PASS (5th to 49th percentile) and FAIL(<5th percentile).

Shelf examination results at the 70th percentile or higher and an overall honors on the composite Clinical Performance Evaluation, with no evaluator concerns, will be required for a grade of HONORS in the clerkship.

HIGH PASS will be awarded to a student who receives HONORS or HIGH PASS in the clinical performance or the shelf examination and a HIGH PASS in the counterpart. HONORS in the clinical performance and a PASS in the shelf examination will also result in a n overall HIGH PASS.

Shelf examination results between the 5th percentile and the 49th percentile and/or an overall HIGH PASS or PASS on the composite Clinical Performance Evaluation, with no evaluator concerns, will be assigned a grade of PASS in the clerkship. Students may also receive a PASS with a MARGINAL evaluation and/or Evaluator Concern.

A shelf examination results less than the 5th percentile will result in an INCOMPLETE grade. An overall FAIL on the composite Clinical Performance Evaluation will be assigned a grade of FAIL in the clerkship.

If the shelf examination results are below the 5th percentile, the student is required to retake the shelf examination according to UNSOM policy. If the final on the composite of the Clinical Performance Evaluation is FAIL, the student will be required to repeat the clerkship according to UNSOM policy.

Note: Initial failure and subsequent pass of the shelf examination will result in no greater than a maximum grade of High pass, depending on the clinical performance evaluations.

The final grade for the Pediatric Clerkship will be assigned by the clerkship coordinator.

Clerkship Shelf Examination Protocol

In the event that a student fails the shelf examination given as a required final in a required clerkship, the student will be awarded an "incomplete" grade for the course until the shelf examination is repeated and passed. The shelf examination should be retaken within twelve weeks of receipt of the failing score of the first attempt. It is strongly recommended that the student form a plan of study collaboratively with the clerkship director in whose clerkship the shelf examination was failed. If the student fails the shelf examination on the second attempt, the student will receive a "fail" grade for that clerkship and that clerkship will be repeated. The student must follow a prescribed plan of study during the repeated clerkship. This prescribed plan of study will be designed by the clerkship director and tailored to the specific deficiencies of the individual student. If the student fails the shelf examination on the third attempt, they will receive a failing grade for the repeated clerkship and will be dismissed from medical school. A passing grade on the shelf examination is at the fifth percentile or better during the academic quarter that the test is taken.

SECTION II

PEDIATRIC DATA BASE INFORMATION

The examination of an infant or child may at times be very problematic. I would therefore recommend that you view (DVD) the **"Introduction to the Pediatric Physical Exam"** developed by the Ambulatory Pediatric Association as part of the COMSEP curriculum. The DVD is available in the clerkship coordinator's office.

THE PEDIATRIC PROBLEM-ORIENTED RECORD

Introduction

The following suggestions are for your reference in recording the basic data into the Pediatric Problem-Oriented Medical Record. They may be used at the time of taking the history. Not all points listed below will be pertinent in each case. In your organization of each history, use the most logical organization depending upon the specific problem(s) described by the patient. Do not repeat yourself. The order of recording the history and physical examination is frequently very different from the order in which the information is obtained. In general, first allow the informant to talk freely about the patient and then ask questions. Be polite and avoid using the history-taking to correct flaws in parental education.

What is a problem?

The consensus is that anything that affects the health of an infant or child, suggests a predictable outcome in the medical field or handicaps the potential of competitive abilities as an adult, should be defined as a problem and should have a plan of resolution. The following are examples of these types of problems:

Disease – which is self-explanatory, it is, anything that would be called or classified under the usual nomenclature system as disease.

Genetic Background – of significance, such as siblings with phyenylketonuria, both parents with strong allergic histories or the child of a diabetic mother or consaguinity in parents.

Socioeconomic – needs, as reflected by unusual situations that might influence the solution of particular problems, e.g. objection of the Jehovah Witness to blood transfusions. Situational occurrences, e.g., recent death of a family member or a recent change such as a move into this country. Other examples (often referred to as determinants of health) are educational problems, family disorganization, alcoholism in the family, lack of immunizations, accidents, poisonings or sex offenses.

Signs and Symptoms – e.g., abdominal pain which cannot be diagnosed specifically or respiratory distress which is as yet undifferentiated in diagnosis; psychiatric problems which are not clearly defined, abnormal laboratory results which do not fit any other problem.

Each problem of the patient must be considered individually and be recorded separately, with a different number. Each problem should be titled by main symptom or etiologic diagnosis.

LINE OF HISTORY, PHYSICAL EXAMINATION AND PROBLEM LIST

I. **<u>Data Base</u>** Informant:

Date: ______________________________________

Name: ______________________________________

Birthdate: ___________________________________

Referring Physical: ____________________________ City: __________________________

A. Chief Complaint – Set forth mother's reason for bringing child to medical attention. Give duration of complaint. "Why is the child attending clinic today?"

B. Patient Profile – Give pertinent social data which sets the patient in his environment, e.g., age, sex, race, ethnicity of patient, number of hospital admissions, with whom the child resides, how many children in the family, who is primary caretaker, and other information which immediately permits the individual reading the record to have some understanding of how this child lives. This will also assist you in retaining information and in identifying the child as a part of a family unit.

C. History of Present Illness (presenting problem) – Describe in chronological order the events of the patient's presenting illness. Include relevant negative information. What signs and symptoms of illness is the child showing? List symptoms in order of appearance. Sometimes specific questions must be asked, e.g., "Is he coughing?" When? What kind? How much?" "Does he have diarrhea? When? What kind? How much? For how long?" "How is the child acting otherwise? How is his appetite? Bowels? Fluid intake? Sleep? Activity?" "Has the child been exposed to others with illness? Anyone in the family? Relatives? Friends? School? What type of medications? Any procedures?"

D. Previous Known Problems – (only as listed on problem status index) –

E. Past Medical History –

1. Prenatal: Mother's health during pregnancy, i.e., drugs, x-ray, first trimester difficulty or illness. Attitude towards pregnancy, blood and Rh type, weight gain. Birth order (i.e., first or second, etc.) of gravida _____ para _____ ab _____ non-consanguineous (or consanguineous) couple of (ethnic) background.

2. Natal: Name of hospital and city where born, length of gestation, length of labor, type of delivery (anesthesia, forceps, etc.), birth weight, immediate cry and color, was mother awake at time baby was born.

3. Neonatal: Problems with jaundice, cyanosis, bleeding, infection, how did baby feed, age and discharge from hospital.

4. Diet: Feeding – diet by age. Ease of feeding. Breast or bottle? Vitamins, iron. Give a current diet, done by describing a typical day's intake when patient is well. Weight history in infants, including complications (vomiting, diarrhea, etc.)

5. Developmental: Denver Developmental Screening Inventory until age six. Thereafter, record school performance, find out about progress of sexual maturation.

6. Illness: Previous illness including communicable disease.

7. Accidents: Accident, injuries, ingestions

8. Hospitalization: Those not related to the present illness (include any surgical procedures such as T & A). Previous hospitalizations related to present illness should e summarized under history of present illness.

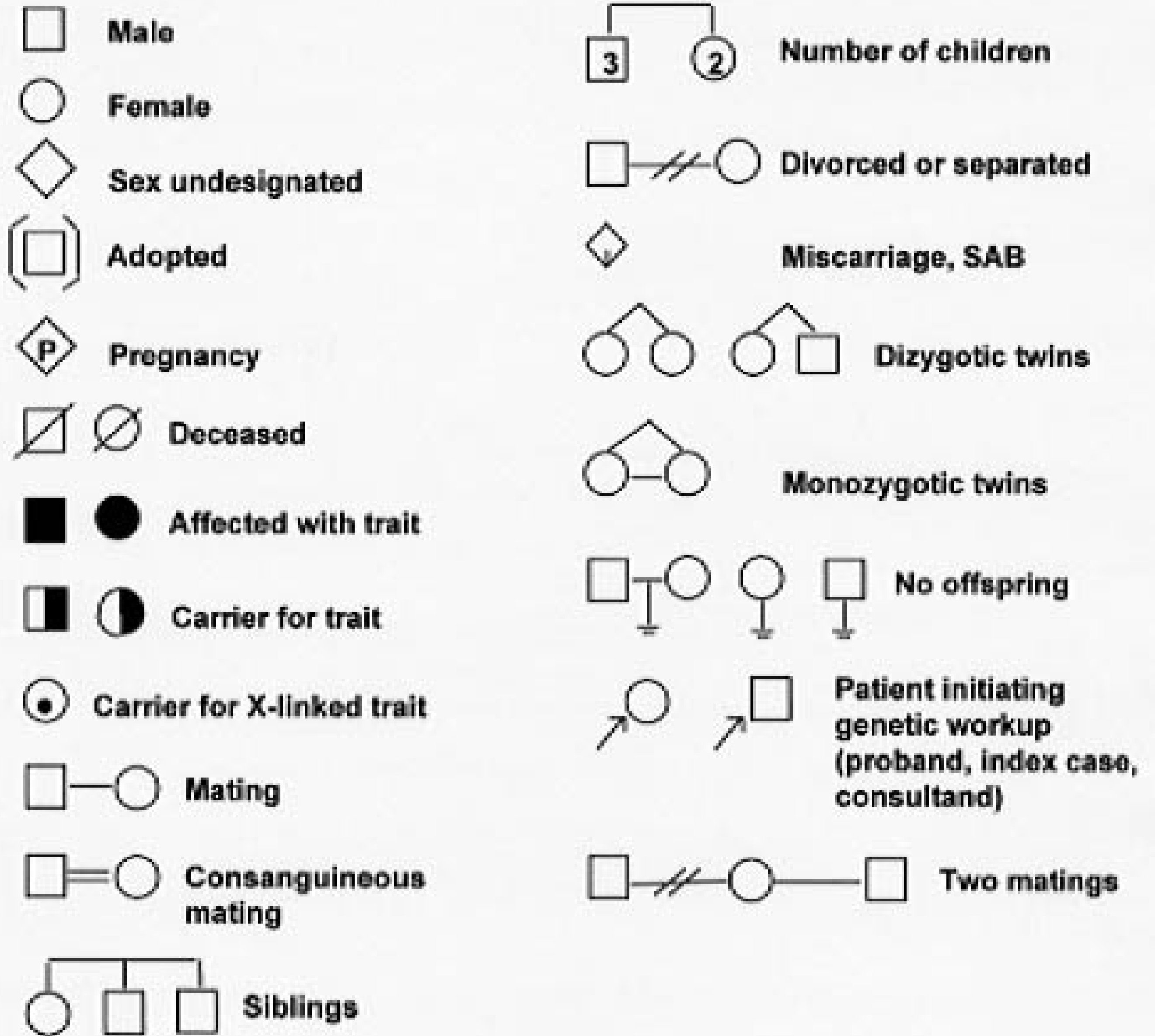
9. Allergies: Allergies and drug reactions-if patient has never had any drugs, please state this.

10. Immunizations: List type of immunization, e.g., DPT, polio; age and place where received; reactions, if any. This is best obtained from "baby book".

11. Habits and Behavior: Describe temperament, mood, toilet training problems, sex education.

F. Family History – this is done best by reviewing the health of siblings, parents, parents sibs, grandparents individually, rather than by diseases. This should be done diagrammatically.

Pedigree Symbols



G. Social History

1. Family:
   a. What individuals are members of family unit?
   b. Attitude of each parent towards each child; attitude of children towards each other.
   c. What are the educational backgrounds of mother and father? How would you characterize them? What are there feelings toward the child?
   d. Does the mother work? Who is the regular caretaker? What is the fathers employment? Is he regularly employed? Income disbursements of money for rent, food etc., debts, insurance. Public assistance?
2. Home living condition
3. Companions-is the child a leader? Dose he mix well with other children?
4. Recreation-how does the child spend his play time?

H. Review of systems – Review of systems starts with a general section which is an overall statement about the child's health. Sections in the systems review should include:

Eyes: (crossed eyes, difficulty seeing or reading, wears glasses)
Ears: (difficulty hearing, pain, discharge, infection)
Teeth: (toothaches, toothbrush use, when last seen by dentist, fluoride in water [or supplemental])
Respiratory Tract: (frequent colds, sore throats or coughs, mouth breathing, snoring, wheezing)
Cardiovascular: (tired or short of breath excessively, heart murmur, rheumatic fever)
Gastrointestinal: (frequent vomiting, frequent abdominal pain, bowel movements, pinworms)
Genitourinary: (frequent or painful urination, infection, poor stream [boys], hematuria, enuresis, nocturia [girls only – vaginal itching or discharge, period begun – age started, problems])
Neuromuscular: (frequent headaches, convulsions, coordination, joint trouble, gait)
Skin: (chronic rash)
Hematologic: (anemia, bleeding)
Misc.: (recent weight loss, wears seat belts in car – special restraining device needed under four years, syrup of ipecac at home [toddlers])

Please remember that this history is usually taken from an observer rather than the patient who is experiencing problems. Make your questions appropriate to things that an observer can answer. Whenever possible, try to get a review of systems from the patient. Most children, six and over, can give a fairly good history about the present.

I. Physical Examination – Physical examination of the child may require the greatest skill and tact. A friendly contact with the child should already have been established during the history-taking and before the examination is started. Be patient, remember, the child is in a new situation and may be very apprehensive. Reassure him and allay as much fear

as possible. Make the order of your examination fit the child and the circumstances. Do not make a sudden approach or sudden motion. Defer all necessary, painful or disagreeable procedures to the last; then be honest and warn the child before you start. Do not impede the child's movements, but if necessary, use restraining blankets and the aid of the nurse or mother, so that no time is wasted. It is important that the condition of the fontanel is determined before the child starts to cry. Abdominal palpitation, heart and lung's auscultation should also be carried out while the child is still cooperative.

Much of the examination of a young child or infant can be completed easily and atraumatically while the child is on the mother's lap or in her arms. Take the easiest, most convenient course during physical examination of a young child or infant, e.g., if the child is sleeping, listen to the chest, make measurements and gentle palpitations, etc., before awakening the child.

Thoroughness is essential. The child must be completely undressed, but usually not all at once. Respect the child's modesty, even though it seems silly and exhibited too early. Do not let the child be embarrassed; protect him from exposure to others.

Examination

1. Vital signs: Weight   Circumference of head (percentiles)
   Height   Circumference of chest (percentiles)
   Temperature
   Blood pressure Right and left are if elevated;
   Take lower extremities also.
   Pulse Respiration

2. General appearance: Estimate severity of present illness. Looks well, sick, general development and state of nutrition, state of hydration. Type of cry or voice: hoarse, husky, weak, high-pitched. Speech, state of consciousness, coma, apathy, restlessness, delirium, irritability, position in bed, splinting of any part, gain and posture, if ambulatory.

3. Skin and mucous membranes: Texture, color, icterus, rashes, cyanosis, pigmentation, petechiae, ecchymosis, sweat, edema, dryness, scaliness or desquamation. Tissue turgor fissures, collateral circulation, striae.

4. Hair: Amount, color, texture, alopecia, pediculi, scalp, eyebrows, lashes, axillary, pubic, trunk, limbs, face.

5. Lymph nodes: Enlargement, size in cm, location, moveable or fixed, tender, isolated or matter, fluctuant.

6. Head: Shape, symmetry, bosses, fontanels, open – size – depressed – bulging, sutures – open overriding – craniotabes.

7. Face: Expression – alert, dull, apprehensive, etc., paralysis.

8. Eyes: Motion (extrocular movements), lids – ptosis, strabismus, equality and size of

pupils, reaction to light and accommodation, conjunctive, cornea, sclera. Opthalmoscopic in older children or at any age, if indicated. Nystagmus, exophthalmos, photophobia, excessive lacrimation.

9. Nose and sinuses: Shape, movement of alae, sinus tenderness over frontal or maxillary. Septum deviated, mucosa pale, red, boggy, atrophic. Secretion and discharge. Obstruction to breathing (acute or chronic).

10. Ears: Shape of external ear, discharge, tenderness over mastoids. Drums – red, bulging, light reflex, perforation, hearing (older children – watch or whispered voice). In infants, determine whether child turns toward a loud sound (clapping of hands, whistle).

11. Mouth and throat: Postpone until last but NEVER omit. Does child breathe with mouth open, snort, wheeze or snore? Lips: color, dryness, sores, fissures, herpes, rhagades.

12. Teeth: Number, caries, hygiene, occlusion.

13. Gums: Color, swelling, hemorrhage, ulceration, edema, hypertrophy.

14. Buccal membranes: Enanthem, ulceration, petechiae. Palate, arch, perforation. Tongue– coating ulceration, fissures, dryness, color, thrush. Pharynx, color, edema, ulceration, vesicles, presence of membrane.

15. Tonsils: Size, crypts, exudate, inflammation, pillars, edema.

16. Neck: Rigidity, retraction of head, thyroid, lymph nodes, other masses, trachea in midline. Venous engorgement, pulsations.

17. Larynx: Voice, hoarseness, cough, stridor, speech defects

18. Chest: General shape (round, flat, pigeon breast, funnel-shaped, flaring of ribs, expansion, retraction – suprasternal or subcostal. Rate, type of breathing (shallow, deep, grunting, labored, wit or without the use of accessory muscles). Palpation, tactile fremitus, thrills. Percussion – resonance, tympany, dullness or flatness. Auscultation – character of breath sounds, pitch intensity rales, rhonchi, wheezes.

19. Cardiovascular system: Radial pulse, rate, rhythm, collapsing pulse, tension, pulsations or engorgement of neck vessels. Murmur over neck vessels – transmitted? Bruits over vessel. Bulging or heaving of pericardium, point of maximum impulse, abnormal pulsations and thrills. Measurements – character of sounds, murmurs, location, time, transmission, effect of change of position, after exercise (if not contraindicated by patient's condition). Presence of third heart sound.

20. Abdomen: Shape, size, veins, diathesis recti, umbilicus, tenderness, rigidity, visible peristalsis, masses, fluid. If you expect to elicit tenderness of pain (as in appendicitis, etc.), DO NOT ask the patient, "Does this hurt here…does it hurt here?" Some children will say "yes" because they confuse the possible discomfort of palpation with actual pain. Distract the child by conversation appropriate to his age level, go over the entire abdomen very gently at first, and then, as you explore a little more firmly, watch the child's face for evidence of pain or expressed by a grimace, a wincing or sudden

cessation of conversation in the middle of a sentence, etc. Determine any rigidity, visible peristalsis, masses, fluid. Palpate for liver, spleen, kidneys and hernia. Listen for gas and fluid sounds.

21. Genitalia: Abnormalities of development, hydrocele, hernia, prepuce, testicles, ureteral orifice, ureteral or vaginal discharge, DO NOT do even a fifth finger vaginal unless you consult with a resident or instructor who will decide whether this is indicated. Usually, a rectal examination will suffice in children, in case of suspected foreign body, etc.

22. Spine: Pain, tenderness, limitation of motion, posture, curvatures. Examine sitting, standing and lying, if possible.

23. Extremities: Symmetry, masculature, gait, joints (inflammation, motion, size or tenderness), deformity, edema, feet (flat). Finger tips, nails, clubbing or cyanosis. Always have the child walk unless he is too young or too ill.

24. Neurological: Mental state, intelligence, restlessness, apathy, coma, stupor, convulsions, delirium. Cranial nerves-paralysis, spasticity, flaccidity, atrophy, coordination, ataxia. Reflexes – biceps, triceps, abdominal, patellar, cremasteric, Babinski (normal up to 18 months),
Brudzinski, Kernig. Etc.

25. Developmental examination: Using the Ages and Stages Questionaire.

J. Baseline Laboratory Data

K. Diagnostic Impression - Based on all of the above, a single major diagnosis should be stated, that is the basis for the chief compliant.

L. There are a variety of "tools" that you need to become familiar with in relationship to completion of your history and physical examination of infants and children. Besides the standard graphing of height (length, stature) weight, head circumference, and weight to height ratio, the ASQ developmental screening test tool should be reviewed and utilized as noted in the history and physical examinations section of this syllabus. In relationship to the premature infant, a maturational assessment of gestational age tool is very useful, including measurements (length, weight, head circumference) to determine gestational assessment.

II. **Formulation Of All Problems**

This list should include all problems – present and past, resolved and unresolved, of major significance and incidental, medical, psychiatric and social problems. Each problem is listed at a level of refinement that is known and falls into one of four categories, e.g., diagnostic, physiologic finding, symptom or physical finding, abnormal laboratory finding.

In the conventional "Weed" approach, a list of problems and then a list of plans follow the acquisition of the Data Base. We have modified this by using the progress note format, "SOAP", for the initial problem formulations. The acronym SOAP is comprised of the first letters of the words: Subjective, Objective, Assessment and Plans – the elements of the problem analysis. The SOAP format is written in the record after the conventional history and physical examination.

SOAP takes the place of the traditional impression or different diagnosis. The SOAP format is as follows:

Problem Number and Title:
Subjective: - Brief summary of pertinent history for this problem; several lines only.
Objective: - Pertinent objective information; may refer to physical examination; Results of laboratory tests.
Assessment: - The most precise analysis of the problem at this time.
Plans:
A. Diagnostic
    1. Additional studies necessary to further define the problem. Here is where all questionable and "rules outs" belong.
    2. Management parameters to be followed, e.g., RR, P, intake, output
B. Therapeutic (medication, etc.)
C. Patient and/or parent education—what was told to the patient or parent about this problem.

Each problem must have a separate initial plan. The data for each problem are presented in the first two components (subjective and objective). The entire problem list should be reviewed to see if it is reasonable to combine several problems into one. Each problem in the final list should have an assessment and set of plans developed. The problems identified and their plans should represent a joint effort of all those responsible for care of the patient.

III. **Master Problem List**
The Master Problem List is the first sheet of the record because it provides an index to all of the patient's problems. The number, date and title of each problem as written within the test of the record is transferred to the Master Problem List. These problems may be from hospital admissions, emergency room visits or ambulatory care visits.

Problems are given an Arabic number and title. The specific number does not have intrinsic value: number "1" is not more important than number "2". These numbers serve as an index to the progress noted to follow in the patient's chart. As new problems arise, they are given the next number and written in the progress notes formal SOAP.

Problems are sorted into active and inactive/resolved categories. The problem title is entered in the upper portion of the space to permit later changes to more precise statements (see third question, below). The date column should include month, day and year for each problem, as well as the dates of change in problem formulations. Abbreviations are confusing and should not be used on the Master Problem List. As problems become better defined or merged during the patient's course, this information should be reflected in the progress notes, as well as on the Master Problem List.

These are questions commonly asked about the Master Problem List. Examples follow this section. What is done about well child? Immunizations, normal child development, psychosocial adjustment and safety education are often overlooked. For this reason, all patients should have entered as **active problem #1,** "Well Child Care," on the Master Problem List. This serves as a reminder to consider all aspects of the child, each time he is seen.

How do you indicate that the child has been given a comprehensive evaluation, including review and problem orientation of the old records? When this has been completed, an entry should be made on the Master Problem List, "Data Base Reviewed", and dated. This is entered in the inactive column opposite the entry of "Well Child Care". It means for a new patient that the

history and physical have been completed and all of the child's problems have been listed. For old patients, this also indicates that old records have been reviewed, verified and problemoriented.

If this has not been done, the entry, "Data Base Reviewed", should not appear.
How is a more precise formulation of an original problem entered? When data are available to more precisely define an original problem, they should be included in the progress note for that problem. At that time, the problem title is changed on the Master Problem List. Draw an arrow through the original title and enter the date and the new title. The progress note for Problem #2 on 6/7/97 should include the data to substantiate the diagnosis of urinary tract infection (see Problem #2 in example).

What do you do with several separate problems that are later found to be parts of a single problem?

Initially, these problems were identified and diagnostic studies undertaken. When the data were available to establish that these were parts of one problem this information was included in the progress note on 8/15/97 and the change made on the Master Problem List. The lowest number of the series is the one used to show this change. Numbers 5 and 6 will not be used again for this record (see problems #4, 5 and 6)

IV. **Acute Problem List**
<u>What about recurring problems?</u> Many pediatrics problems may recur such as otitis media or URI. For simplification and for ease of review, such problems are initially entered on an Acute Problem List and titled with a capital letter, rather than a number. Recurrences are then noted and dated, and if the recurrence of the problem is of sufficient significance to merit special attention, it is transferred to the Master Problem List, as noted in the example.

Progress notes for acute problems are titled by a letter and the SOAP format used. After transfer to the Master Problem List, the assigned number is used in all following progress notes.

Are illnesses such as upper respiratory infection or gastroenteritis given an acute problem letter and entered on the Acute Problem List? All illness or other minor problems through the life experiences must be entered on the Acute Problem List. Many of these are non-specific and selflimited and for this reason, should not be entered onto the Master Problem List.

They are included in the progress notes listing the letter and titled, and written in the SOAP format. Assuming they are resolved in several days, no number is assigned and they are not transferred to the Master Problem List. If they should recur with unusual frequency or result in some complication, they are then transferred to the Master Problem List. It is not necessary to date resolved or inactive problems on the Acute Problem List.

V. **<u>Progress Notes</u>**
Every progress note should be titled and numbered. Only those problems being considered at that particular time are put into a progress note. Under each problem there are four headings.

Subjective Data - e.g., how the patient feels
Objective Data - this may be physical findings, laboratory data, etc.
Assessment -
Plan of Therapy -

To facilitate following a patient's progress, it is suggested that Flow Sheets be made with the appropriate parameters that are being followed for each patient.

VI. **Flow Sheets**
The easiest way to understand multiple variables changing over time, is to plot them on graph paper as a flow sheet. The parameters and frequency of the observations are determined by the problem. Date and/or time entries should be made in the far column and the parameters being studied should be entered at the top. The far right side of the horizontal lines can be used for comments. Using the flow sheets in such fashion, permits unlimited additional sides or sheets to be used to continue the observations. The objective section of the progress note referring to this problem may state, "see flow sheet", rather tan re-entering the same data in the progress note.

VII. **Discharge Summary***
Discharge summary may also be called the final progress note. At this point, all problems are to be listed. Those resolved need only a brief statement explaining their resolution. Those remaining should be described in three parts:

Subjective - Course of subjective parameters
Objective - Course of objective parameters
Assessment - Projected and probable course to follow: defined outcome to guide therapy and determine when expert advise should be sought. Emphasis is on unresolved problems.

The caveat for performing and recording a knowledgeable history and physical examination lie in the following statement by Carl Gerhardt, 1873.

"The fruit of healing grows on the tree of understanding. Without diagnosis, there is no rational treatment. Examination comes first, then judgement, and then we can give help"

*Format (for inpatient discharge)
- Admitting Date:
- Discharge Date:
- Admitting Diagnosis:
- Discharge (Established) Diagnosis:
- Clinical Course:
- Laboratory Data:
- Discharge Plans:

INTERVIEWING CHILDREN AS AN ASSESSMENT TOOL

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INTRODUCTION

Interviewing the child in pediatrics is a new practice. Traditionally, the parent is interviewed about the child and that information used to establish the medical history. The current backlash of misdiagnosed cases of child abuse (one in every five children) and the number of families with undetected alcoholism (one in eight), which have major effects upon child health, has led us to recognize the critical importance of the "child's story". Our goal is to facilitate the child's telling of his or her story so we can best understand his view of information denied or deliberated deleted by adults. Children have fewer "masks" than adults. Often, they will give us information denied or deliberately deleted by adults. Children take "wooing," however, and patience to reveal their perceptions. Ideally, the physician welcomes both child and parent to the office. While interviewing the parent, give the child a piece of paper (8 x 10) and a pencil and ask him or her to draw a "picture" of the family. This provides time for the child to "size you up" and get more comfortable. After the parent interview, take a few minutes with the child alone for the child interview. Conduct the interview in the spirit of play, get down on the child's eye level, put a toy or play dough into the child's hands to decrease nervousness, watch body language as much as content, and use questions which are simple and factual before moving to questions which are family oriented.

A CHILD'S VIEW

The interview is an unnatural means of communicating for children. They are action oriented, and since they have trouble verbalizing their problems, they often feel uncomfortable trying. They may not have the vocabulary or experience in verbal expression to put their thoughts into words, even though the concepts may be fairly well formed. Trusting an unfamiliar adult, even one who seems warm and friendly, is not easy. Often, children are confused about why a clinician wants to talk with them. They may see the interview as an indicator that they have been bad or are being singled out as different from their peers. Discussing family problems may break family rules or may be feared as disloyal behavior that will result in punishment or guilt. The confusion is enhanced by the fact that it is usually adults and not the children themselves who are seeking help.

POINTERS FOR CONDUCTING THE INTERVIEW

1. An office or clinic may not be the most comfortable environment for the child. A walk on the playground or around the block may help ease tension and allow the interviewer to be seen as friendly and less threatening. Even a walk to the coke machine can be appropriate way to get to know a child. Often, more information is revealed "enroute" than in the office.

2. Conduct the interview in a spirit of fun, exploration and enthusiasm. Be friendly, relaxed and unhurried, not serious and super professional. It is all right to get down on the floor and join a child on his or her own level. When talking to children, give them reassurance, act interested and provide feedback. Don't pass judgement – good or bad – on what they are saying.

3. Use action-oriented tools. With younger children, these will be play materials. With older children, playing a game or making something, can act as a tension reliever. Equipment for interview can include paper, pencils, crayons, play dough, puppets, dolls, toy soldiers, toy cowboys, cars, trucks, rocket ships, card games, checkers, storybooks at various levels, rubber balls and building blocks. Allow the child who is hyperactive to jump on a "bouncer".
4. Try to balance providing a sense of direction with following the lead of the child. His or her best perceptions of life events tells most about the child's self-concept and developmental functioning. Avoid providing suggestions, answers and solutions to problems except as they fit into the child's version of the story. It is important to be aware that some children will not take the lead and need guidance from the interviewer in beginning the process of discussing problems.
5. All communication encompasses two levels – the process or the form of communication, and the content. Look and listen closely. The way a child behaves can be as important as what he/she says and all observations are relevant data. A child's response to the interviewer's touch, for example, can be a measure of his or her ability to relate to adults. Eye contact and body movements can be as significant or more significant than words.

WATCH FOR:

1. Fluctuations or changes in mood and their apparent relationship to interview content;
2. Ease of constriction which child displays in venting emotions;
3. Degree of avoidance or relatedness to interviewer and how that may change;
4. Degree of relating through activity of verbalizations;
5. Age-appropriate conversational and social abilities;
6. Responsiveness to suggestions, questions;
7. Themes – feelings of inadequacy, perceptions of the family
8. Use of examiner for direction, help;
9. Degree of initiative, creativity, control;
10. The way a child copes with stress-producing content;
11. Points of change in activity or content.

6. Direct questions can be threatening to children. They relate more easily to examples and fantasyand talk more freely about other children than about themselves. Try to establish the normality of feelings when talking with children through approaches, like the follwing: "A little girl told me the other day that she had lots of trouble with her brothers and sisters. Have you ever known anyone who feels like that?" "Tell me about some good (bad) mothers (fathers) you have seen on TV or read stories about. Do you know anyone like that?" Most kids your age would be scared if they were in a ________________ and might have a hard time sleeping or have bad dreams. Which did you have?" "Some kids are afraid of things when they are little, before they're old enough to go to school like you do. They're afraid of the dark and animals and storms and monsters. What were you afraid of? Sometimes fears don't go away – which ones didn't go away for you?"

7. In trying to explore and follow-up on subjects after they have been brought up, use the child's language and form of reference. Try discussing things in immediate terms. ("I wonder what made him do that?" "How come that happened?") Avoid complex verb tensors and complicated adult words.

8. At times of stress, be empathic and take the child's side. Give feedback that lets the child know she/he is not being judged or criticized. In sensitive areas such as the child's feelings about family conflict or his own behavior problems, a monologue works nicely. Tell a story and watch carefully for nonverbal responses.

9. Don't limit an assessment to one session or observation. It is rare that a child will respond fully on the first meeting, especially with a stranger. Additional contact adds validity and reliability to the data base.

10. Don't immediately "tell" parents what the child said without carefully weighing the effect that it will have on the child after leaving your office. Be the child's advocate. Maintain confidentiality until certain of your information. When you do tell the parent, rehearse with the child how and what will be revealed. Include the child in the feedback to the adult.

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Edited and reproduced from an article by Brian G. Zack, M.D., Director of Pediatric Education and
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Title: **A GUIDE TO PEDIATRIC CASE PRESENTATIONS**

Abstract: The ability to give well constructed, complete and concise and oral case presentations is an important skill that is often not emphasized in medical school and residency training. The author offers a guide to aid you in preparing more interesting and informative pediatric oral case presentations. Few written guidelines are available to physicians to aid in preparing and delivering well constructed, complete and concise oral case presentations. This important skill often is under emphasized and poorly learned in medical school and residency training. A recent publication provided some useful advice in this regard, but clearly was oriented toward internal medicine. It did, however, serve to highlight the need for a similar discussion written from a pediatric perspective. As this article is meant to stand alone, it repeats some of the more important advice found in the earlier publication, advice applicable to both medicine and pediatrics. Most of the material, however, differs significantly, reflecting the intended pediatric orientation, as well as some of the author's own preferences. The purpose of this article is to provide medical students, residents and attending physicians with general guidelines regarding oral case presentations of pediatric and adolescent patients. It is not meant as a guide for written histories and physicals, which necessarily will be far more complete and will contain a great deal more information than oral presentations. The oral presentation format outlined here is appropriate for most situations, including attending rounds, case conferences, grand rounds and information discussions. A good oral presentation will include all pertinent aspects of the patient's history, physical examination, laboratory evaluation and hospital course including pertinent negatives, without wasting time on irrelevancies such as a detailed family history or review of systems. The presentation should be well organized, following a relatively set format. The listener should be able to build a coherent picture of the patient's problems in his/her mind, a the presentation unfolds, and should be able to develop and modify his own differential diagnosis and come to his own conclusions as to the appropriateness of diagnostic, therapeutic and patient education interventions as the story is told. It is particularly important not to "jump around" during the presentation, such as by mentioning physical findings during the history or discussing events in a nonchronological order, since this can be very confusing to the listener. A useful time limit to impose upon yourself for the entire presentation, including your assessment and plans, is seven minutes. It is hard to imagine many people listening with interest to a longer presentation, and even the most complex cases can be presented in that time period if well organized. For good examples on how to organize information, read some of the presentations which begin the Case Records of the *New England Journal of Medicine.*

Opening Statement
The opening statement should include the patient's name, age, ethnic origin, sex and reason for admission, as well as the number of admissions the patient has had, setting the stage for the presentation. The reason for admission is particularly important. Sometimes referred to as the "chief complaint," it should not be in the patient's or parent's own words, although this is sometimes taught. The purpose of using the patient's own words is to indicate what the patient's perception of the problem is; however, this can be mentioned during the present illness when appropriate as it often is.

The reason for admission should be just that, and usually is provided by the admitting physician. The specificity of the reason for admission will depend upon what is known about the patient. For example, the opening statement for a patient admitted because of shortness of breath, even if he is diagnosed as having asthma after admission, might be, "This is the first Middlesex Hospital admission for Tom Jones, a nine-year-old black male who was admitted at 8:00 p.m. last evening for evaluation and treatment of shortness of breath." In contrast, if the patient was a known asthmatic, the opening statement for the same problem might be, "This is the fifth Middlesex Hospital admission for Tom Jones, a nine-year-old black male who was admitted at 8:00 p.m. last evening for treatment of status asthmaticus."

Present Illness
The present illness should include all positive historical findings, as well as pertinent negative, regardless of where in the history the information normally should be placed. For example, the immunization history should be mentioned here for a patient suspected of having measles, even though immunizations usually are mentioned in the past history. Similarly, a family history of sickle cell anemia should be mentioned in a patient admitted for evaluation of anemia, even though it usually is discussed in the family history.

Begin the present illness with the statement that, "The patient was in good health until…" or if the patient has a chronic illness, "The patient was in his usual state of health until…" Then begin the story of the present illness with the earliest relevant facts and proceed in chronological order.

Remember that physical examination, laboratory evaluations, assessments and treatments which occurred before the present admission are now part of the history and should be discussed now, at the appropriate chronological point in the history. This segment should include statements regarding what the patient's physician though in the past, giving the reasoning behind past interventions whenever possible. However, avoid giving your current assessment at this point; this belongs later, in the assessment section.

It is useful to remember a number of "descriptors" which can be applied to most symptoms and which must be mentioned to give a complete picture of each symptom. These include the following:

- When the symptom first occurred.
- Type of onset (sudden, gradual).
- Frequency of occurrence (daily, every few days, weekly, etc.)
- Time of day of occurrence.
- Factors which appear to precipitate, relieve or otherwise affect the symptoms (exercise, emotional stress, position, etc.).
- Associated symptoms (e.g., nausea and vomiting with headaches).
- Further description appropriate to particular symptom (e.g., for pain, mention location, severity, type of pain and radiation).

The present illness should include how the illness has affected the patient's and family's lifestyle. This includes information on days missed from school, problems with peers and stress in the family.

The present illness should end with a brief description of the visit to a physician, clinic or emergency room which resulted in the present admission, including information on any physical or laboratory evaluation done before admission, as well as any treatment at that time.

Past History

The past history covers a wide variety of miscellaneous categories. It is in this section that the format for history taking in the infant and young child differs most dramatically from history taking in the adult. While complete past history must be obtained as a data base and recorded in the chart, only relevant portions of it need be mentioned during an oral presentation. Categories which contribute no information relevant to the present illness may be passed over with a statement such as, "The family history is noncontributory." Exactly how much past history to include in an oral presentation is a matter of judgement and no firm guidelines can be set. Include any information, whether positive or negative, that possibly could be helpful in evaluating the patient's present problems, as well as any information that you feel your audience is likely to ask about if left out.

The following are brief comments on the various categories of the past history. Remember that all categories need not be mentioned.

Feeding History – This generally is mentioned only when the patient is under two-to three years of age or has a history of a feeding problem. Relevant information may include initial type of feeding (breast, formula or milk); age at weaning; age at introduction of solid foods, history of feeding problems; adverse reactions attributed to foods, vitamins, minerals and fluoride preparations; and typical feeding schedule.

Growth and Development –Mention recorded weights, heights and head circumferences with percentiles, only if relevant to the present illness. Do not mention the measurements recorded during this admission. They belong in the physical examination. A few developmental milestones may be mentioned during this admission. They belong in the physical examination. A few developmental milestones may be mentioned if the patient is an infant or young child and is developmentally normal. These might include age at rolling over, sitting alone, standing alone, walking alone, speaking first words and the patient's verbal ability. This area often is disposed of, particularly in the older child, with the statement, "Developmental history is normal." If there is any question of a developmental problem, a more complete developmental history must be given. It may be helpful to use the items in the Denver Developmental Screening Test as a guide.

Immunizations --These need to be mentioned only if relevant, e.g., if the child is suspected of having an illness for which an immunization is available or if child abuse or neglect is suspected, in which case a failure to have the child immunized may be indicative of neglect.

Previous Illnesses, accidents and Hospitalizations – Mention these only if relevant to the present illness or if they were of serious nature.
Current Medication – These should always be mentioned, including indication and dose. If they are related to the present illness, they should be included in that section of the presentation.

Health Practices and Habits – Items to be covered here vary greatly with age, from thumb-sucking, temper tantrums and bed-wetting through use of alcohol, other drugs and cigarettes.

Mention only if relevant. While a sexual history should be taken from adolescent patients, including knowledge about and use of contraceptives, and, in females, a menstrual history, these need not be mentioned in the oral presentation unless relevant.

Many physicians prefer that all information from the past history that might be relevant to the present problem be discussed as part of the present illness. This is a reasonable format, but is important to avoid going too far and including a complete recitation of the past history under the present illness. It might be more preferable to include all clearly relevant information in the present illness, and then to describe each category in the past history as being “unremarkable, except as mentioned in the present illness”. However, be prepared to answer questions about information that you have left out.

Family and Social History
Often neglected in written histories, the family and social history frequently are overemphasized in oral presentations. Family history, including age and state of health of relatives, should be described only if clearly relevant to the present illness. It is important to include a brief social history in most presentations of pediatric patients, including members of the household, significant family stresses and any problems the child has relating to family, peers and school. A detailed discussion should be included only if relevant.

Review of System
In general, all positive findings in the review of systems should have been mentioned in the appropriate place in the present illness. Thus, at this point, it is only necessary to state “the review of systems is noncontributory, except as noted in the present illness”.

Physical Examination
Always start this section with a general statement as to the patient’s condition, such as, “The patient was a health-appearing chubby infant in no apparent distress who was playing quietly when first seen,” or “The patient was a very thin teenage girl who was lying in bed in a fetal position, holding her lower abdomen and groaning in pain.” It is preferable not to use the terms, “well-developed” or “well nourished”, as they are so over used as to be meaningless.

Next should come the vital signs: Temperature (including where it was taken), pulse, respirations and blood pressure. The blood pressure ideally should be taken in any patient, must be taken in older children and adolescents, and always should be taken whenever a blood pressure problem is a consideration, regardless of the patient’s age. Doppler blood pressure instruments are available for use in small infants.

Next, the height and weight are reported. These should be accompanied by the percentile for age. The head circumference and its percentile are reported for infants under two years of age and for any patients with possible CNS disease.

The physical examination of the various systems is then described in the standard order: head, eyes, ears, nose, mouth, throat and so on. It is not necessary to go through an exhaustive list of negative for each system. However, each system generally should be mentioned, if only to say, “extremities normal”. If you are in a particular hurry, it may be acceptable to report on only those systems with positive findings, stating that, “The remainder of the physical examination is normal,” but this practice should be the exception, not the rule. The reason for this is that it is very easy to forget some positive or pertinent negative finding unless each system is considered individually. Those systems with positive finds, or for which negative finds are pertinent to the present illness, should be described fully.

One area which often presents problems in organization of information is the nervous system examination. There are a number of acceptable ways of reporting this. One useful method is to describe the system when a full description is needed, according to the subcategories.

- Mental status, including alertness, orientation and mood, at a minimum. A complete mental status examination may take several minutes to present; such thoroughness is not necessary unless specifically indicated.
- Cranial nerves two to 12; these need to be discussed separately only if abnormalities are found. A common mistake is to report that, "cranial nerves were not testable because the patient was unconscious". Cranial Nerves are testable regardless of the state of consciousness; patient cooperation is not necessary.
- Motor system, including strength, tone, bulk, symmetry and abnormal movements.
- Sensory system, including at least pain and light touch; other modalities are tested as indicated.
- Reflexes, including deep tendon reflexes and plantar reflexes, at a minimum.
- Coordination and gait, including finger-to-nose, heel-to-shin and rapid alternating movement testing, as well as a description of the gait.
- In infants, the presence or absence of a variety of primitive reflexes, such as Moro, tonic neck and parachute are usually mentioned.

Assessment and Plan

Following presentation of the history and physical examination, and before discussing laboratory findings done after admission or going over the hospital course, a concise but complete discussion of your assessment of the patient's problems should be given, based upon the information already presented. This should be done in a problem-oriented fashion. That is, each problem you have identified from your history and physical examination should be discussed separately. Points to be covered include your differential diagnosis, points for and against the various possibilities, diagnostic procedures and their rationale, therapeutic interventions and their rationale, plans for following the course of the illness, and not least important, but often ignored, plans for patient education. Remember to give the reasoning behind what you are doing.

Laboratory Examination

Many physicians in other fields consider a relatively large battery of tests to be routine and order them for every patient on admission. These physicians may expect the laboratory findings to be presented immediately after the physical examination, before discussing the assessment and plan. In pediatrics, no test should be considered routine, including the CBC and urinalysis. The laboratory tests done should be those examinations indicated during the discussion of your assessment. The findings available at the time of presentation may be discussed following your assessment and plan or alternatively may be integrated into the assessment and plan. For example, if one problem is "possible meningitis," then you may state that, "A lumbar puncture was indicated to evaluate the possibility of meningitis and the findings were…"

Hospital Course

Finally, a brief description should be given of what has happened to the patient since admission. This should be in exactly the same format as the present illness, with a chronological discussion of each of the patient's problems, including diagnostic testing, therapeutic interventions, changes in the illness and patient education. As with the present illness, this discussion should also include the rationale behind the decisions which have been made. Conclude with a statement regarding the current condition of the patient and current plans.

Conclusion

Remember that there is no "right" way to give a presentation. Every listener has different expectations and a presentation which is considered perfect by one, may elicit criticism from another; you cannot please everybody. Your goal should be to present all of the relevant findings, both positive and negative, in an organized, chronological fashion so that your listener can build a coherent picture of the patient and his problems in his mind and can form his own assessment and plans, even as you discuss yours. After a good presentation, the listener should know all that he/she needs to know to take over the patient him/herself. Finally, always expect questions. No matter how careful you think you have been to include everything of importance, someone is going to want to know something you left out. A lack of questions is more indicative of a somnolent audience than of a perfect presentation. With some practice, your ability to give concise, organized, relevant presentations can be built into a skill that will serve you well, whether student, resident or attending physician.

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INDICATIONS FOR GENETIC CONSULTATION

Genetic consultations by an appropriately trained geneticist are indicated in a wide variety of clinical situations in infancy, childhood and adulthood. The following are situations arising in pediatric practice which may indicate the need for further consultation.

I. INDICATIONS FOR GENETIC CONSULTATIONS IN PEDIATRICS

A. One or more major structural malformations or a single, uncommon malformation (e.g., cleft lip and palate, limb reduction defect, iris colobomata).

B. Minor anomalies or nonspecific unusual physical features forming a potentially recognizable syndrome or unknown pattern of malformation.

C. Mental retardation/developmental delay without an obvious etiology.

- Many cases have a genetic basis. Empiric recurrence risks for "isolated: mental retardation are significant. Mental retardation is sometimes erroneously ascribed to problems a the time of birth or to relatively insignificant trauma, thus obscuring the real etiology.
- Children NOT usually requiring consultation may include: Retardation secondary to a clearly identifiable external event, e.g., severe head traumas and sequelae of documented bacterial meningitis.

D. Unexplained hypotonia especially in the neonatal period.

E. Neonatal coma, vomiting, lethargy, lactic acidosis, hyperammonemia, ketosis, seizures, hypo/hyperglycemia, hypo/hyperammonemia or combinations of these symptoms without an identifiable cause (e.g., sepsis).

F. Hearing impairment.

G. Visual impairment other than simple refractive errors or strabismus, (e.g., optic atrophy, rod/cone dystrophy, retinitis pigmentosa, coloboma, retinal detachment).

H. Unusual dematologic conditions (e.g., pigmentary dysplasias, ichthyosis, bullous disorders, unusual birthmarks, hemagniomas, Ehlers Danlos sndrome, neurofibromatosis, etc.).

I. Tumor or malignancy with a suspected genetic predisposition (e.g., retinoblastoma, Wilms tumor,optic glioma).

J. Stillborn infants with known or suspected external or internal abnormality (e.g. hydrops, growth retardation, dwarfism or suspected malformation).

K. Child with disproportionate or proportionate short stature (e.g., achondroplasia, osteogenesis imperfecta, Russell-Silver syndrome).

L. Unusual growth patterns (short, tall, asymmetric, macrosomic, microcephalic) after preliminary screening tests have ruled out common causes or a likely endocrine etiology (such as hypothyroidism)

M. Ambiguous genitalia or other genital abnormalities.

N. Loss of developmental milestones.

O. Known or suspected genetic/inherited disorder or family history of same.

II. INDICATIONS FOR ADULT GENETIC CONSULTATION

A. Patient is affected with or has a family history of a known or suspected genetic disorder (e.g. cleft lip and palate, limb reduction defect, iris colobomata).

B. Cystic fibrosis, adult type polycystic kidney disease, Marfan syndrome myotonic dystrophy, Huntington's disease, Charcot-Marie Tooth Disease, alpha-1-antitrypsin deficiency hemochromatosis, nondietary hyperlipidemia, psychiatric illness.

C. Individual is affected with and/or has a family history of family members with cancer with a known or suspected genetic predisposition (e.g., retinoblastoma, malignant melanoma, multiple individuals with breast, colon, ovarian cancer, etc.,).
D. Woman has amenorrhea or sterility suspected to be on genetic basis.
E. Woman has a history of multiple pregnancy losses.
F. Individual is affected with or has a family history of mental retardation.
G. Individual has had a child with a birth defect, mental retardation or other suspected genetic disorder.

III. **INDICATIONS FOR PRENATAL GENETIC CONSULTATION**

A. Advanced maternal age (over 35 at delivery).
B. Either parent or a family member has a balanced chromosomal rearrangement.
C. Previous child with a chromosome abnormality.
D. Previous child with a known or suspected inborn error of metabolism (e.g., maple syrup urine disease, PKU, galactosemai, Hurlr syndrome, sanfilippo syndrome, Ornithine- Transcarbamylase deficiency, lactic acidosis, etc.).
E. Previous child with or family history of a major structural abnormality (e.g., neural tube defect, congenital heart disease, cleft lip and palate).
F. Fetus with anomalies suspected on ultrasound, (e.g., single or multiple malformation, hydrops, oligohydramnios, growth retardation without known etiology, etc.).
G. Woman exposed to known or suspected terategen in pregnancy (e.g., alcohol, Parvo virus, anticonvulsants, Accutane).
H. Consanguinity.
I. Previous child with undiagnosed problem (e.g., mental retardation, neonatal death).
J. Multiple pregnancy losses (recurrent abortion and/or stillbirths).
K. Either parent is a known carrier or has a family history of a disorder for which prenatal testing may be available, (e.g., Tay Sachs, cystic fibrosis, sickle cell anemia, alpha thalassemia).
L. Abnormal NS-AAFP or triple (multiple marker) screen test results.
M. Woman has a condition known or suspected to affect fetal development and/or outcome (e.g., diabetes, myotonic dystrophy, alcoholism).

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The Prenatal Visit

Committee on Psychosocial Aspects of Child and Family Health

The American Academy of Pediatrics last endorsed the prenatal visit in a policy statement in April 1984. The Committee on Psychosocial Aspects of Child and Family Health recognizes that significant social changes have occurred since then and assets its continuing support for this service as a valuable component of comprehensive pediatric care.

Most pediatricians think that the prenatal visit is helpful to themselves and prospective parents. Because they do not initiate the visits, many pediatricians have found that discussing concept with the referring obstetrician in the community has been very helpful in increasing the number of these visits.

Objectives of the Prenatal Visit

Several objectives can be served by the prenatal visit.

1. Establishing the physician-parent relationship. The prenatal period is a good time to start building the therapeutic alliance that should last throughout the child's pediatric care. Pediatricians who meet with the parents before the delivery demonstrate how much they value this relationship. A prenatal visit introduces the parents to the concept of a medical home for the child's future health and development needs.

2. Gathering basis information. The most important information to collect concerns the general assets and needs of the parents and their worries about the expectant infant. Pertinent areas to discuss in addition to the family medical history are the parents own experiences being reared, their background with other children and medical care, complications and concerns with this pregnancy, and possible problems with their newborn. Knowledge about the parents' occupations and education may be useful. Some other matters to cover are basic information on the expected date of delivery, feeding plan (breast or formula), parents' views and current scientific information about circumcision, and other issues about the care of the newborn. Additional issues to consider are the age of the parents and the nature and extent of supporting family and friends. Factors that may be contributing turmoil and stress or stability and contentment to the parents, such as employment,, housing and likely effect of the arrival of the infant on the family, may be discussed.

3. Providing information and advice. The pediatrician can describe the anticipated behavior of the neonate and the routine care provided in the nursery. It may be helpful to ask, "Have you considered breastfeeding the baby?" This can be followed with an offer of information about the benefits of breastfeeding along with a gentle endorsement and an offer of continuing support. A decision on the method of feeding should not be requested during this prenatal visit, but the parents may be encouraged to learn more about breastfeeding. A description of the pediatrician's role at that time and in the months and years to come informs the parents of the ways in which the pediatrician will be available to help them do as much as possible for themselves as well as provide assistance for them whenever needed. Anticipatory guidance can begin at this point. Parents should be

encouraged to participate in childbirth classes if they are not already doing so. If an early discharge is foreseeable, plans for either a home visitor or an early office appointment may be established.

4. Building parenting skills. One of the pediatrician's most complex but gratifying tasks is to help parents mature into more competent caregivers. This process can begin before the birth of the child by discussing the parents' concerns and planned strategies.

Types of Prenatal Visits

The prenatal visit can take several possible forms depending on the experience and preferences of the parents, the competence and availability of the pediatrician, and the provisions of the health care system.

The Full Prenatal Visit

The optimal form of visit is a regularly scheduled office visit with both parents present. During this visit, the four objectives listed above are pursued. This type of visit is most appropriate for a first pregnancy, for young parents, when there are pregnancy complications or other anticipated problems of consequence for the newborn, when parents are unusually anxious for any reason, or before an adoption. Many parents do not take the opportunity to have such a prenatal visit when offered. Extensive clinical experience by seasoned practitioners, however, attests to the value of this visit in ways that are difficult to measure precisely. The establishment of a mutual commitment to a sound and regarding professional relationship usually results from this visit.

The Brief Visit to Get Acquainted

A brief encounter lasting 5 to 10 minutes between the physician and parent at the physician's office allows a superficial meeting of the two parties. The visit may include an introduction to other members of the staff and a short tour of the facility. This arrangement is appropriate for the parent who is still in the process of selecting a pediatrician and is not yet ready for more extensive involvement. There is not enough time to cover all the desirable elements of a visit as listed above, but the pediatrician can personally offer an opportunity for scheduling a longer visit on another occasion.

The "Basic Contract" Visit or Telephone Call

This prenatal contact involves the prospective parent calling the physician's office and either the physician or the support staff describing the basic practice arrangements, assuming the physician is accepting new patients. (This should also be part of the two longer visits.) Discussion usually focuses on the office hours, the telephone hours, fees, hospital affiliations of the physician, coverage for night, weekend, and emergency care, and what arrangements can be made if the infant is born at a hospital where the pediatrician is not on staff. During the telephone call, the parents are requested to provide the following basic identifying information: name, address, telephone number, origin of referral, place and expected date of delivery, and type of insurance coverage. The pediatrician or the support staff also invites them to make an appointment to discuss any substantial concerns. If a sheet or booklet describing the practice is available, it can be mailed to the prospective parents. In this common arrangement, the physician's services are offered but they may not be accepted.

No Prenatal Contact
If no prenatal contact has been made, all of the objectives listed above can be addressed in the newborn nursery or at the fist postnatal office visit. Although a sound therapeutic alliance can be formed at this time, a prenatal contact is advantageous in the event of problems in the newborn period.

Group Prenatal Visit
The concept of the group well-child can be extended to the prenatal visit. Arranged either as a large group (e.g., a monthly meeting in the evening) or a small group of three to five parents, the group prenatal visit encourages mutual support among pregnant women and spouses while providing a forum for information similar to traditional individual sessions. It has the added advantage of saving clinician time and expense. Participation by a pediatrician in a prenatal class provides an alternative setting.

Recommendations

1. Every practice needs to establish a policy on prenatal visits. The services offered can be flexible and designed to meet the needs of parents. In some cases, a full prenatal visit is necessary. For others, a briefer encounter is sufficient.

2. When appropriate for a particular practice, a policy on charges for prenatal visits should be established and communicated both to third-party payers and families. It may be necessary to persuade some insurance companies of the cost-to-benefit ratio of prenatal visits in certain cases.

3. This policy on prenatal visits should be made known to local obstetricians and to prospective parents who telephone pediatricians to inquire about available services. Health maintenance organizations and managed-care insurance companies should be encouraged to accept the long-term advantages of prenatal visits. It is important to encourage prospective parents to begin a congenial relationship with their pediatrician through a prenatal visit.

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SUGGESTED READINGS

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The recommendations in this statement do not indicate an exclusive course of treatment or serve as standard of medical care.
Variations, taking into account individual circumstances, may be appropriate.

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PEDIATRIC TELEPHONE TRIAGE

Protocol

1. Identify caller
2. Relationship to patient
3. Identify patient's primary care physician (ask about other physician's involved in patient's care, e.g., sub-specialist, if appropriate)
4. What is reason for call, e.g., chief complaint not complaint"s"
5. Do history of present illness (classic HPI)

   You should be able to do this over the phone without difficulty by simply visualizing the patient and the problem.

As part of the history of present illness obtain the **time sequence** of the complaint, the **severity** of the complaint, quantifying if possible, and **how treated.** Then elicit other symptoms related to what you think the possible diagnosis may be and then ask about other **systemic symptoms** or problems e.g., fever related to the history of present illness.

6. Ask questions in the review of systems format
7. Ask whether there are "other" issues/complaints not covered
8. Ask about how the child "looks" and again try and visualize
9. Make recommendations
10. Write a note regarding the call for the patient's record and include the above plus the time and date
11. Consider faxing and/or e-mailing the written note to caller (if possible) and to any other physician involved in patients care, e.g., primary care physician

This protocol may seem cumbersome and time consuming for which you will not be reimbursed unless the patients insurance covers phone calls. However, from a professional and patient care perspective if as a physician you have made a contract to care for patients and accept phone calls than it is the better part of valor to complete the task of appropriately recording information and assuring that the patient/caregiver and other professionals involved in the patients care receives and understands your recommendations and if possible the reason for such. There are a number of textbooks and manuals available through online searches. The American Academy of Pediatrics sponsored a publication of an "office" version of Pediatric Telephone protocols (2002)by Brian D. Schmitt.

CPT 2003

TEAM CONFERENCES

99361 Medical conference by a physician with interdisciplinary team of health professionals or representatives of community agencies to coordinate activities of patient care (patient not present); approximately 30 minutes

99362 approximately 60 minutes

Telephone Calls

99371 Telephone Calls by a physician to patient or for consultation or medical management or for coordinating medical management with other health care professionals (eg, nurses, therapists, social workers, nutritionists, physicians, pharmacists); simple or brief (eg, to report on tests and/or laboratory results, to clarify or alter previous instructions, to integrate new information from other health professionals into the medical treatment plan, or to adjust therapy)
CPT Assistant May 00:11

99372 intermediate (eg, to provide advice to an established patient on a new problem, to initiate therapy that can be handled by telephone, to discuss test results in detail, to coordinate medical management of a new problem in an established patient, to discuss and evaluate new information and details, or to initiate new plan of care)
CPT Assistant May 00:11

99373 complex or lengthy (eg, lengthy counseling session with anxious or distraught patient, detailed or prolonged discussion with family members regarding seriously ill patient, lengthy communication necessary to coordinate complex services of several different health professionals working on different aspects of the total patient care plan)
CPT Assistant May 00:11

SECTION III

MISCELLANEOUS INFORMATION