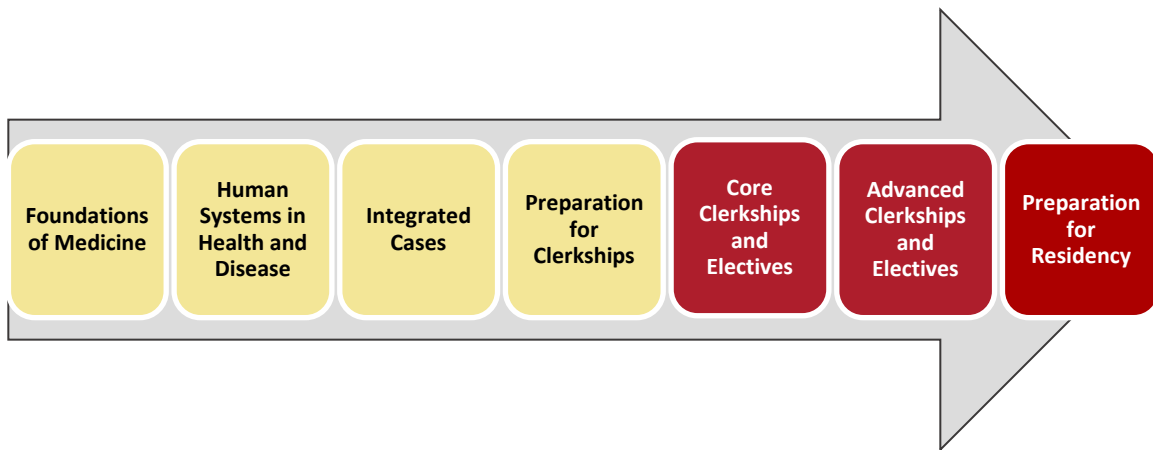


MEDICINE



Summer Clinical Practicum BMS 6940



Florida State University
College of Medicine

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Faculty and Staff

Block Administrator

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Daytona Beach Regional Campus
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Block Director

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Regional Campus Dean,
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Overview

Course Overview

The Summer Clinical Practicum [BMS 6940] is an immersive, experiential learning activity providing opportunities for students to practice and improve basic clinical skills. Students are assigned to a primary care physician to participate in patient care activities under the direct supervision of the primary care physician. This course also provides students opportunities to participate in patient care activities at locations throughout the state of Florida and into southern Georgia.

Course Goals

- Provide clinical learning experience
- Increase awareness of the impact of wellness and illness on the patient.
- Increase awareness of the impact a physician may have in the lives of his/her patients.
- Increase awareness of the responsibilities of a physician in a community
- Develop life-long learning skills of reflection and self-evaluation

Learning Objectives

By the end of this experience a student will:

- Demonstrate the ability to obtain a focused history and perform a physical exam appropriate to the patient history.
- Demonstrate the ability to identify personal, social and spiritual factors important to an individual patient's health care.
- Document subjective and objective information in a SOAP format.

- Develop a set of goals and objectives for his/her own continued growth and development
- Use reflection to enhance experiential learning.

Course Dates

- Session 1: May 7 through May 25, 2018
- Session 2: May 29 through June 15, 2018

Competencies

Competency Domains	Competencies Addressed	Methods of Assessment
Patient Care	Demonstrate the ability to obtain a focused history and perform a physical exam appropriate to the patient history.	Direct observation by Clinical Faculty
Knowledge for Practice	Document subjective and objective information in a SOAP format.	Direct observation by Clinical Faculty and SOAP note reviewed by Course Director or designated Clinical Faculty.
Practice-based Learning and Improvement	Develop a set of goals and objectives for continued growth and professional development	Direct observation by Clinical Faculty
Communication and Interpersonal Skills	Demonstrate the ability to identify personal, social and spiritual factors important to an individual patient's health care.	Direct observation by Clinical Faculty; Narrative Competency reflection reviewed by Course Director or designated Clinical Faculty
Professionalism	Maintain patient confidentiality	Direct observation by Clinical Faculty and Course Director
Systems-based Practice	Function effectively as part of a health care team	Direct observation by Clinical Faculty and Office Staff

Grading System

Assignments and Grading

The basic responsibility for achieving course objectives rests with the student. The Clinical Faculty role is to act as a resource and provide feedback and appropriate patient care experience within the clinical faculty's practice. The student is responsible for accomplishing the objectives and completing the assignments.

FSU COM has adopted a pass/fail grading system which is used in the curriculum for the first and second years (See page 31 of [Student Handbook](#)). To achieve a grade of Pass in the Summer Clinical Practicum [BMS 6490] a student must meet all of the following requirements:

1. Receive a satisfactory evaluation from the Clinical Faculty Preceptor.
2. Define personal objectives for the course. Discuss these objectives with Clinical Faculty at the beginning and at the conclusion of the clinical experience.
3. Submit a de-identified and HIPAA-compliant progress note on one patient encounter using the appropriate SOAP format. (SOAP template and rubric are available on Canvas in the *Interviewing and Patient Encounters* module and *SOAP Note Assignment and at the end of this document*)
 - a. This assignment should be submitted through Canvas as a word document NO LATER THAN **5 PM EST on Sunday** of the second week of the course.
 - b. All aspects of the SOAP-Subjective/Objective/Assessment/Plan should be addressed in the SOAP note.
 - c. While the Assessment and Plan portion of the SOAP note are areas that might not have been covered in the curriculum prior to this course, students need to get into the habit of thinking about an assessment and plan for every patient they see.
4. Record in a minimum of 10 **total** patient encounters in the encounter tracking system for the three weeks of the course during which they perform either a history and/or a physical exam. While most students will record many more encounters for the three weeks of this course, 10 is the MINIMUM a student must record for the three weeks of the course and would reflect minimal effort on the part of the student.
5. Complete the narrative competency module:
 - a. Watch an 18 minute TED talk "[Honoring the Stories of Illness](http://tedxatlanta.com/videos/09132011-balance/rita-charon/)" by Rita Charon (embedded on Canvas in the *Narrative Competency* module and *Narrative Competency Assignment*, (or available directly at either of the following links)
<http://tedxatlanta.com/videos/09132011-balance/rita-charon/>
<http://www.youtube.com/watch?v=24kHX2HtU3o>
 - b. Read the story **Chocolate Cake** – a good example the importance of narrative competency in a patient interview (available on Canvas in the *Narrative Competency* module and *Narrative Competency Assignment*).
 - c. Complete a "no-agenda" interview of one patient or patient family dealing with a chronic health issue. **IMPORTANT**: After introducing yourself and asking for permission to talk with the patient, begin the interview with the exact phrase: "**Please tell me what you think I should know about your situation.**" Do not add words about specific health problems or diseases. "Situation" is meant to be open to the patient's interpretation.
 - d. Write a reflection (no more than 1 page) on this experience, focusing on differences you perceive between this patient encounter and others you had in the summer and how narrative competence supports patient centered care. You may consider differences in the kind of information offered by patients in this interview compared to their answers to questions in the medical interview. A few **examples** along with the feedback they received are available on Canvas in the *Narrative Competency* module and *Narrative*

Competency Assignment.

- e. Submit your reflection as a Word document to the *Narrative Competency Assignment* on Canvas **NOT LATER THAN 5 PM EST on Sunday** of the last week of the course.

Suggested Reading Materials

- Seidel HM, Ball JW, Dains JE, Benedict GW. *Mosby's Guide to Physical Examination*. (7th Ed). St. Louis: Mosby, 2010.
- Seidel HM, Ball JW, Dains JE, Benedict GW. *Mosby's Physical Examination Handbook*. (7th Ed). St. Louis: Mosby, 2010.
- Lo Bernard. *Resolving Ethical Dilemmas A Guide for Clinicians*. Philadelphia: Lippincott Williams & Wilkins, 2009 (also available on Reserve in COM Library)
- Dutton G, Gabriel J, eds. *Basic Interviewing Skills Booklet* (on Blackboard under Tool Belt)
- Fitzgerald, FT "The Emperor's New Clothes", *Ann Intern Med*. 6 March 2012; 156(5): 396-397
- Facioli AM, Amorim FF, Almelda JQ A Model for Humanization in Critical Care, 2012; *Permanente Journal* 16: 75-77

Policies

Americans with Disabilities Act

Candidates for the M.D. degree must be able to fully and promptly perform the essential functions in each of the following categories: Observation, Communication, Motor, Intellectual, and Behavioral/Social. However, it is recognized that degrees of ability vary widely between individuals. Individuals are encouraged to discuss their disabilities with the College of Medicine's [Director of Student Counseling Services](#) and the FSU Student Disability Resource Center to determine whether they might be eligible to receive accommodations needed in order to train and function effectively as a physician. The Florida State University College of Medicine is committed to enabling its students by any reasonable means or accommodations to complete the course of study leading to the medical degree.

[The Office of Student Counseling Services](#)

Medical Science Research Building, G146

Phone: (850) 645-8256 Fax: (850) 645-9452

This syllabus and other class materials are available in alternative format upon request. For more information about services available to FSU students with disabilities, contact the:

[Student Disability Resource Center](#)

874 Traditions Way
108 Student Services Building
Florida State University
Tallahassee, FL 32306-4167
Voice: (850) 644-9566
TDD: (850) 644-8504
sdrc@admin.fsu.edu

Academic Honor Code

The Florida State University Academic Honor Policy outlines the University's expectations for the integrity of students' academic work, the procedures for resolving alleged violations of those expectations, and the rights and responsibilities of students and faculty members throughout the process. Students are responsible for reading the Academic Honor Policy and for living up to their pledge to "...be honest and truthful and...[to] strive for personal and institutional integrity at Florida State University." (Florida State University Academic Honor Policy, found at <http://fda.fsu.edu/Academics/Academic-Honor-Policy>)

Attendance Policy

The College of Medicine has detailed attendance policies as they relate to each cohort and events that conflict with course schedules. See pages 28-29 of [FSUCOM Student Handbook](#) for details of attendance policy, notice of absences and remediation.

Students are expected to be present with their Preceptor whenever the Clinical Faculty is seeing patients.

Summer Clinical Practicum BMS 6940 -- SOAP NOTE RUBRIC

Student Name: _____

Date: _____

SOAP NOTE COMPONENTS	YES	NO
Mark NA for components that may not be applicable for the session.		
S=Subjective (What the patient/family tells you and/or information received from other professionals.)		
1. Note includes only elements of the history (subjective elements); does not include elements of the physical exam.		
2. Note contains chief concern in patient's own words in quotation marks and includes all agenda items.		
3. Note includes at least 5 elements of the history of present illness (" <i>sacred seven</i> ": <i>location, quality, quantity, timing, context, modifying factors, and associated symptoms</i>).		
4. Note includes impact on daily functioning (e.g. BADLs, IADLs, and/or AADLs) and at least (1) other indicator of "patient-centeredness," e.g. comment re: <ul style="list-style-type: none"> • ideas/ hypotheses about causation • worries/fears about symptoms or condition • impact on relationships/ self-concept 		
5. Note includes at least (4) indicators of an expanded history with <u>pertinent</u> review of systems, and relevant components of past medical history, social history, and family history.		
O=Objective (What you observed and the findings of the physical exam maneuvers you performed.)		
1. Note includes only elements that are truly from the physical exam (objective elements); does not include elements of the history.		
2. Note includes ALL vital signs (<i>P/BP/RR/Temp/Ht/Wt/BMI</i>) with correct units of measurement and other relevant descriptors (e.g. B.P. = 120/70mmHg in the left arm while sitting).		
3. Note includes a general assessment of the patient with at least (2) items from each category listed below: <ul style="list-style-type: none"> • Category 1: age comparison, apparent gender, body habitus, consciousness level • Category 2: demeanor, eye contact, health status, mannerisms, notable characteristics 		
4. Note includes observation of the affected area and, when appropriate, comparison made upon inspection and examination of the corresponding area on the opposite side.		
5. Note describes an examination of the affected area and an adjacent area (i.e. adjacent organ system or joint).		
6. Note includes at least (4) pertinent (<i>positive and negative</i>) findings including: <ul style="list-style-type: none"> • Reference to degree of discomfort, if applicable (e.g. comment re: absence or presence of tenderness or discomfort during physical exam maneuvers). 		

Comments (e.g. organization of note, demonstration of clinical reasoning, etc.):

Assessment: How the student/author interprets the information obtained in the history and exam, includes all diagnoses/conditions that impact the treatment decision.

Plan: Actions to be taken based on the assessment including:

- Tests ordered
- Medications/prescriptions given
- Patient instructions
- Follow-up instructions

Student signature including title

NOTE: Make sure the date of visit is included in the note, preferably at the beginning of the note.