Introduction and Overview of Year 1 Clinical Skills

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Staff in the Simulation Unit:

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Phone</th>
<th>Email</th>
</tr>
</thead>
<tbody>
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<td>Lecturer</td>
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</tr>
</tbody>
</table>
**Tutorial group contact details**

**Group Number:**

**Room number:**

**Group Secretary:**

Email address:

Mobile number:

**Students:**

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<thead>
<tr>
<th>Name</th>
<th>Email</th>
<th>Mobile</th>
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</table>
Doctor and Patient is one of the three themes of the medical course. Its aim is to provide students with an introduction to clinical performance in medical practice. Students participate in sessions dealing with communication and patient interaction skills, history taking and physical examination and introductory clinical procedures.

The following knowledge, skills and procedures are introduced:

- clinical interviewing, communication skills, history taking, physical examination
- introductory clinical procedures, Basic Life Support
- personal development, student-patient, student-hospital, student-doctor and student-allied health professional relationships

Format
The course consists of three to five hours of formal contact each week and includes the following components:

- A weekly Clinical Skills Tutorial - on Tuesdays or Fridays
  - Semester 1 - 3 hours long
  - Semester 2 - 3 hours long
- Basic Life Support sessions – 4 x one hour sessions over the year plus an assessment session, rostered on Wednesday mornings
- Clinical Skills Practical Sessions - hourly sessions, rostered on Wednesday mornings
- Acute Patient Care (Recovery room) session - one 3 hour session during the year

Students are expected to attend all sessions. Attendance records are kept.

Clinical Skills Tutorials (Tuesdays or Fridays)
In these tutorials, students are taught communication skills, history taking and examination skills. The format of these tutorials include tutorial discussions, role plays, watching videos of role plays, interviews with "standardised patients" followed by a review session with your allocated tutor, visits to the hospital wards to practise history and examination skills and case discussions/presentations by students. The tutorials will provide an opportunity for the presentation of new material, discussion and review of clinical experiences. Students are expected to practise history and examination skills between sessions, and will be guided in this by their tutors.

Tutorial groups will correspond to PBL groups (8 students). The tutors will be experienced clinicians (mostly General Practitioners).

The content and format of the clinical tutorials differs between semesters. Semester 1: aims to provide a supportive and appropriately integrated introduction to clinical medicine, with its main objective being the acquisition of the clinical skills of the process of taking a history. This will be using the Calgary-Cambridge model and discussed in more detail later. The tutorials will be weekly 3 hour tutorials. Semester 2: follows from semester 1 with the addition of the clinical skills of the content of history taking focussing on the cardiorespiratory system and renal whilst concurrently learning the examination skills for the cardiovascular system, respiratory system and abdomen. These tutorials are weekly 3 hour tutorials.

Wednesday morning sessions
On Wednesday mornings, student groups (which correspond to the PBL groups) are rostered for one of the following sessions - Basic Life Support or Clinical Skills Practical sessions. The timetable for these sessions is printed in this booklet on page 5. A more detailed timetable with allocation of specific times for each group will be posted on FLO and on the Simulation Unit noticeboard, in the corridor outside the Simulation Unit. Each group will have some Wednesday mornings free - ie you will not be rostered for a session every Wednesday.
Clinical Skills Practical sessions
Students are rostered for sessions in the Simulation Unit where they will be learn how to conduct safe practice on a hospital ward, examination skills and minor procedures. Students will have the opportunity to practise on each other and on manikins.

Basic Life Support
By the end of first year, all students should be able to save a life in the community by achieving competence in CPR. Students are taught in groups of 4, learning skills on anatomical models (manikins) and then practising these skills in real-life scenarios. There are 4 one hour sessions spread over the year and an assessment session. A separate handbook with notes and timetables for these sessions will be provided. Coordinator: Cyle Sprick (cyle.sprick@flinders.edu.au)

Acute Patient Care (Recovery Room) Session
Students need to arrange one session during the year to attend a Recovery Room to practice airway support and management of an unconscious patient. More details are available in the BLS handbook.
Aims and Objectives of Doctor and Patient semester 1

By the end of the semester, the students should be able to demonstrate competence in the following:

• Establish rapport readily with patients
• Demonstrate acceptable standards of professional behaviour with patients, staff and students
• Ability to communicate effectively with patients, including active listening, and understanding the effects of non verbal communication
• Demonstrate understanding of the patient’s agenda and their experience of their health condition
• Ability to gather information effectively and sensitively from patients about their presenting problem
• Ability to take a complete history including past illnesses, family, social history, medications etc
• Write up patient histories in a clear and logical fashion
• Present a verbal patient history
• Collect and document a patient’s vital signs
• Basic life support

Wednesday Timetable S1 2011

BLS = Basic Life Support
CSPS=Clinical Skills Practical Sessions

Check Simulation Unit noticeboard for detailed timetable for BLS and CSPS for each week. The timetable on the noticeboard will also tell you which room your group has been allocated to for each session.

*Please check the Simulation Unit noticeboard prior to the week of the scheduled CSPS as the group timetable may change.

Bring your own stethoscope to the CSPS (if you have one).

<table>
<thead>
<tr>
<th>Week</th>
<th>Wednes date</th>
<th>Groups</th>
<th>Session title</th>
</tr>
</thead>
</table>
| 1    | Feb 23th    | BLS: No sessions  
CSPS: 1,2,3,4,5,6,7,8,9 | No Sessions  
Practical Session 1: Ward Safety |
| 2    | March 2nd   | BLS: 1,2,3  
CSPS: 10,11,12,13,14,15,16,17 | BLS session 1: The First Minute  
Practical session 1: Ward Safety |
| 3    | March 9th   | BLS: 4,5,6  
CSPS: 1,2,3,7,8,9,10,11,12 | BLS session 1: The First Minute  
Practical Session 2: Vital signs A |
| 4    | March 16th  | BLS: 7,8,9  
CSPS: 4,5,6,13,14,15,16,17 | BLS session 1: The First Minute  
Practical Session 2: Vital signs A |
| 5    | March 23rd  | BLS: 10,11,12  
CSPS: 1,2,3,4,5,6,13,14,15 | BLS session 1: The First Minute  
Practical Session 3: Vital signs B (PPE form to be completed before this session) |
| 6    | March 30th  | BLS: 13,14,15  
CSPS: 7,8,9,10,11,12,16,17 | BLS session 1: The First Minute  
Practical Session 3: Vital signs B (PPE form to be completed before this session) |
<table>
<thead>
<tr>
<th>Week</th>
<th>Wednesday date</th>
<th>Groups</th>
<th>Session title</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>April 6th</td>
<td>BLS: 16,17, CSPS: 1,2,3,4,5,6,7,8,9</td>
<td>BLS session 1: The First Minute Practical session 4: Introduction to Clinical Examination A (Hand Hygiene Certificate must be completed before this session)</td>
</tr>
<tr>
<td>8</td>
<td>April 13th</td>
<td>BLS: 1,2,3, CSPS: 10,11,12,13,14,15,16,17</td>
<td>BLS session 2: Compressions Practical session 4: Introduction to Clinical Examination A (Hand Hygiene Certificate must be completed before this session)</td>
</tr>
<tr>
<td>9</td>
<td>April 20th</td>
<td>BLS: 4,5,6, CSPS: 1,2,3,7,8,9,10,11,12</td>
<td>BLS session 2: Compressions Practical session 5: Introduction to Clinical Examination B</td>
</tr>
<tr>
<td>9</td>
<td>April 27th</td>
<td>No sessions mid-semester break</td>
<td>No sessions</td>
</tr>
<tr>
<td>10</td>
<td>May 4th</td>
<td>BLS: 7,8,9, CSPS: 4,5,6,13,14,15,16,17</td>
<td>BLS session 2: Compressions Practical session 5: Introduction to Clinical Examination B</td>
</tr>
<tr>
<td>11</td>
<td>May 11th</td>
<td>BLS: 10,11,12, CSPS: 1,2,3,4,5,6, 13,14,15</td>
<td>BLS session 2: Compressions Practical session 6: Introduction to Clinical examination C</td>
</tr>
<tr>
<td>12</td>
<td>May 18th</td>
<td>BLS: 13,14,15, CSPS: 7,8,9,10,11,12,16,17</td>
<td>BLS session 2: Compressions Practical session 6: Introduction to clinical examination C</td>
</tr>
<tr>
<td>13</td>
<td>May 25th</td>
<td>BLS: 16,17, CSPS: 1,2,3,4,5</td>
<td>BLS session 2: Compressions Practical session 7: Vital signs summative assessment</td>
</tr>
<tr>
<td>14</td>
<td>June 1st</td>
<td>BLS: 1,2,3, CSPS: 6,7,8,9,10</td>
<td>BLS session 3: Ventilation Practical session 7: Vital signs summative assessment</td>
</tr>
<tr>
<td>15</td>
<td>June 8th</td>
<td>BLS: 4,5,6, CSPS: 11,12,13,14,15</td>
<td>BLS session 3: Ventilation Practical session 7: Vital signs summative assessment</td>
</tr>
<tr>
<td>16</td>
<td>June 15th</td>
<td>BLS: 7,8,9, CSPS: 16,17</td>
<td>BLS session 3: Ventilation Practical session 7: Vital signs summative assessment</td>
</tr>
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</table>
Clinical Skills Tutorial Topic List

There is a mid semester break of one week from the 25th April to the 29th April (this incorporates 2 public holidays: Easter Monday and Anzac Day).

Tuesday tutorial timetable
If your tutor has chosen to give the tutorials on Tuesday morning or afternoon, this is the list for you.

<table>
<thead>
<tr>
<th>Date</th>
<th>Topic</th>
<th>Tutorial task</th>
<th>Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Tues Feb 22nd</td>
<td>Group Introductions, Discussion of course structure, content and assessment, History Demonstration</td>
<td>WV</td>
<td></td>
</tr>
<tr>
<td>2. Tues Mar 1st</td>
<td>Initiating the consultation</td>
<td>RP</td>
<td></td>
</tr>
<tr>
<td>3. Tues Mar 8th</td>
<td>Standardized patient interview(recorded)/Gathering information 1A</td>
<td>RP</td>
<td>Submit ward safety reflection Interview</td>
</tr>
<tr>
<td>4. Tues Mar 15th</td>
<td>Gathering information 1B/Review</td>
<td>WV</td>
<td>Submit write up(I/V 1)</td>
</tr>
<tr>
<td>5. Tues Mar 22nd</td>
<td>Gathering information 2: Patient’s Perspective</td>
<td>RP</td>
<td>Submit first clinical encounter</td>
</tr>
<tr>
<td>6. Tues Mar 29th</td>
<td>Gathering information 3: Biomedical Perspective</td>
<td>RP</td>
<td></td>
</tr>
<tr>
<td>7. Tues April 5th</td>
<td>Gathering information 4: Attentive listening and Building the relationship</td>
<td>WV</td>
<td></td>
</tr>
<tr>
<td>8. Tues April 12th</td>
<td>Gathering information 5: Biomedical Perspective /Building Structure</td>
<td>RP</td>
<td>Submit 2nd clinical encounter</td>
</tr>
<tr>
<td>9. Tues April 19th</td>
<td>Standardized patient interview(recorded)</td>
<td></td>
<td>Interview</td>
</tr>
<tr>
<td></td>
<td>Student holiday week</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Tues May 3rd</td>
<td>Review</td>
<td></td>
<td>Submit write up (I/V 2)</td>
</tr>
<tr>
<td>11. Tues May 10th</td>
<td>Introduction to physical examination/Explanation/Closing the interview</td>
<td>WV</td>
<td></td>
</tr>
<tr>
<td>12. Tues May 17th</td>
<td>Building the relationship</td>
<td>RP</td>
<td>Submit 3rd Clinical Encounter</td>
</tr>
<tr>
<td>13. Tues May 24th</td>
<td>Standardized patient interview(recorded)</td>
<td></td>
<td>interview</td>
</tr>
<tr>
<td>14. Tues May 31st</td>
<td>Review</td>
<td></td>
<td>Submit write up (I/V 3)</td>
</tr>
</tbody>
</table>

Note: There are 16 weeks in semester 1. The 16th week will be for remedial teaching/reassessments as required. You tutor may choose to defer one tutorial during the semester and you will still have your last tutorial in week 15, which would be Tuesday 7th June.
**Friday tutorial timetable**
If your tutor has chosen to give the tutorials on Friday morning or afternoon, this is the list for you.

<table>
<thead>
<tr>
<th>Date</th>
<th>Topic</th>
<th>Tutorial task</th>
<th>Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Fri Feb 25th</td>
<td>Group Introductions, Discussion of course structure, content and assessment, History Demonstration</td>
<td>WV</td>
<td></td>
</tr>
<tr>
<td>2 Fri Mar 4th</td>
<td>Initiating the consultation</td>
<td>RP</td>
<td></td>
</tr>
<tr>
<td>3 Fri Mar 11th</td>
<td>Standardized patient interview(recorded)/Gathering information 1A</td>
<td>RP</td>
<td>Submit ward safety reflection Interview</td>
</tr>
<tr>
<td>4 Fri Mar 18th</td>
<td>Gathering information 1B/Review</td>
<td>WV</td>
<td>Submit write up(I/V 1)</td>
</tr>
<tr>
<td>5 Fri Mar 25th</td>
<td>Gathering information 2: Patient’s Perspective</td>
<td>RP</td>
<td>Submit first clinical encounter</td>
</tr>
<tr>
<td>6 Friday 1st April</td>
<td>Gathering information 3: Biomedical Perspective</td>
<td>RP</td>
<td></td>
</tr>
<tr>
<td>7 Fri April 8th</td>
<td>Gathering information 4: Attentive listening and Building the relationship</td>
<td>WV</td>
<td></td>
</tr>
<tr>
<td>8 Fri April 15th</td>
<td>Gathering information 5: Biomedical Perspective /Building Structure</td>
<td>RP</td>
<td>Submit 2nd clinical encounter</td>
</tr>
<tr>
<td></td>
<td>No tutorial as Public Holiday (Good Friday)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fri April 22nd</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Student holiday week</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Fri May 6th</td>
<td></td>
<td>Interview</td>
</tr>
<tr>
<td></td>
<td>Standardized patient interview(recorded)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fri May 13th</td>
<td></td>
<td>Submit write up (I/V2)</td>
</tr>
<tr>
<td></td>
<td>Review</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fri May 20th</td>
<td></td>
<td>WV</td>
</tr>
<tr>
<td></td>
<td>Introduction to physical examination/Explanation/Closing the interview</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fri May 27th</td>
<td></td>
<td>RP</td>
</tr>
<tr>
<td></td>
<td>Building the relationship</td>
<td></td>
<td>Submit 3rd Clinical Encounter</td>
</tr>
<tr>
<td></td>
<td>Fri June 3th</td>
<td></td>
<td>interview</td>
</tr>
<tr>
<td></td>
<td>Standardized patient interview(recorded)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fri June 10th</td>
<td></td>
<td>Submit write up (I/V 3)</td>
</tr>
</tbody>
</table>

The last tutorial will be on Friday June 10th
Further Information for Clinical Skills tutorial (Tuesdays and Fridays)

These tutorials will be 3 hours long. The tutorial will be a mixture of observing videotaped role plays, tutor information giving with questions and answers, student role plays with feedback, and standardized patient ("actors") interviews.

You are expected to do the pre-reading from “Skills for Communication with patients” (2nd edition) by Silverman, Kurtz and Draper. The pages to read are listed in the tutorial outline of this booklet.

Role plays

During the semester, all students will undertake role plays as both the medical student/doctor and as the patient. These will be conducted in front of your tutorial group as a teaching and learning experience for the entire group. Following a role play, there will be a feedback session facilitated by your tutor. Role plays are used to highlight a specific point and, in first semester, this will be a specific process of communication skills (e.g. How well did the student pick up on the patient’s non verbal cues?). When first starting to do role plays some students may find it a little nerve wracking and/or embarrassing. It is important that students are supportive, respectful and encouraging of each other.

What happens in a tutorial, which includes a peer’s role play performance, is treated as confidential. If all students within the group participate, role plays are an effective teaching and learning method. Over time, I am sure you will find role plays to be enjoyable. Role plays act as simulation to the real doctor-patient interaction whereby you can trial new communication skills in a safe supportive environment. Role plays are also now commonly used as a method of assessment throughout medical school training but also beyond, in medical specialist examinations and hence a skill well worth learning early. It would be fairly easy for you to find out specifics of other groups’ scenarios for the role plays but we advise you not to do it because being “blinded” to the scenario simulates real life and the exam situation better. Additionally, knowing the scenario will hinder your learning as you anticipate instead of reacting.

How role plays will be run:

1. To demonstrate specific communication skills, your tutor may act as the doctor or the patient and one student will be asked to play the reciprocal role with the remaining students in the group watching and giving feedback (see below for further detail). Or else the tutor may show a video recording of a consultation.

2. Then it is expected that two students will play the role of doctor and patient. A student may initially volunteer to be the first role-player but all students are expected to participate each session.

3. It is important that those who are not doing the role play are actively involved as they will be giving feedback (“feed backers”) and hence actively engaged in the teaching and learning process.

4. Your tutor will define the agenda for the role play, that is, they will explain what the group is aiming to learn from this role play.

5. The “feed backers” will be using the Calgary-Cambridge model checklist (see appendix) and making additional notes on their observations and also thinking of any questions they may have for the tutor.

6. The student who is playing the role play of the doctor will be asked to leave the room for a few minutes whilst the student role playing the patient and the remaining group members are briefed on the patient story (verbally and written script).

7. The role play is undertaken.

8. Feedback session facilitated by the tutor

9. In order to save time, tutors may decide to hand out all the cases at the beginning of the tutorial so that all students have time to read through them and to ask the tutor any specific questions.

Feedback:

It is important that the feedback is constructive. The feedback is a teaching and learning experience for all students in the group. The environment should be a supportive and safe such that you can try these new skills. The feedback must be descriptive and specific rather than vague, judgemental or already interpreted (where you make assumptions about either what the patient or the doctor is thinking and why they have acted in some way – it is better just to describe what you actually saw). Your tutor will guide the feedback as appropriate.

Process of feedback in a role play situation:

1. The tutor will set the agenda for the role plays being run in a tutorial session, that is what you are expected to learn from the role plays in that session.
2. The student playing the doctor will be asked “How did you feel you went?”
3. The student playing the doctor will be asked “What problems did you experience?”
4. The student playing the doctor will be asked “What would you like to discuss with the group?/What do you feel you need help with?”
5. The students in the group will be asked “How did you all think the role play went?” (Commenting on what went well first and then what could have been done better)
6. The students can then make offers and suggestions on how to improve the communication skills in the role play.
7. The students who have done the role play can then be given the opportunity to do the role play again. The tutor may select another two students to do the role play or may ask the group to practice this role play in pairs.
Assessment
During this semester, there will be three standardized patient (“actor”/SP) interviews which will be observed by your tutor and videotaped and stored in the MLS (METI Learning Space) System. You will be allocated a starting time which will be during your tutorial time for the interview which will take place in the Simulation Unit.
These interviews will be assessed using the Calgary Cambridge (CC) checklist which you have been using in your tutorial sessions.
Your tutor will complete a checklist on MLS but will not discuss this with you until the review session. In fact there will be no written or verbal feedback from the tutor until the review session.

Following the interview you will be expected to undertake the following tasks:
1. Watch your interview again by logging into MLS using your FAN. You only have access to your own videos.
2. Complete the CC checklist on the MLS. You need to check each item in the following way:
   - ✔ correctly done,
   - ✗ not done or done incorrectly,
   - ✔/✗ partially done
3. Spend some time reflecting on the interview and how you felt you went and how you could improve (i.e. your personal learning objectives)
4. In the space provided on MLS, please enter your specific learning objectives i.e. How you feel you can improve/What you would like to focus on next time (approx 100 words)
5. In the space provided on MLS, write a case note entry (the content and length of this will depend upon whether it is interview one, two or three). Look at the clinical skills website where sample case entries will be shown.
6. This must be completed 48 hours before your tutorial so that you tutor has time to read through your entries before the tutorial. If students fail to upload their entries in time, this reflects poorly on their professionalism and their time management skills and may lead to being asked to complete remedial work.
7. At your review session in your tutorial, you will have individual time to spend with your tutor to discuss how you are going with clinical skills in general and specifically this SP interview. You will be allocated a 15-20 minute time slot. You will go through the interview checklist with your tutor who will also provide you with feedback from their notes which include comments from the SP. Your tutor will give you feedback on your case note entry. You will discuss your learning objectives with your tutor.
8. Tutors/Students will update their learning objectives (if necessary)
9. When all steps are completed, tutors and students will sign the (paper) assessment sheet and students will be documented as passing the interview/review.
10. Tutors to keep the assessment sheet.

For SP interview one and two a pass grade will be given if the SP interview is undertaken and Steps 1-10 (see above) are undertaken. For SP interview three, the actual interview itself must be assessed as a pass grade by the tutor along with steps 1-10 being completed. If students are not felt to be a pass grade in the third SP interview, then remedial work and repeat interview will be done in the last week of the semester until the student is felt to be of a passing standard.

A vital signs assessment will be undertaken on Wednesday morning sessions (weeks 13-16) which must be passed.

e-Portfolio tasks:
All students have been given an e-Portfolio account for the duration of their time in medical school. An e-Portfolio is a useful way to store teaching and learning assets which belong to the student but can be individually sent to tutors or potential employers as a way of demonstrating competence and experience.

Last year, for the first time, students were required to complete a series of tasks on their e-Portfolio for BLS and this was part of the final assessment. From last year’s experience, we learnt that students can find new software daunting and prefer to postpone using it unless encouraged by assessment deadlines. New training sessions, helpful videos and earlier assessment deadline will be utilised in 2011 to encourage students to successfully use the e-Portfolio earlier in the year.
This year, the use of the e-Portfolio has been expanded to the clinical skills tutorials. Students are expected to post comments/thoughts on pebble pad to send these assets to their clinical skills tutor. The content of these assets include reflections on the Ward Safety session, the Hand Hygiene certificate and write ups of Clinical Encounters.

Please see page 38 for details on how to complete the pebblepad entry for Ward Safety session

Please see page 44 for details on how to complete the Hand Hygiene Certificate

Clinical Encounters (CE):
These are write ups of ward visits. You should go in pairs. The student who talks to the patient and asks the questions, writes up the CE. The observing student cannot write up the encounter. They can only write up the encounter where they have played a dominant role.

Students must complete 3 Clinical Encounters. They are due by tutorial 5, tutorial 8 and tutorial 12. As you will have learnt more about the interview as the semester progresses, your CE’s should reflect this. Plus, it is important that your tutor sees that you have learnt from issues brought up in the reflections of your previous encounters.

What is contained in these write ups must be all your own work. You cannot make anything up. You cannot copy details from case notes (without acknowledging it. You cannot take another student’s work and pass it off as your own. The University has a policy on Academic Honesty and any evidence of Academic Dishonesty will be penalised according to the University’s guidelines.

Please refer to Appendix 5 (Ward visit information) for further details.

How to access your pebblepad
Please log in to www.pebblepad.com.au/flinders and use your FAN
We ask that you create a new “thought”
And that you use the “reflective journal” version

The first page asks for a title:
Please use a simple summary Clinical Encounter (or CE) Number 1(or 2 or 3) and then your name

The next page is titled Description
We would ask you to fill this out as a case note entry:
  1. Demographics of the patient
  2. Details of the problem. (CE 1 is initiating the consultation, plus any other history; CE2 is full history of the presenting problem (but not background history); CE3 is full history, including background information),

The next page is Reflection
We would ask you to fill this as two parts:
  1. Reflection: What did you learn, what did you feel, what do you think that patient has? (see below)
  2. Planning: what are your learning objectives now? (see below) and plans to close the loop

The next page asks you what you want to do with your asset. Please send it to your tutor (whose email address you should have).

Sample Clinical Encounters:
CE 1 (due by tutorial 5) Angela Mc Michaels
Description:
Demographics: Mr JB, 27 yo, Male, Diesel mechanic, lives in Seacliff, Defacto relationship, no kids.
Details: MR JB presents with pain in R leg following a sporting injury yesterday. He was playing soccer, when he tripped and heard a crack as he fell to the ground. He felt immediate pain in his r ankle and was not able to move it. He had to be carried off the pitch and was brought to FMC by ambulance. He had Xrays and was found to have a broken R ankle and he had pins put in it last night.

Reflection:
I went with Juanita Garcia. She observed while I asked the questions. I was quite nervous but the patient was very chatty and said that he would be bored otherwise. I didn’t know how much more information to ask for and it sort of just petered out. When I let the ward, I realised that I forgot to follow the CC method. Juanita felt I asked a lot of closed questions. This is an area I need to improve on.

CE 2 (due tutorial 8) Vijay Kumar
Description:
Demographics: Mrs GI, 78yo woman, retired sales assistant, lives in Brighton with husband, children and grandchildren live nearby.
Details: Mrs GI presents with a week’s history of worsening shortness of breath. She is normally very healthy.
Mrs GI started to notice that she was short of breath when she was climbing up the stairs to her unit last week. She had to stop and rest. This happened every time she climbed up the stairs. Three days ago, she noticed that she was short of breath just walking around her unit and started to spend more time sitting down. She even found she was short of breath getting dressed and undressed. She was very short of breath last night and couldn’t sleep lying down so her husband brought her in to the hospital. The shortness of breath usually lasts about 5 minutes after she exerts herself. When it happens, she feels like something is stopping her from getting enough air in. It is now happening about 5 times a day. There are no other symptoms. Rest makes it better. She is worried about what might be causing it, especially her heart as her brother died of a heart attack 6 months ago and she is now worried she may have a weak heart. She has been unable to do anything these last few days because she gets so breathless. She is hoping the doctors can fix up her problem so she can go home soon.

Reflection:
I went with Mark Wright. He observed and suggested a few questions from the WWQQAAB when I forgot them. I found Mrs GI easy to talk to and she was happy to tell her story but I didn’t know what to say when she started to talk about her brother dying six months ago. Reading the textbook, I probably should have just said that I was sorry to hear about it and I can understand how worried she was. I will try that next time.

CE3 (due tutorial 12) Talitha Sargent
Description:
Demographics: Mr PR, 81yo man, retired policeman, widowed, lives in retirement village in Panorama.
Details: Mr PR presents with a progressively swollen abdomen for the last 2-3 weeks and jaundice noticed since yesterday.
Mr PR has had cancer in his bowel removed 2 years ago. He made a good recovery after the operation and has been in fairly good health since then. He started to notice his abdomen swelling about 2-3 weeks and thought that it was just because he was a bit constipated, although his bowels had been fairly normal. It has been slowly increasing in size (no variation over the day) and was starting to get hard. He also noticed that his appetite has not been as good and he feels a bit nauseous. His daughter came to see him yesterday and said that he looked yellow and took him to his GP, who sent him straight to the hospital. It is his whole abdomen that is swollen. He says that his skin feels tight and itchy and it is more difficult to bend over. Nothing makes it better or worse. He has noticed poor appetite, itchy skin, nausea. His daughter noticed the yellow skin. He thinks that it might be the cancer returning and he is worried that this may be terminal. He would like a straight answer from the doctors because he would like to have some time to prepare his affairs before he dies. He doesn't know if his symptoms can be improved but if they cannot be, he might have to move into a nursing home, which upsets him as he likes his independence.
Background information:
Past history: bowel cancer removed 2 years ago. Good recovery from surgery.
Prostate operation 10 years ago (good result)
Mild hypertension (on tablets for 5 years)
Family History: father died of stroke (aged 70), mother died of heart attack aged 85.
2 brothers – one died of prostate cancer 5 years ago and the other alive and well (aged 78 years)
3 children, all in good health, 7 grandchildren some have asthma, otherwise all well, 2 great grandchildren, all well.
Non smoker (never smoked)
Drinker 1 standard drink per day (last 15-20 years) prior to that 3-4 per day from age 18 years.
Nil illicit drug use.
Medication: blood pressure tablet (uncertain about name)
Allergies: nil

Psychosocial: married for 55 years. Wife died 4 years ago. Lives in retirement village. Daughter lives nearby and drops over to help with shopping tidying about once per week.

General Observation: he looked Jaundiced and his abdomen was very swollen. He also looked like he had sunken cheeks as if he was wasting away.

Reflection:
I went with Nathan Brinkley. He observed while I asked the questions. I needed help with the background information (eg I forgot smoking initially). I was comfortable talking with the patient and he was quite calm when he spoke about wanting to know whether he was going to die or not, which helped me keep asking the questions. I feel like I have learnt how to talk to patients this semester and look forward to next semester.

In Training Assessment (ITA)
The summary of tutorial performance will be stated on the In-Training Assessment (ITA) which documents the three SP interview/reflection/review cycles, the three clinical encounters, ward safety reflection and it assesses student's attendance, participation and professional behaviour.

Student attendance is compulsory and absence for health reasons need a sick certificate to be sighted by your tutor. If a student fails to attend two tutorials without documentation or prior permission, they will be asked to discuss their situation with Dr Anna Vnuk.
Flinders University

STATEMENT OF ASSESSMENT METHODS – Semester One 2011

Students’ attention is drawn to the Student Related Policies and Procedures Manual 2010 (http://www.flinders.edu.au/ppmanual/student.html), which outlines the University’s Assessment Policy.

In the case of professional experience topics, information on the following will be provided to students either in course booklets or in the form of separate hand-outs, prior to the commencement of their placements: the location of placements; supervisory arrangements; duties to be undertaken; codes of behaviour and industry regulations and requirements; assessment and reporting; health or other preliminary checks required by the placement provider; provisions for inability to meet health or other required checks; provisions in the event of unsatisfactory performance either by the student or the placement provider; and any other requirements or conditions relating to the placement.

Topic number and title: MMED8101 Doctor and Patient semester 1

Date on which this statement was provided to students: 28th Feb, 2011

Duration of topic: semester 1

Academic Organisational Unit(s) responsible for topic (Department/School): School of Medicine

Topic Coordinators: Dr Anna Vnuk (Bedford Park) and Dr Clare Fenwick (Darwin)

Telephone number of Topic Coordinators: 8204 6131 (Bedford Park) and 040848632 (Darwin)

Expected student workload*: number of hours per week or in total (specify): Total of 180 hours

* Indicative only of the estimated minimum time commitment necessary to achieve an average grade in the topic. Expected student workload should be based on the standard student workload of approximately 30 hours of student time commitment per unit.

Topic Learning Outcomes:

By the end of the semester, the students should be able to demonstrate competence in the following:

- Establish rapport readily with patients
- Demonstrate acceptable standards of professional behaviour with patients, staff and students
- Ability to communicate effectively with patients, including active listening, and understanding the effects of non verbal communication
- Demonstrate understanding of the patient’s agenda and their experience of their health condition
- Ability to gather information effectively and sensitively from patients about their presenting problem
- Ability to take a complete history including past illnesses, family, social history, medications etc
- Write up patient histories in a clear and logical fashion
- Present a verbal patient history
- Collect and document a patient’s vital signs
- Basic life support

Methods of assessment:

In training assessment (ITA): attendance, participation and professional behaviour – students cannot miss more than 2 tutorials per semester unless they have a sick certificate or documented approval from the Director/Deputy Director of years 1&2 (Bedford Park) or Year One/Two Coordinator, (Darwin). Students who have more than have more than two unapproved absences will be asked to see the relevant Topic Coordinator. The consequences of this are failing the ITA, which would lead to failing the semester. Students in this situation will be asked to do remedial work in order to pass the ITA.

Reflection on Ward Safety – write up on pebble pad completed by tutorial 4.

Clinical Encounters: Three clinical encounter write ups on pebble pad, based on patients seen during ward visits (in pairs) where the student writing up has completed the majority of the interview. The first one must be submitted to the tutor before tutorial 5, the second one by tutorial 8 and the last one before tutorial 12.

Semester 1: Interview/Reflection/Review cycle Students are expected to interview the standardised patient (SP), view their video, mark themselves against the checklist, write learning objectives arising from the interview and a case note entry. This must be submitted 48 hours before the review session. They must attend a review session with their tutor to discuss the student’s performance in the interview, their learning objectives and their case note entry. There are 3 cycles in semester 1. The student must satisfactorily complete all the elements of the cycle to pass, apart from the interview itself. As an absolute minimum, students must show satisfactory competence in interview 3 in semester 1. Students who do not pass the interview in cycle 3 will have remedial teaching and practice and will re-do the interview until they are of passing standard.
**Hand Hygiene Certificate**: completed before students undertake Introduction to Clinical Examination A, the certificate uploaded to pebble pad and sent to Maria Perez-Marrero (Bedford Park) and Clare Fenwick (Darwin)

**Vital signs assessment**: students must pass an assessment where they must measure and record all 5 vital signs (temperature, pulse, BP, respirations and oximetry)

**Basic Life Support assessment task and portfolio**: Participation in 2 hands-on sessions with continuous reflection on BLS learning using an ePortfolio. Students will be provided with the template for a Life Support Skills Webfolio in PebblePad. The front pages of the webfolio should be submitted and post-encounter activities (including the self-assessment) for session 1 to be published to the gateway within 2 weeks of the student doing the session.

This should be updated and the session 2 post-encounter activities should be completed within 2 weeks of the student doing the session.

If any of the following summative assessments are failed: Interview 3 or the vital signs assessment students will receive feedback, remedial assistance and opportunities to re-take the assessment until they pass. Students will be asked to do remedial work if ITA unsatisfactory. For other assessments (work done via pebblepad), they will be asked to complete their work, plus do remedial work.

**Details of assessable work in the topic**. (Optional forms of assessment, where permitted, are also detailed):

<table>
<thead>
<tr>
<th>Format of each form of assessable work</th>
<th>Proportion of total marks</th>
<th>Deadline for submission*</th>
<th>Penalties to be applied if deadline is not met*</th>
<th>Date work is expected to be returned to students</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vital signs assessment (undertaken during CSP session 7)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Immediate</td>
</tr>
<tr>
<td>In-training assessment semester 1</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Week 16</td>
</tr>
<tr>
<td>3 interview/reflection/review cycles</td>
<td>N/A</td>
<td>48 hours before each review session.</td>
<td>N/A</td>
<td>In each review session</td>
</tr>
<tr>
<td>Ward Safety pebble pad entry</td>
<td>N/A</td>
<td>By tutorial 3</td>
<td>Complete work, plus remedial</td>
<td>Tutorial 3</td>
</tr>
<tr>
<td>Hand Hygiene Certificate</td>
<td>N/A</td>
<td>By Introduction to Clinical Examination A</td>
<td>Complete work, plus remedial</td>
<td>Immediate</td>
</tr>
<tr>
<td>3 clinical encounters</td>
<td>N/A</td>
<td>By Tutorial 5, 8 and 12</td>
<td>Complete work, plus remedial</td>
<td>By tutorial 6, 10 and 14</td>
</tr>
<tr>
<td>BLS portfolio</td>
<td>N/A</td>
<td>2 weeks after session 1 completed and 2 weeks after session 2 completed</td>
<td>Complete work, plus remedial</td>
<td>2 weeks after submission (or by end of semester), whatever comes sooner.</td>
</tr>
</tbody>
</table>

*Students who do not submit their assessment when documented or as requested, may be given a fail in the assessment at the topic coordinator’s discretion and be asked to re-submit new assessment. Serial offenders will be reported to the professional behaviour committee.

The criteria for successful completion of the topic (including, where appropriate, the achievement of a certain minimum level of competence in both the theoretical and practical components of the topic and details of special requirements concerning particular elements or aspects of the topic such as attendance/participation requirements, group activity) are as follows:

An overall pass in the Topic requires a pass in each of the following components:

- Vital Signs Assessment
- Interview/Reflection/Review cycles (3 cycles in semester 1)
- In-Training assessment by clinical tutor (including attendance requirements, participation and professionalism)
- 3 Clinical Encounters
- Ward Safety pebble pad entry
- Hand Hygiene certificate
- Basic Life Support portfolio

Detection of Breaches of Academic Integrity

Staff may use a range of methods (including electronic means) to assist in the detection of breaches of academic integrity. In addition, the University makes available for staff and student use the electronic text matching software application – SafeAssignment.
Will the electronic text matching software application SafeAssignment be used?:  No

If Yes, students will receive a written statement describing how the software will be used and be advised about the Flinders Learning Online (WebCT) Academic Integrity site.

Will scaling procedures be used in determining marks for each piece of work or for determining the final topic grade?: No

May assessment exercises be resubmitted after revision for re-marking?: Yes

The circumstances under which assessment exercises may be resubmitted, the form this may take and the maximum mark obtainable are as follows:

Where assessment is deemed not to be of a passing standard, for example the clinical encounters or case write ups, the student will be asked to resubmit. Occasionally, at the discretion of the topic coordinator, a student will be asked to submit assessment on a new patient.

Students who believe that their ability to satisfy the assessment requirements for this topic has been or will be affected by medical, compassionate or other special circumstances and who want these circumstances to be taken into consideration in determining the mark for an assessment exercise may apply to the Topic Coordinator of the topic for special consideration. The preferred method of application is:

By application in writing on the appropriate form, available from the Courses Administration Unit or at http://www.flinders.edu.au/current-students/exam-assess-results/examinations/examination-forms.cfm The form should be sent to Tina Comely in the Health Sciences Faculty Office, Bedford Park or Mary Pocock, Flinders NT, Darwin.

Supplementary assessment for this topic may be approved on the following grounds:

- **Medical/Compassionate** – a student who is unable to sit or complete the original examination due to medical or compassionate reasons may apply for supplementary assessment. If the illness or special circumstance prevents the student from sitting or completing the scheduled supplementary examination, or from submitting by the agreed deadline a supplementary assessment exercise, the student will be either: awarded a result in the topic of Withdraw, Not Fail (WN); or be offered the opportunity to demonstrate competence through an alternative mechanism. If the illness or special circumstance is demonstrated to persist up to the commencement of the next academic year, then the student will be awarded a result in the topic of WN.

- **Academic** – a student will be granted supplementary assessment if he/she:
  - achieves an overall result in the topic of between 45 and 49%, (or between 40 and 49% where a student obtains a fail grade in the last 12 units required for completion of a course) or the equivalent where percentage marks are not awarded;
  - has completed all required work for the topic;
  - has met all attendance requirements; and
  - obtains at least a pass level grade in any specific component of assessment (other than an examination) for the topic where this is explicitly stated to be a formal requirement for the successful completion of the course or topic.

A student with a disability, impairment, or medical condition who seeks reasonable adjustments in the teaching or assessment methods of a topic on the basis of his/her disability may make a request to the Topic Coordinator or the Disability Liaison Officer as soon as practicable after enrolment in the topic. Any such reasonable adjustments must be agreed in writing between the student and the Topic Coordinator and must be in accordance with related University policy. A student who is dissatisfied with the response from the Topic Coordinator or with provisions made for reasonable adjustments to teaching or assessment methods may appeal in writing to the Faculty Board.

.......................................................... .......................................................... .......................................................... ..........................................................
Signature of Topic Coordinators Date SPJ:sj 09.12.08
Further Information for Doctor and Patient

Equipment:

Stethoscopes, Watches
You are expected to have your own stethoscope by the start of semester 2. However, if you purchase a stethoscope before semester 2, please bring it to the Simulation Unit Clinical Skills Practical Sessions on Wednesday mornings. We request that all students have a watch with a second hand in time for the Simulation Unit vital signs session (week 3 or 4). This is required to measure pulse and respiratory rates.

Clinical Skills website
There is a lot of material on the Clinical Skills website, particularly for the Simulation Unit sessions. You can access it through the GEMP website in the first year homepage under “Doctor and Patient (Clinical Skills/BLS)” or directly at http://cal.fmc.flinders.edu.au/gemp/ClinicalSkills/clinskil/default.htm

Student use of Clinical Skills equipment
We have several computers in the Simulation Unit. They are useful to watch your videos. The computers can be used every day as long as the labs or the computers are not being used for teaching. You may need to ask the staff to log on for you. The Clinical Skill Learning Unit has purchased more equipment for teaching. We also have a sphygmomanometer and stethoscope for overnight borrowing.

Otherwise, all other equipment can only be used in the Simulation Unit eg pelvic models, auroscope and ophthalmoscopes. If you wish to have tutoring, assistance or supervision during the use of these models, please organise with the clinical skills staff for a mutually convenient time. This will usually be at the pre-arranged “Consolidation sessions”

The Simulation Unit office will be open everyday from 9-5pm.

To borrow or use equipment:

1. The student must discuss this with Maria Perez–Marrero at the front desk in the main Simulation Unit office.
2. The student must show their student card to Maria who will record details in our equipment book.
3. The student will be told when and how to return the equipment
4. Books and the sphygmomanometer need to be returned the next working day to the Simulation Unit, preferably in the morning.
5. Equipment used in the Simulation Unit needs to be returned to the Simulation Unit office before it closes for the day unless another arrangement is made.

Please note that Harvey permanently resides in a separate room in the Simulation Unit and can be used by students. Harvey is our cardiovascular simulator and is excellent for learning and revision cardiovascular examination and diagnosis.

Please do not use audio-visual equipment without consent by a member of staff and training. The contact person for specific training needs is Lynne Sanderson (Web, IT and audiovisual development office) Lynne.Sanderson@flinders.edu.au ext 66861

Clinical Skills Consolidation Sessions
For a student to gain proficiency in the performance of a clinical skill, the skill must be continually repeated successfully under varying circumstances so that the brain learns and remembers the correct sequence of events. It is most beneficial if a skill is taught just before it will be used in the clinical setting. However, if there is a long gap between learning and using or if the skill has multiple complex steps, it becomes important for revision of the skill to occur to remind the brain of the correct sequence of events.

Therefore, to support the high quality clinical skills teaching that takes place in first and second years of the course, we have opportunities for revision sessions in the clinical skills lab. These sessions are
optional. They will be supervised by Simulation Unit staff who will also be available to answer any questions about the topic.

These consolidation sessions will be run from 1300 to 1400 on either Monday or Friday s (depending upon staff availability). The dates of the consolidation sessions will be displayed on the Simulation Unit notice board. There is a limit to the number of students that can be accommodated in these sessions therefore students need to sign up to attend.

**Occupational health and Safety Issues in the Simulation Unit**

**Bags.** The best place to store your bags is in your own lockers, so please arrive in enough time to do this. If you leave your bag in the main reception area of the Simulation Unit, you should leave them on the shelves and not on the floor or in the passageway. You also do so at your own risk (some bags were stolen last year).

**Latex allergy** affects many healthcare professionals and patients. Allergic reactions to latex are usually limited to dry, itchy, irritated areas on the skin (contact dermatitis) or eye irritation (conjunctivitis) but they can be severe enough to be life-threatening (anaphylaxis). If you react to some fruit or vegetables (latex-food syndrome) you may also have a serious latex allergy. Foods that have been linked to latex allergy include melon, peach, banana, kiwi fruit, coconut, avocado, pineapple, papaya, fig, chestnut, hazelnut, plum, nectarine, apricot, cherry, passionfruit, grapes, strawberry, capsicum, paprika, tomato, celery, carrots, potato or soy. Wherever possible, the Simulation Unit uses latex-free products but some older items may still contain latex. For that reason we ask anyone who may have an allergy to latex to tell a simulation unit staff member before entering.

**First Aid:** If you require first aid, please speak to your tutor who will direct you to the appropriate staff member. In the case of a life threatening emergency, dial 33# and state that you in the Simulation Unit on Level 5.

**Equipment and Medication:** Some of the defibrillators are live and can cause serious and fatal problems if used without due care. The medication used in simulations is expired but will still exert therapeutic or toxic effects if taken.

**Textbooks and Reference Books**

**Semester One** you will need to purchase or secure weekly access to the following book

**Semester Two** it is recommended you purchase one of the following two clinical examination textbooks

Both have excellent descriptions and pictures and while the level of detail is more than what you will need this year, it will come in very handy for later.

Other well written clinical skills textbooks include:
Tutorial one
Introductions

Welcome to medicine!
This session provides the opportunity for each tutorial group to spend some time getting to know each other and their tutor. As each tutorial group will be spending a lot of time together this semester, you may as well become well acquainted.

Then your tutor will discuss the general outline of the semester. Some people are very surprised when they hear that we are going to spend an entire semester teaching them how to “talk to patients”. “Ridiculous!” the students say, “I am very good at talking.” However, communication is also about listening. And we are not just teaching you how to sit there with a straight face, we are teaching you how to listen and understand and express understanding and empathy and learn to ask further questions that reflect this: questions that allow the patients to express their real concerns and get to the very heart of the matter.

Last year was the first time that we used the Calgary Cambridge method and there were a few teething problems. However, in semester two, students said that it now all made sense and they were grateful for the thorough grounding in communication skills. This year, we expect that it will make sense a lot sooner!

During the first tutorial, your tutors will take you on a short tour of the medical centre. This is only a brief tour as too much is not useful at this point so we would encourage you to ask a more senior student to take you on a more detailed tour later in the semester.

The main purpose of going to the wards this week is for you to see the tutor interview a patient. We feel that it is very important that in the very first week of your medical studies, you get to see at least one real patient and hear their story as your tutor takes a history from them.

After this is done, you will go back to your tutorial room and discuss what you observed in the tutor-patient interaction.

Objectives of tutorial 1:
Introduction to each other
Introduction to the topic
Introduction to the hospital
Introduction to patients and history taking

By the end of this tutorial students should be:
• Familiar with the wards
• Understand what we mean by history taking and communication with patients
**Tutorial two:**  
**Initiating the session**

Anyone can start a consultation but the CC method gives you the tools to do it effectively: finding out about the patient’s problem/s briefly, ensuring that you have allowed the patient to mention all the things that are concerning them and then coming to an agreement with the patient as to what you will deal with in this consultation. One big problem that patients face is not being able to bring up all their problems with their doctor or doing it so late in the consultation that the doctor doesn’t want to hear about them. Finding out all their concerns upfront is a more effective and ultimately more efficient method of running consultations. Whilst this way of initiating the consultation may seem artificial to you, it immediately shows your interest in the whole patient (and not just one problem) and you will come across as a more caring doctor.

You will watch a video to demonstrate how to do it (well and not so well). Then you will all get a chance to try out your skills in role plays. See the first part of this book for an explanation.

**Pre-reading** pp35-55  
Objectives:  
Skills for initiating the consultation  
Establishes initial rapport  
Identifying the reason for the consultation  
(points 1-7 on framework)

By the end of this tutorial, students should be able to  
• initiate a consultation
**Tutorial 3: SP interview number 1**

(Initiating the consultation 1-7 of CC checklist)

Each student will be rostered to come to the Simulation Lab for their first Standardised Patient (SP) interview. This interview will be videotaped. You are asked to follow the first 7 steps of the CC checklist, as you introduce yourself to the patient, check their name and comfort level, listen as you find out the main problem that has brought them to see you today and then negotiate the agenda. You are role playing a medical student who is on placement at a General Practice: you are taking the history from the patient and then you will present your findings to your GP supervisor. This interview should take about 5 minutes (maximum). Please see the explanation at the beginning of the document for greater detail. This part of the tutorial should only take about 30-60 minutes.

**Plus Gathering Information (GI 1a)**

In the rest of the tutorial, the tutors will discuss how to find out more information once the patient has given you the brief description of their problem/s and, in particular, the advantages and disadvantages of open and closed questions and when and how to use them. There is a video to demonstrate this and students will have the chance to practise with role plays.

**Pre-reading pp71-77**

**Objectives:**

Questioning skills for information gathering

Open and closed questions (point 9 on checklist)

By the end of this tutorial

Students should be able to

- appreciate the advantages and disadvantages of open and closed questions
- identify whether a question is open or closed
- Use both appropriately
Tutorial 4: Review session 1

Whilst there is great value in doing the interview, a lot more is gained from reviewing it yourself, before you get feedback from others as it allows you to develop self-assessment skills. Then discussing what happened and what you have learnt and how you plan to improve next time with your tutor is closing the loop of learning.

Each student is allocated a 15 minute session with their tutor. It is really important that you have completed the checklist, case note entry and learning objectives 48 hours before your tutorial so that your tutor has time to look over it before your review session.

Gathering information 1b

In this part of the tutorial, the tutor will discuss with you how important it is to allow the patient to tell all of their story, with minimal interruptions from you. The patient feels like their story is important and it is much nicer to get information from the patient with them telling you, rather than you questioning them.

The Calgary Cambridge method has several items on the checklist that will assist you in eliciting the patient narrative. There should also be time in this tutorial for a ward visit, so please dress accordingly.

Objectives:
- Overview of Gathering information (see page 3 of framework)
- Importance of patient narrative (point 8 on the checklist)
- Revision of open and closed questions

By the end of the tutorial, students should be able to
- Understand how to elicit the patient’s narrative

Plus

Before tutorial 5, there will be a lecture on the Patient’s Perspective given by Malcolm Bond and Anna Vnuk.
**Tutorial 5:**  
**Patient’s perspective:**  
One of the most important things that you learn in clinical practice is that you don’t really know what the patient is thinking, unless you ask. You can make assumptions and guess but you never know unless you check. The following questions will assist in eliciting this information. However, students tell me that they feel uncomfortable asking these questions and many still avoid them because they say “well, it was obvious”. This is a concerning attitude and we would encourage you to try these questions on the standardised patients because we have trained them to have a response. If you find that it it really difficult asking a patient about their emotions, you need to ask if you are afraid of emotions and why. We will teach you how to deal with crying patients and remind you that you do not have to solve their problems, just to listen and acknowledge. Occasionally patients will be surprised at you asking these questions but, in general, they are pleased that someone cares enough to ask. There are role plays for you in this tutorial.

**Pre-reading** Pp60-67 and 93-97  
**Objectives:**  
Importance of the patient’s perspective  
Eliciting the patient’s perspective (points 17 and 18 on CC list), (plus page 3 of framework)

By the end of the tutorial, students should be able  
• to elicit from the patient their perspective  
  o Ideas and beliefs  
  o Concerns  
  o Expectations  
  o Effects on life  
  o Feelings:
Tutorial 6
Biomedical perspective – symptom analysis:
When a patient has a problem, there are certain details that you need from the patient to analyse the symptom and to help you make a diagnosis. Once you have identified the problem, you should encourage that patient to tell you the whole story (elicit the narrative) and then to discuss their perspective. By that time, you will have a lot of information about the patient’s problem but any information that you do not have, that you require for the symptom analysis, you should ask now. There are role plays for you in this tutorial.

Pre-reading pp68-69
Objectives:
Understand the questions and responses that help the doctor uncover the medical causes for the patient’s problem (page 3 of framework)

By the end of this session, students should be able to use their questioning and listening skills to be able to
- Elicit sequence of events
- Elicit symptom analysis
- Understand the place of relevant systems review (see tutorial 8 for more information).

WWQQQAAB (Page 68 Silverman et al, 2005)

Where –

When –

Quality –

Quantity –

Aggravating and Alleviating Factors –

Associated Manifestations –

Beliefs – (should have been already asked as part of patient’s perspective – kept here as a reminder!)
Tutorial 7:  
Attentive listening: 
Now that you have the potential to obtain lots of information from the patient, we need to focus on skills that will allow this to happen more easily. Attentive listening skills will help you hear what the patient is saying, will encourage that patient to reveal more and will help you work out what is important. Some of you already use these skills but you may not be aware of what you are doing. Some of you may be surprised that just a few subtle changes in to your listening skills will make a significant difference to the consultation and its outcome. Instead of role plays, students will go with their tutors for a ward visit, so please dress appropriately.

Pre-reading pp78-85
Objectives
The Rationale and skills of attentive listening (points 10-16 on CC checklist)

By the end of this tutorial, students should be able to:
• Facilitate the patient’s response
• Pick up patient’s verbal and non verbal cues
• Clarify the patient’s story
• Make internal summaries
• Use clear jargon free language
After you have obtained all the information about the patient’s symptoms, you need to find out about their background health. There are a whole series of questions to ask which are not difficult in themselves. Patients expect health professionals to ask these questions but you need to work out the best way to frame these questions so that you are not offending or missing out on important information. You have already been taught several different parts of the consultation but moving abruptly from one section to another can sometimes really confuse that patient. The Calgary Cambridge method gives you the skills to move easily from one section to another. This is called “signposting”, where you let the patient know that you have finished with one section and are now moving to the next section and why you need to ask the following questions. For example, “thank you for all the information about your sore leg, now I need to ask you some questions about your health in general”. This lets the patient know where you are heading. Signposting is not hard and some of you would already do it but it should be used by all as it aids consultation flow.

Summarising as you go along in the consultation is another key skill. This is particularly important for several reasons:

- it shows you have been listening and you know what is important to the patient,
- it allows the patient to add anything else and
- it cements the information in your mind, thus making it possible for you not to take notes during the patient narrative part of the consultation.
This following document is another way of looking at the structure of the CC interview.

<table>
<thead>
<tr>
<th>Question Type</th>
<th>Structure of Interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>OPEN</td>
<td><strong>Introduction</strong></td>
</tr>
<tr>
<td></td>
<td>Initial information gathering</td>
</tr>
<tr>
<td></td>
<td>- Anything else?</td>
</tr>
<tr>
<td></td>
<td><strong>Summarise</strong></td>
</tr>
</tbody>
</table>

| CLOSED        | Negotiate and choose main/first problem |
|              | **Signpost to history of presenting problem** |

| OPEN          | **HPC/Tell the story/have a chat** |
|              | **Optional summary of HPC if required** |

| FOCUSED OPEN  | Pt perspective |
|              | - beliefs |
|              | - concerns |
|              | - expectations |
|              | - affect on life |
|              | **Optional summary of patient’s perspective if required** |

| Signpost for WWQQAAB |

| CLOSED        | - W |
| CHECKING SYSTEM | - W |
|              | - Q |
|              | - Q |
|              | - A |
|              | - A |
|              | - B |
|              | **Summarise above HPC and WWQQAAB if not already done** |

| Signpost for Background information |

| FOCUSED OPEN  | - Past medical history |
|               | - Social history |
|               | - Family history |

| LESS OPEN     | - Allergies |
|               | - Medications |
|               | - Illicit |

| CLOSED        | - EtOH |
|              | - Smoking |
|              | **Summarise background information** |

| Signpost for closing the interview |

| CLOSED        | Closing the Interview |
|              | - Summarise problem/s |
|              | - Check and correct |
|              | - Forward planning |
|              | - Safety Netting |

| Final checking and correction |
| Close interview |
Purposely omitted systems review, physical examination and explanation and planning as this is not taught in Semester One (Caroline Phegan, January, 2011)

There are role plays in this tutorial to allow you to practise these skills.

**Pre-reading:** pp69-70, 107-116

**Objectives:**

**Background information**

A revision of gathering information incorporating building structure in the interview (19-22 on CC checklist)

By the end of the session, the student should be able to

- Elicit the following form the patient
  - past medical history
  - drug and allergy history
  - smoking, alcohol, illicit drugs
  - family history
  - personal and social history
  - review of systems (see below for explanation)

- Summarise
- Progress (using signposting)
- Logical sequence
- Timing and keeps interview on task

There are role plays for you to practise these skills.

**Systems**

Clinically we can think of the body as different systems for example: cardiovascular, respiratory, musculoskeletal etc. Each system is usually studied under the following topics:

- **Anatomy** dealing with structure of the system
- **Physiology** dealing with normal function of the system
- **Pathology** dealing with abnormal changes to structure and function
- **Pharmacology** dealing non surgical correction of pathological process
- **Clinical presentation** dealing with how a patient presents to the clinician – taking history and examining the patient

For example patient presents with painful ankle due to trauma

- **Anatomy** ligament and bone of ankle joint
- **Physiology** normal range of movement
- **Pathology** bone fracture, ligament tear
- **Pharmacology** analgesia
- **Clinical presentation** history: what happened?, pain location- examination: swelling, tenderness

**Relevant system questions**

Each system has a series of questions that need to be asked when taking the history to ensure that most of the symptoms caused by the derangement of that system are covered. Sometimes the patient may have a symptom but may not have connected its occurrence with their presenting problem. Asking the questions from the relevant system will assist you.

The questions for each system will be taught, starting with the cardiovascular, respiratory and renal system questions in semester 2. These questions are generally asked after the symptom analysis. You need to know what system the patient’s problem is most likely to be arising from and it is usually obvious what the relevant system is eg cough with green phlegm (respiratory), passing blood in urine (renal). Sometimes it is not and sometimes it can be due to multiple systems (see below section on review of systems for how to resolve this)

**General questions**

There are a set of symptoms that may be caused by several systems, they tend to be non specific, sometimes vague, not usually volunteered by patient, of gradual onset say 2-4 weeks. These symptoms may indicate serious illness like depression, diabetes, or cancer. One way of not missing a serious
illness that the patient may not be aware of, is to ask a set of questions called general questions that have a good probability of detecting these illnesses clinically. The general questions are usually asked after the symptom analysis and the rest of that system questions but before background information. For example “Over the last 2-4 weeks, have you noticed any change in appetite or mood, unexplained weight change, tiredness, fever, night sweats, or sleep disturbance?”

**Review of systems**

You need to ask all of the questions from each system. This is called the “Review of Systems”. It is done after the background information section of the history taking. The purpose of the review of systems is

- to determine if the symptom being investigated is actually from the system that you think it is from (eg you may think that the cough is respiratory but may change your mind when you realise that the patient has all the symptoms of heart failure when you ask the cardiovascular system questions)
- to determine if the symptom/s currently being investigated is having effects in other systems (eg if the blood in the urine is caused by renal cell cancer, it may have spread to the lungs and be causing shortness of breath)
- to detect any other conditions that have not been diagnosed yet (eg coughing after exercise may be related to undiagnosed asthma)

You will accumulate the questions for each system, as you do each system in KHI and D&P, starting in semester 2.
Tutorial 9  
SP interview II  
This interview is naturally longer than the first interview as it includes points 1-22 of the CC method and page 3 of the framework and you will be rostered at 20 minute intervals. The interview should take 15 minutes and your tutor will stop you after 20 minutes. We realise that this may not be enough time all that is expected but we will be assessing you on what you do and are keener to see your skills in eliciting the patient’s narrative and the patient’s perspective and performing symptom analysis than your skills in asking the background information. We are expecting that you will be able to demonstrate your content and process skills ie your ability to ask all the questions (content) following the process outlines in the CC method.

We also would encourage you not to take copious notes. You will be given a sheet of paper with the patient demographics (half an A4 size). There is really only room to write the basic symptoms and any other notes to yourself (points mentioned that need to be brought up later). **You cannot bring the checklist into the room.**

Tutorial 10  
Review session II  
Please remember to watch your video, complete the checklist, write up the case note entry and complete your learning objectives. Even though you have a week off and so your tutor is not expecting it for nearly two weeks, it is better to do it soon after the session, while it is still fresh in your mind.

There will be 20 minutes for each review. Your tutor is hoping (as you are) that you will display a satisfactory level of competence in the interview. If there are any issues, your tutor will work with you to improve them before the next interview. If you need more remedial work than this, your tutor may refer you to one of the clinical skills staff for more intensive assistance.

Before this tutorial, there will be a lecture on the complete history, followed by an explanation of what the doctor is thinking before they start physical examination and what they are looking for on physical examination.
Tutorial 11

Role of physical examination, Explanation and information giving, Closing the interview

This session is designed to highlight the final parts of the consultation. Closing the interview is an important skill. It is easy for you to do it in these interviews as you are role playing a medical student who is going to give the information to your GP supervisor, so the summary to the patient echoes the summary that you would give the GP supervisor.

The role of physical examination is discussed fully in the lecture. In summary, a thorough history gives you information on what you need to do on examination and what you are expecting to find or expecting not to find in order to make a diagnosis. All of history comes before examination, apart from general observation or in an emergency situation.

We would encourage you to try to learn some of the skills involved in explanation and planning. We would encourage you to use the conditions of the patients in your PBL in order to practise these skills. You will be going to the wards for a visit so please dress accordingly.

Pre-reading: pp199-205

Objectives

Physical examination’s role in the CC framework
Introduction to explanation and information giving
Closing the interview
(points 33-37 of CC Checklist)

By the end of this tutorial, students should be able to

• Understand the role and thinking of physical examination
• Understand concepts and skills involved in explanation and information giving
• Close the interview
  • Gives any preliminary information
  • Checks patient understanding
  • Encourages patient to discuss any additional points
  • Summarises session
  • Makes contract with patient
Tutorial 12

Building the relationship

Building the relationship with the patient is a critical part of the consultation and is a constant theme that runs through the entire consultation.

Two important skills are:

The Accepting Response: acknowledge, allow for more (use the “pause/full stop”), avoid the tendency to correct if they are wrong or to give premature reassurance.

Use of Empathy: Understand the patient’s situation and communicate that understanding to the patient. Written down like this, they seem quite simple but putting them into practice can be trickier because it goes against the way we normally communicate with people where we negate their feelings by telling them not to worry and, while we may understand other people’s predicaments, we seldom communicate that we understand them (which is closing the loop for empathy).

Most of you are doing medicine because you are caring people. The wonderful thing about the Calgary Cambridge method is that allows you to demonstrate your caring for people. What is really good is that it allows you to acknowledge emotions and show caring without actually having to solve the patient’s problem because it is very unlikely that you can help their daughter’s drug addiction, their disputes with their crazy neighbours, the waiting list for prostate surgery etc. Feeling overwhelmed by their inability to solve their patients’ problems seems to be one of the main reasons why people do not delve into patient’s emotions during a consultation. Sure, patients would love it if you could solve their problems but in the meantime, you can show you care.

Pre-reading pp117-140

Objectives:

Develop skills and ability to build a good therapeutic relationship with patients, use of non verbals, develop rapport and involving the patient (points 23-32 of CC checklist)

By the end of the session, students should be able to:

• Demonstrate appropriate non–verbal behaviour
• Make notes without interfering with consultation
• Demonstrate appropriate confidence
• Be non judgemental
• Use empathy
• Provide support:
• Deal sensitively
• Share thinking
• Explain rationale
• (understands that during physical examination, explains process, asks permission
Tutorial 13

SP interview III
The third interview is again longer as it contains Initiating, gathering information, providing structure, building the relationship and closing the interview (1-30, 35-37 of CC checklist and page 3 of framework). Students must demonstrate competence in the interview to pass this section and if the tutor considers their performance to be below the standard, they will be contacted and a review session and remedial teaching will be organised (as necessary) so that they can successfully complete the interview. Students must also complete the checklist, case note entry and the learning objectives and have the review interview with their tutor to pass.

Tutorial 14

Review session III
This is the last clinical skills session for semester 1 with your tutor. We have left the final week of the semester free so that we have time for remedial sessions and re-assessment as necessary.
Clinical Skills Practical Sessions

These sessions usually take place in the Simulation Unit on Level 5. Please check the timetables on the Clinical Skills noticeboard before your session. Students will be rostered to attend with their PBL groups. Sometimes students will be rostered in groups of 4 (half their PBL group).

If you are unable to attend your rostered session, you can swap with someone else but please let us know by emailing Maria (maria.perezmarrero@flinders.edu.au). If you are absent on the day or unable to swap with anyone, let us know and we will see what we can arrange. Maria is in charge of the student attendance database, so let her know. Also, if you are sick on the day, let us know.

We do not want you to miss any of these sessions. If you miss a session, you are at a disadvantage.

Almost all of the clinical skills teaching is taught in a sequential manner, that is, we start explaining or demonstrating and then move on to the next task. If you are late, you will miss out on that demonstration or explanation. These schedules are very tight and there is not enough time for us to repeat ourselves. If you are late, you will be disadvantaged throughout the whole session.

Please arrive on time.

We have organised clinical skills consolidation sessions for students who wish to have extra help or revision in a certain area. If there is some teaching that you missed and were unable to make it to another session, there may be an opportunity to repeat some of the teaching then. You will need to email Maria and organise a time in the consolidation sessions when this can be done.

There will be 7 Simulation Unit sessions and the content of these sessions is as follows:

<table>
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<tr>
<th>Session</th>
<th>Content</th>
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<tbody>
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<td>Session 2</td>
<td>Vital signs A</td>
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<td>Session 4</td>
<td>Introduction to clinical examination A – percussion and auscultation</td>
</tr>
<tr>
<td>Session 5</td>
<td>Introduction to clinical examination B – palpation and lymph nodes</td>
</tr>
<tr>
<td>Session 6</td>
<td>Introduction to clinical examination C – neurological examination</td>
</tr>
<tr>
<td>Session 7</td>
<td>Vital signs summative assessment</td>
</tr>
</tbody>
</table>
Session 1
Ward Safety

The aim of this tutorial is to introduce you to hospital ward protocol for interviewing a patient and to feel comfortable in taking history in ward setting. There will be four stations each of 15 minutes highlighting different scenarios and how to deal with them. Standardised Patients (SPs) will be used in these scenarios. The tutor will facilitate this session and we will discuss issues as they arise.

By the end of this session, students should be

- confident in dealing with most common issues that will arise when they are talking to patients on the wards.

Appropriate ways to approach the CSC (Clinical Services Coordinator – the nurse in charge of the ward):

Introduce self (both names), role, rank and request:
“Hi, I'm Fred Bassett, a first year medical student and I'm looking for some patients that I could take a history from”

In semester 1, you only need patients that are happy to talk to you (history)
In semester 2, you may also want patients that are willing to let you examine them (history and physical examination)

Sometimes students ask for patients with a specific problem eg heart, lungs etc so the CSC may ask if you the patient needs to have a particular problem. At this stage, you are interested in anyone who is willing to talk to you.

You would prefer a patient who is relatively well and talkative. It is more difficult for you to take a history from a patient who has English as a second language or if they are confused or suffer from dementia.

As your history taking is just for your benefit (ie the patient doesn’t get anything from it), it is better to spend time with patients who are relatively well and not in pain or distress. The only benefit for the patient is to relieve their boredom, so you talking with them has a bit of a social aspect – be polite and be prepared to listen to stories that you wouldn’t otherwise!

If the CSC or the ward is very busy,
1. Negotiate another time
2. Go to another ward
3. Don’t take it personally

Can you approach doctors or other staff members?
If the CSC is not available (and you have checked by asking), another member of the nursing staff will have taken on his/her duties – check with that person. If a patient is suggested to you by another member of the team (eg an intern), check with the nurse in charge of the patient before you approach them – their nurse will have some idea of how they are eg just had some bad news, did not sleep well, going for a CT scan in 5 minutes and whether you talking to them is appropriate or not.

Appropriate way to approach a patient
Always wash hands before and after patient contact (check posters in the clinical skills lab for the 5 moments of Hand hygiene)

Introduce self to patient, showing name badge and clearly stating first name (at least) and role (first year medical student from the university). You should probably add that you are not part of the team looking after the patient but you have come to learn how to talk with patients.

Check that you have the right patient
Check how they wish to be addressed
Ask their permission to take a history: ie ask a few questions about the problem that has brought them into hospital.

Moving patients:
All patients should have mobility and assistance signs above their bed.
If the patient goes to move from chair to bed and you can see that they have been documented as independent mobility, then that is OK.
If the patient asks you for assistance and you can see that they are documented as requiring assistance, ask them to ring the nurse’s bell and to wait for the nurse to come.
If you are trained as a physiotherapist, nurse or another health professional who regularly assists with patient movement, still ask the patient to ring for the nurse. Do not do this on your own as you are not currently employed to work with this patient. You are here in the role of medical student now.

If the nurse asks you to help, you can assist but only under their direction. This goes for all medical students, no matter what their background.

What do you do if there is no sign above their bed?
If they ask you for help, ask them to call the nurse.
If they move without asking you for assistance, allow them to continue.
If they seem to be struggling, suggest that they return to their bed or chair and press the nurse button.

Food and drink:
If the patient asks you to get them something to eat or drink, you can check the instructions above the bed and then check with their nurse. If you give the patient something to eat or drink and they are meant to be fasting for theatre, this can upset a theatre list and will incur the wrath of surgeons and anaesthetists alike. It is worthwhile to always check with their nurse if a patient asks you to get them food or drink which is not in front of them.

Medication:
If a patient asks you to get their medication from their bedside locker, then it is important to note that patients shouldn’t have medication in their lockers, unless it is for asthma or angina. If they have developed asthma and angina and will require medication, their nurse should be notified.
If a patient asks you to get their medication which is in a little white cup on their bedside locker (for example) then this medication was delivered by the nurse for them to take. If you saw it being delivered, then pass it over to the patient to take. If you did not see it delivered and you are concerned that it has been there for a long time eg a few hours, it is worth checking with the nurse before you give it to the patient.

Vomiting patients:
Ring the nurse bell. Look for a vomit bowl and give it to the patient. Look for the nurse in the bay and ask for his/her help.

Patient with chest pain:
Ring the emergency bell. This is the red button above the patient’s bed. This will summon help from staff on this ward. Also, call for assistance from any staff nearby. Once you have learnt how to, you can apply oxygen by mask. Prepare what you will say to the staff when they arrive (handover). Later, you will learn about ringing 33#. This is the emergency number and this will either call a “Code Blue” or the MET team – both of which are the staff and equipment needed for life threatening situations.

Patients and confidentiality
If a patient presents you information that they would like you to pass on to the caring team, you should remind them that you are a medical student, not a doctor, but pass the information to the nurse caring for the patient (or the doctor, if he/she is readily available). The treating doctor should then clarify the details directly with the patient as it may not be prudent to act on indirect information from a student. If the patient informs you that they would like to tell you information but they do not want you to tell anyone else, immediately stop them from revealing anything more and suggest strongly that they tell their doctor or other member of the caring team. Remind them again that you are a medical student from the university and not a member of the team caring for them.

It is important to note that when you are a member of the team looking after the patient, it is accepted that information (subject to medical relevancy) is passed on freely between members without it being considered a breach of confidentiality. However, you are not part of that team yet.
If the patient still wishes to give you information, you could say that you would like, with their permission, to tell a member of their caring team (perhaps they would be happier for you to tell their nurse but not their doctor).
If they still wish to tell you, despite all your warnings and information, you cannot breach this patient’s confidentiality unless
- You believe a third party is to be injured (patient informs you that he is going to kill his brother)
- You believe the patient is a suicide risk (patient informs you that she has made plans to kill herself)
• You are required by law (eg reporting of sexually transmitted disease for contact tracing or child abuse or if required to give evidence by a court). You will be taught about the process of mandatory reporting later.

Otherwise, confidentiality should be preserved.

Remember that curtains may provide a little visual privacy but you can hear everything that a person says or does behind the curtain. So be aware that others in the ward bay can hear what you are saying. Also, make sure when you are working with patients’ case notes, you do not make it easy for other patients to see and read them.

Medical advice
Also remember that, as junior medical students, you should not give out medical advice. You have not been taught enough to give useful and balanced information to the patient.

If you have detailed health knowledge, perhaps because you have been trained as a health professional, remember that you are not seeing the patient in the capacity as a health professional, you are seeing them as a junior medical student and it is not your place to give out information, suggest or give treatment. It is important for medical students to act within their role. If a claim is made against you, there will be problems protecting you if you were acting beyond your role.

Anna Vnuk, John Agzarian, Jo Wiese, David Worswick
1st April, 2010

Ward safety reflection
Follow up task: You need to enter some reflections from this session and your first ward visit on pebblepad (part of your e-Portfolio) and send it to your clinical skills tutor.

This is what you need to do:

How to access your pebblepad
Please log in to www.pebblepad.com.au/flinders and use your FAN
We ask that you create a new “thought”
And that you use the “reflective journal” version

The first page asks for a title:
You can just write Ward Safety and your name.

The next page is titled Description
We would ask you to fill this out as follows:

3. What was something that you noticed when you visited the wards, that surprised you, that interested you, that confused you? Write a description.

The next page is Reflection
We would ask you to fill this as two parts:

3. What did you learn from the ward safety session that confirms that what you saw was correct or whether it was not done according to current teaching

This should only be about 100-250 words.

The next page asks you what you want to do with your asset. Please send it to your tutor (whose email address you should have).

Two examples of entries:

Ward Safety (Sean O’Leary)
Description: What I went to the wards for the first time, I was surprised to see handwash at the end of every bed. I saw one nurse come in and wash her hands both before and after she touched the patient’s drip stand. And she did the same with each patient. I thought that was a bit excessive. Nobody else did it as much as she did.
Reflection: When I did the ward safety session, I realised that there are 5 points of Hand Hygiene and that the nurse was following the correct protocol and no one else was. It makes you wonder whether people actually know what to do or whether they are just lazy. (116 words)

Ward Safety (Yoke-Mee Tang)
Description: When we went to the wards and our tutor interviewed a patient, I was amazed at all the things that the patient told our tutor—really private stuff. Things that I would never talk about at home, the patient was happy to tell the tutor. This took me by surprise and made me realise that I would have to get used to asking the questions and hearing the answers to all this stuff.

Reflection: when we had the ward safety session, it put a whole new spin on the information that a patient gives—I now realise that patients tell us these things because they believe that we will treat this information confidentially. However, the issue of what to do if the patient tells you something that they haven’t told anyone else, I found quite concerning as we have a big responsibility, even as medical students. It was helpful to know what to do and I hope that I will remember. (162 words)
Session 2
Vital signs A
By the end of this session, students should be able to:
• Make general observations on the patient in the ward or ambulatory setting
• Perform respiratory rate, pulse rate and temperature measurements
• Plot them on the observation chart

General Observations (or "no touch" examination)
The aim of the "no touch" technique is to train you to use your powers of observation to obtain useful clinical information about the patient at the beginning of an interview or before you lay hands on them to perform a physical examination. Much information about the patient can be obtained by just standing back and observing them.

In the hospital setting, describe what you see when you first meet the patient. For example:
• Age, race, approximate weight
• Is the patient comfortable or distressed?
• Conscious state - drowsy or alert?
• Posture - is the patient in bed or are they sitting in a chair?
• Any intravenous tubes, wound drains and oxygen connected to the patient?
• Grooming - is their hair done or are they unshaven?
• Non-verbal communication, eye contact
• Mood - withdrawn, crying, aggressive, facial expression

In the general practice (or ambulatory) setting, observation begins and information can be obtained when you direct the patient from the waiting room to the consulting room, for example,: 
• Age, race, approximate weight
• Appearance - dress, grooming, etc
• Facial expression
• How they walk or their posture
• Are they alone or accompanied by another person?

Like vital signs, (temperature, pulse, BP and respiratory rate), the no touch technique may reveal important information at the initial interview and during the follow up review. For example, in the initial examination, the patient may be in bed, connected to intravenous tubes and look uncomfortable and, on subsequent occasions, he may be sitting in a chair, having lunch.

Most people will appreciate that the patient looks different or has altered in some way. The idea behind encouraging students to perform a no-touch examination is to train them to be consciously aware of these signs as it may convey to you important clinical information about the patient.

Temperature
Types of thermometers
There are four types of thermometers commonly used in clinical practice: mercury filled glass thermometers, digital thermometers, infrared ear and skin thermometers.

Mercury thermometers and digital thermometers can be used to measure body temperature via the oral, axillary or rectal method. Mercury thermometers should be left in place for at least 2 minutes or until the mercury column has stopped rising. (1,2). Digital thermometers have the advantage of giving a more rapid reading than mercury thermometers. Newer thermometers using infrared technology can measure body temperature from the ear. These thermometers are similar in shape to an otoscope and measure the temperature of the tympanic membrane.

Also using infrared technology is a forehead thermometer which is commonly used in general practice. This thermometer measures temperature over the skin of the forehead. Limited information suggests it is at least as reliable as tympanic membrane thermometry (3).

Sites of temperature measurement
The ORAL method is a convenient site to measure temperature in adults. The thermometer is placed under the tongue. If using a digital thermometer, it should be covered with a plastic sheath to avoid contamination. Oral readings can be affected by eating, drinking, smoking and tachypnoea (4,5).

The AXILLARY method is commonly used in children and adults using a digital or mercury thermometer. A mercury thermometer usually needs to be left in place in the axilla for longer than the oral method (2).

The FOREHEAD method is quick and convenient, especially for distressed children.

The RECTAL method can be used in infants. This is generally regarded as the most accurate site for measuring temperature but is limited by its acceptability to patients and parents. (3)

TYMPANIC MEMBRANE (TM) measurement is a quick, convenient, non-invasive method for children and adults, if available. Theoretically, TM temperature best reflects core temperature, (temperature of the hypothalamus), because it is supplied by the same artery as the hypothalamus (4). However, studies have demonstrated greater variability in TM temperature measurements in a single person compared to oral and rectal measurements (4,5). TM measurement will be inaccurate if there is wax obstructing the tympanic membrane (4,6). It is not recommended for use in children less than 2 years old because the ear canal is too narrow to get an accurate reading (3).

Temperature measurements vary depending on the site measured. On average, rectal temperature measurements are 0.4 to 0.5 C higher than oral temperatures (4,7,8). Average axillary measurements are 0.4 to 0.7 C lower than oral temperatures. (4,6,7,8) Tympanic membrane measurements may be lower or higher than oral temperatures depending on the brand of thermometer used. (3,5,6). The tympanic thermometer available in the Simulation Unit gives readings generally higher than oral measurements.

Normal Temperature
Defining normal temperature ranges is extraordinarily complex. This is because there are so many variables that affect temperature measurements.

Body temperature varies from person to person, has a diurnal variation (usually lowest at 6am and peaks at 4-6pm), varies with age (becoming lower with increasing age), sex (women slightly higher than men), menstrual cycle in women (higher premenstrually), the weather (rising in hot weather) and as already stated, with the site measured (3, 4, 5,6,7,9,10). Hence, interpretation of a single temperature reading must take into consideration all of these variables. Ideally, it would be helpful to know each person's baseline body temperature!

Defining normal body temperature is therefore arbitrary. Traditionally, normal body temperature was said to be 37.0 C but this was based on data published in 1868 (9)! A study of 148 healthy 18 to 40 year olds found a range of temperatures, taken orally and at different times of the day, from 35.6 to 38.2 C (9). This study highlights the individual and diurnal variability of body temperature. The diurnal variability ranged from 0.05 C to 1.3 C. Based on their findings, Mackowiak et al recommended that fever be defined as an oral temperature > 37.2 C in the morning or > 37.7 C overall.

"Normal" oral temperature ranges, or maximum normal oral temperature, stated in other references, are as follows:

- 35.5 - 37.5 C (3)
- 36.0 - 37.2 C (7,11)
- 36.0 – 37.5 C (12)
- 35.7 - 37.3 C (13)
- < 37.5 C (14)

The Canadian Paediatric Society has written an extensive position statement on this topic and this can be viewed on their website: www.cps.ca/english/statements/CP/cp00-01.htm. The arbitrary normal values adopted by the Society are as follows:

<table>
<thead>
<tr>
<th>Measurement method</th>
<th>Normal temperature range</th>
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<table>
<thead>
<tr>
<th>Measurement method</th>
<th>Normal temperature range</th>
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<tbody>
<tr>
<td>ORAL</td>
<td>under the tongue</td>
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<tr>
<td>AXILLARY</td>
<td>covered with a plastic sheath</td>
</tr>
<tr>
<td>FOREHEAD</td>
<td>quick and convenient</td>
</tr>
<tr>
<td>RECTAL</td>
<td>limited by acceptability</td>
</tr>
<tr>
<td>TYMPANIC MEMBRANE</td>
<td>TM measurement</td>
</tr>
<tr>
<td>Normal Temperature</td>
<td>extraordinary complexity</td>
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<tr>
<td>Body temperature</td>
<td>varies from person to person</td>
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<td>Traditionally</td>
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<td>35.7 - 37.3 C</td>
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<td>&lt; 37.5 C</td>
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41
Rectal 36.6°C to 38°C (97.9°F to 100.4°F)
Ear 35.8°C to 38°C (96.4°F to 100.4°F)
Oral 35.5°C to 37.5°C (95.9°F to 99.5°F)
Axillary 34.7°C to 37.3°C (94.5°F to 99.1°F)

Hypothermia is defined as < 35.0°C (77°F), and if suspected an appropriate thermometer must be used.

In view of all the variables affecting body temperature measurement, a single reading should be evaluated in context with other physical examination findings. When several readings are available from the same patient, it will then be possible to interpret the temperature measurements.

(see end of book for references for this section)

Pulse
The arterial pulse is a wave generated by contractions of the left ventricle of the heart and can be palpated in several accessible arteries. When palpating a patient's pulse, it is recommended that you use your index and middle fingers rather than your thumb as you may confuse the pulsation in your thumb with the patient's pulse. The radial pulse can be palpated just medial to the distal radius and is particularly useful for assessing the rate and rhythm of the pulse.

When the patient has a low blood pressure, as in cases of fainting or blood loss, the radial pulse may not be palpable. In emergency situations, always palpate the carotid pulse which can often be felt when the radial pulse cannot. It is felt by putting the pad (not the tip) of your finger on the Adam's apple and moving to one side or the other. Stop when you come up against a muscle (the sternomastoid) and you should be able to feel the pulse there. Do not feel both carotids at the same time because, if the patient's alternate blood supply to the brain is limited, blocking the supply from both carotids may dangerously restrict the total supply to the brain and lead to fainting or stroke.

Another pulse to locate is the brachial pulse, useful when taking blood pressure. Turn your arm out so that the palm is facing upwards. Feel on the inside of your elbow. Start at the lateral side of this area (furthest away from the midline of your body), move slowly towards the midline of your body (ie medially). You will pass a hard structure which is a tendon. Medial to this, you will find the brachial pulse. Get the patient to straighten out your arm and the pulse should become stronger. Sometimes you need to move your fingers a bit further up to feel it more strongly.

Measure the rate of the pulse by counting for 15 seconds and multiplying by four.

Make note of the rhythm of the pulse. The pulse normally accelerates during inspiration and slows at the beginning of expiration. This is called “sinus arrhythmia” and is most obvious in children, young people and athletes. Apart from sinus arrhythmia, assess the rhythm for any other irregularity. If there is irregularity, try to determine if the pulse is mostly regular with occasional early or late beats (“regularly irregular”), or if it is totally irregular (“irregularly irregular”).

The values given in textbooks for a “normal” pulse rate in adults is usually 60-100 beats/min (Macleod p84, Talley p36). A slow heart rate, “bradycardia” is then defined as < 60 beats/min and a fast heart rate, “tachycardia” is defined as > 100 beats/min. Frequently, normal healthy young people and athletes have heart rates between 45/min and 60/min. A study of 500 normal adults found the range of resting heart rates to be 46/min to 95/min (Spodick p667). Spodick recommended that the “normal” heart rate values should be changed to 50/min to 90/min. The fifth edition of Talley and O’Connor (2006) states that “a more sensible range is probably 55 to 95 (95% of normal people)” (Talley p 36).

As with temperature, the pulse rate needs to be interpreted in clinical context, ie. the clinical history and other clinical signs need to be taken into consideration.

Respiratory Rate
The respiratory rate is measured over 15-20 seconds while the patient is at rest. If the patient is aware that their respiratory rate is being measured, they become acutely aware of their breathing and often speed it up. Therefore, it is best measured when the patient is not aware of the examiner observing.
Some people pretend to be feeling the pulse while they count the patient’s breaths and calculate it as breaths/min.

The values given for “normal” respiratory rate varies from textbook to textbook eg. 14-18/min (Hutchison p18), 12-20/min (Mosby p370), 16-25/min (Talley & O’Connor p 98). Two studies of respiratory rates in adults have found respiratory rate averages of 20 breaths/min (range 16–25/min) (McGee p 205) but these were elderly hospital patients so it could be argued that these findings do not represent “normal” people. Self measured respiratory rates by Flinders medical students in 2008 ranged from 12-20. Hence, there is probably a broad range of “normal” respiratory rates and therefore it also needs to be interpreted in clinical context, ie. the clinical history and other clinical signs need to be taken into consideration. The respiratory rate does not necessarily correlate with the effectiveness of breathing.
Session 3
Vital Signs B

Before this session, all students must have completed and returned the form “Information Sheet: Clinical Skills – Peer and Standardized Patient (SP) Physical Examination and Videotaping”

By the end of this session, students should be able to demonstrate
- Correct hand hygiene
- Blood pressure measurement
- Pulse oximetry measurement

Hand Hygiene
There are 5 moments of hand hygiene.
These are:
1. Before you touch a patient
2. Before a procedure
3. After you touch a patient
4. After a procedure
5. When touching a patient’s surrounds.

This is important for you to not get infection from the patient and for the patient not to get infection from you (and significantly from other patients that you have been in contact with).

Use alcohol hand wash at these points. Use soap and water if the hands are visibly soiled.

All students must do the hand hygiene certificate prior to the next session.

This is how you do the certificate:

On the final page, you cannot complete the institution (doesn’t have space for Flinders University) but please save your certificate and upload it to your e-portfolio and send a copy to maria.perezmarrero@flinders.edu.au.

Blood Pressure
Introduction
There are 2 readings obtained when measuring blood pressure – systolic and diastolic. The SYSTOLIC blood pressure is the maximum pressure in the artery following ventricular systole. The DIASTOLIC blood pressure is the lowest pressure in the artery during ventricular diastole.

Systolic blood pressure can be measured using both the PALPATION method and the AUSCULTATORY method whereas diastolic blood pressure is measured only by the auscultatory method. The sounds heard by the stethoscope when performing the auscultatory method are called KOROTKOFF sounds.

Factors affecting Blood Pressure
Blood pressure can be influenced by physical activity, posture, the respiratory cycle, smoking, caffeine and anxiety. Hence, it is recommended that routine blood pressure be measured in the sitting position when the patient is relaxed, following a short period of rest and preferably having avoided caffeine and smoking in the previous 2 hours (Hypertension Management Guide (HMG) p8). If the initial reading is high, repeat the measurement after 5 minutes of quiet rest.

Choice of BP Cuff
The cuff which is wrapped around the patient’s upper arm needs to be an appropriate size. The length of the bladder of the cuff should be at least 80% of the circumference of the upper arm and the width of the bladder should be at least 40% of the circumference of the upper arm (HMG p8). The standard size cuff is appropriate for average sized adults. However for overweight or obese patients, a large cuff may be required. Smaller sized cuffs are available for use with children.
Method for Measuring Blood Pressure

Palpation method:
The cuff is wrapped around the patient’s upper arm with the centre of the bladder positioned over the brachial artery. While palpating the radial pulse, the cuff is inflated until the radial pulse disappears. The cuff is then deflated slowly (3 to 4 mmHg per second) until the radial pulse returns. The pressure at which the radial pulse returns is the systolic blood pressure.

Completely deflate the cuff before proceeding to perform the auscultatory method.

Auscultatory method:
Inflate the cuff at least 30 mmHg above the systolic pressure measured by the palpation method and place the diaphragm of the stethoscope over the brachial artery. Slowly deflate the cuff and listen for the Korotkoff sounds, which are divided into 5 phases. The first sounds that are heard are called Korotkoff I and the pressure at which this occurs is the systolic blood pressure. The sounds become more intense (K II), then softer (K III), then muffled (K IV) and then completely disappear (K V). (Talley p 42-43). The pressure at which the sounds completely disappear (K V) is the diastolic blood pressure. Occasionally, Korotkoff IV sounds (muffled) continue towards zero and in this situation, the pressure at which Korotkoff IV sounds appear is taken as the diastolic blood pressure (HMG p8). The result for the systolic and diastolic pressure should be recorded to the nearest 2 mm Hg (HMG p8)

Auscultatory gap:
An auscultatory gap is when the phase I Korotkoff sounds, which normally appear at systolic blood pressure, disappear for varying lengths of time before reappearing. Hence, if the cuff is not inflated above the true systolic pressure, an inaccurate blood pressure reading will be obtained. This is the advantage of using the palpation method first as you can determine the systolic pressure by palpation and then inflate the cuff above that level. Auscultatory gaps are relatively common in elderly people with hypertension (up to 20%) (McGee p 173-175).

Normal Blood Pressure
Normal blood pressure is < 140 systolic and <90 diastolic (HMG p 10, McGee p 177). However, the diagnosis of hypertension should not be made from one single high reading but from several high readings on separate occasions. This avoids relying on possible inaccurate single readings due to compounding factors.

Blood Pressure Tutorial
Students can practice blood pressure reading by doing the tutorial available on the Clinical Skills website and on the computers in the Clinical Skills labs. You can access this in the Vital Signs section of the website. Click on the "Blood Pressure Tutorial from the University of Aberdeen".

Blood pressure trouble shooting:
My cuff won't pump up and air seems to be leaking
Is the valve closed? Remember that clockwise is closed

I can't find the radial/brachial pulse
Remember your anatomy and the tips we suggested but be aware that some people will have anatomical variations. Feel with several fingers.

I can't hear the Korotkoff noises
You will only hear them between systole and diastole so do not expect to hear them when you put the stethoscope on the brachial artery before pumping up.
Are your stethoscope ear pieces pointing forwards in your ear canal? You will hear better if they are. Make sure that the ear pieces fit snugly as this will block out background noise (swap stethoscopes if necessary)
Is your diaphragm on? You should hear a very loud noise if you tap your diaphragm. Turn the diaphragm/bell around until you are certain that the diaphragm is on.
Are you on the right place? Check again for the location of the brachial artery.
Perhaps there is too much background noise. Ensure that the student does not have their arm on a desk as this may transmit extra sounds.
You are listening for a knocking noise. You need to take lots of BP before you become good at blocking out extra noise and being able to focus on Korotkoff noises. Doing the blood pressure (on the clinical skills website) tutorial will help you with this.

**Pulse oximetry**
Pulse oximetry is also called the fifth vital sign and it is very commonly measured in the hospital setting. It is able to determine by measuring in a non invasive way the percentage of oxyhaemoglobin saturation (%Hb sat). %Hb sat reflects oxygenation and is related to partial pressure of CO2 (PCO2) by the oxyhaemoglobin dissociation curve.

It is important to correlate the % Hb sat with the percentage of oxygen that they are breathing in (are they on an oxygen mask?), respiratory effort and how the patient looks before interpreting the reading.

**Observation Charts**
When putting all the information together from the five vital signs on a single observation chart, characteristic patterns may develop and four of these are discussed. However, a diagnosis can never be made from just looking at the observation chart. You must always look at the patient to see if how the patient looks (general observation) correlates with the vital signs.
Session 4
Introduction to Clinical Examination A

Prior to this session, all students must have completed the Hand Hygiene certificate, uploaded it onto their ePortfolio and have sent it to Maria Perez-Marrero.

By the end of this session, students should be able to:
- Understand the basics of inspection, percussion and auscultation
- Demonstrate percussion of the lungs and liver
- Use the stethoscope, for both lungs and heart
- Demonstrate appropriate hand hygiene

The aim of these next 3 tutorials is to familiarise you with the processes the clinicians use during the clinical examination. These are: inspection/observation, percussion, palpation and auscultation and then the basics of neurological examination.

There are roughly two types of clinical examinations:
- Screening examination of an asymptomatic patient, for example, to assess fitness to drive or pre-employment medical. This type of examination is structured, for example, as insurance companies usually have a standard “Medical examination” form to complete. We use a lot of screening examinations of well patients in our assessment and we are concentrating on your technique.
- Clinical examination of a symptomatic patient. This type of examination is usually guided by the history obtained from this patient. It is a purpose driven examination looking for signs to confirm or reject your post history taking diagnosis. We will discuss more about the role of history in the physical examination in the lecture later in the semester.

Remember that before examining a patient or peer, you should always explain what you are going to do and then obtain their consent – even “is that OK?” is sufficient. You need to let a patient know honestly if an examination will be uncomfortable or painful.

Follow hand hygiene principles.

Percussion technique
Percussion is a technique used to determine the degree of resonance of the region being percussed. It is the same principle used by people who tap their rainwater tank to determine how much water is in it, although the technique is a little different as the chest wall is tapped by striking the middle finger of the other hand which is lying on the chest wall.

Please ensure that the nail of your middle finger of your dominant hand is short and not sharp before you attempt this!

Technique: Put your hand flat on the table with the middle phalanx (part) of your middle finger being pressed firmly against the table. The bone (not the pad or the nail) of the middle finger of the dominant hand should strike the bone of the middle phalanx of the hand on the table at an angle of 90°. Move the whole hand from the wrist to strike with the finger - don’t just move the finger (you won’t get enough force) and don’t move from the elbow.

Chest examination:
Inspection, observation
Observe for chest expansion, scars, rashes, skin colourations, lesions etc

Chest percussion
When you percuss the chest wall, the non-dominant hand is placed on the chest with the middle finger between the ribs and running parallel to the ribs. You should compare the noise that you make on both sides of the lungs.
There are three sounds that you will hear: **Dullness** which is a higher, quieter and shorter sound than **resonant** which is louder, longer and has a lower frequency while **hyper-resonant** (or **tympanic**) has a hollow “musical pitch” according to McGee (p327).

You will hear a dull sound over the liver, a resonant sound over the normal lung and hyper-resonant sound over the bowel.

Additionally, experienced clinicians can diagnose from the “feel” when they percuss. It has been proven (McGee p329) that dull areas move less than resonant areas.

**How to Use Your Stethoscope**

There is a lot of variation in the cost and reputation of stethoscopes. According to McGee (p446) the “Most important source of poor acoustic performance is an air leak, which typically results from poor fitting ear pieces”.

Make sure the earpieces are a snug fit and that they are pointing forward, so that they follow the direction of the ear canals (forward and down).

Most stethoscopes have a diaphragm and a bell. The bell detects low frequency sounds better while the diaphragm is preferred for high pitched sounds (Talley and O’Connor p52).

Before you put the diaphragm on the chest, check that the stethoscope is switched over to the diaphragm by tapping the diaphragm. You should hear the noise clearly in your ears.

**Heart Auscultation**

To listen to your own heart, place the diaphragm on the approximate position of your heart. The transmission of sound works best when the diaphragm is on the skin but, when learning on each other or in “emergencies”, you can listen through clothes.

When you listen to the heart, you will hear two sounds: lub dup. The lub is the first heart sound and it is made by the closure of the mitral and tricuspid valves. The second heart sound is made by the closure of the aortic and pulmonary valves.

Mc Gee (p450) summarises the differences between S1 and S2: at the second intercostal space, S2 is louder, shorter, sharper and has a higher frequency than S1. Additionally, when you palpate your carotid pulse, you feel the pulse just after S1 and before S2.

**Chest Auscultation**

When you use the stethoscope to auscultate the lungs, you should use the diaphragm. It is hard to hear breath sounds on yourself, you will need to listen on someone else’s chest. Place the stethoscope on their back and listen as they breathe in deeply through their mouth. You should hear breath sounds that sound longer and louder in inspiration than expiration and have no gap between inspiration and expiration (Talley and O’Connor p115). These are called vesicular breath sounds. Compare the sound produced between sides and between the top and the bottom of the lungs.
Session 5:  
Introduction to Clinical Examination B  
Abdomen Examination and Lymph Nodes

By the end of this session, students should be able to:
- Understand the basic principles of palpation
- Be able to perform the most basic palpation of the abdomen
- Demonstrate percussion and auscultation of the abdomen
- Understand lymph node enlargement
- Be able to perform cervical lymph node examination

Abdomen Palpation

Mosby (p54) states “Palpation involves the use of the hands and fingers to gather information through the sense of touch”.

Palpation of the abdomen can elicit much information about the patient. If the patient is tender when you palpate (that is, you palpating them causing them pain), it can let us know about inflammation and damage to organs and whether it suggests a localised or generalised problem. Palpation can also reveal whether there are masses or if organs are enlarged.

The abdominal organs are guarded by muscles so successful palpation requires relaxation of these muscles.

Ways to ensure that the muscles are relaxed include:
- Making sure your hands are warm - probably the best way to warm them up is to run them under warm water (and dry them).
- Making sure that the patient is lying flat (on just one pillow) with their hands by their side and their legs uncrossed.

When palpating, you should use the flats of your fingers as they are the most sensitive part of your hand. If you use the tips of your fingers, you will "poke" the patient which has the effect of making them contract their muscles - which will interfere with your palpation. Please make sure that all the nails on your examining (dominant) hand are cut, otherwise they may dig into the patient.

When you palpate the abdomen, you are placing the flat of your hand on their abdominal wall. To feel even less like poking, it helps if your wrist is straight. Only if the bed is high or you are short, can you do this when standing up next to the bed. Otherwise, you can sit on the side of the bed or on a chair or kneel down.

If you are right-handed, you should approach the patient from their right side as then you can palpate their abdomen with your right hand while you can see their face. This is important as when you palpate you are trying to determine which area is tender. Some patients will not say anything, so you will need to monitor their facial expressions.

Conversely, if you are left handed and wish to palpate with your left hand, you should theoretically approach the patient from their left hand side. Many clinicians for some odd reason feel very strongly about only approaching the patient from their right but they should understand if you point out the logic behind this.

To gain the confidence of the patient, ask them which area is tender and palpate that area last.

Light palpation: press no more deeply than 1cm (Mosby p545) and keep your hand in contact with the abdominal wall as you move from one part to the next because every time you take your hand off and put it back on again, you run the risk of making the patient contract their abdominal muscles. This voluntary contraction is called guarding and it prevents you from feeling the underlying structures. It is usually due to fear, anxiety or cold hands (Mc Gee p616) or may be due to tenderness or pain but it can be overcome – you can get the patient to relax their muscles if you are gentle and persistent enough. More significant is rigidity which is the reflex involuntary contraction of the abdominal muscles.
associated with tenderness and in response to inflammation of the peritoneum (Talley and O’Connor p168).

**Deep Palpation:** pressing down to a depth of about 4cm (Mosby p54) will help find deeper masses (Talley and O’Connor p168) and the outlines of the abdominal organs. Mosby (p547) suggests that you may be able to feel the following structures: the borders of the rectus abdominis muscles, the aorta (with its prominent pulsation) and parts of the colon, especially the sigmoid colon.

**Abdomen Percussion**
This will help determine which parts of the abdomen are predominantly hyper-resonant (filled with air - bowel) or dull (solid organs such as the liver). This technique is particularly useful for determining the liver span. In the mid-clavicular line, percuss down over the lungs and up from the abdomen. The total area that is dull is called the liver span. Textbooks put the range of the liver span determined by this method to be 6-12cm (Mosby p542) or less than 13cm (Talley and O’Connor p169). However, Mc Gee (p595) states that while there is a correlation between the estimated size and actual size, it is not a precise measurement.

**Abdomen Auscultation**
Place the diaphragm of your stethoscope on the abdominal wall and wait to hear bowel sounds. They sound just like the gurgling that you will hear from the person next to you in lecture theatres at lunch time. The presence and quality of bowel sounds is not as reliable a physical sign as heart or lung sounds because of the huge variation within individuals. Mc Gee (p636) states that a healthy person may have no bowel sounds for up to 4 minutes and when examined later you may hear thirty “rumbles” in a minute, so that listening for a short time and pronouncing the absence of bowel sounds does not correlate with the absence of bowel activity.

**Lymph Nodes**
Throughout the body, there is a series of lymph channels and lymph nodes (or glands). The lymph nodes drain from certain regions so their enlargement is often a sign of disease in the area that they are draining. You would be aware of the presence of lymph nodes especially when you have a sore throat and you can feel them as lumps or localised tenderness under and around your jaw.

It is not uncommon to be able to feel a lymph node that is not diseased - you may feel one on yourself or when you are examining each other - soft, mobile and non tender. A tender lymph node is usually the sign of an acute infection and, if monitored, will return to normal size soon after the infection resolves. The presence of an enlarged lymph node over weeks to months which is firm, rubbery or hard should probably be checked out by your local doctor.

**Background to Lymph node examination**

- **Lymph nodes are examined**
  1. When patient complains of a painless or painful gland/lump
  2. As part of your examination if you suspect occult malignancy
  3. For clinical staging of cancer by assessing if cancer has spread to regional lymph nodes
  4. For clinical assessment of localised or generalised infection/inflammation
    - Eg infected toes may be associated with palpable enlarged tender inguinal node
  5. As part of a screening physical examination

**Types of lymphadenopathy**

- **Regional (localised)**
- **Generalised**

**Causes of lymphadenopathy**

- **Primary haematological malignancy - leukaemias/lymphomas**
- **Infection - bacterial/viral etc**
- **Inflammatory eg sarcoidosis**
- **Metastatic spread**

**Where are the lymph nodes**
1. Superficial (subcutaneous) - assessed clinically
2. Deep lung/abdomen - assessed by CT

**When examining lymph nodes, think**
1. What region it drains
2. Any specific disease that causes the regional lymph adenopathy
   - preauricular nodes → viral conjunctivitis
   - epitrochlear node → TB, lymphoma
   - posterior triangle nodes → glandular fever

**Lymph node examination**
1. Size > 1cm
2. Consistency - tissue paper/cotton ball
3. Mobility - skin over lump/lump over subcutaneous tissue
4. Skin reaction over lump
5. Is lymph node or not - eg thyroid lump
   Certain manoeuvres may help eg swallowing (thyroid lump moves, not lymph node)

**Technique**
1. Position patient - aim to relax muscles for better access to nodes eg flex neck
2. Coronal/sagittal palpation of nodes

**Cervical Lymph nodes**
The lymph nodes in the cervical region are divided into groups. Talley and O’Connor (p201) describes 8 groups, Macleods (p59) describes 10 groups, Swartz (p197) describes 10 groups and Mosby (p240) also describes 10 groups. These textbooks may use different names for some of the lymph node groups. The following description is based mainly on the image from Swartz (p197 see Clinical skills website), but alternative names of the lymph node groups are given in brackets.

Start from behind the patient and feel under the point of the chin for the submental nodes, then follow the line of the jaw. About halfway along the jaw are the submandibular nodes (submaxillary) and at the angle of the jaw are the tonsillar nodes (retropharyngeal). In front of the ear are the preauricular nodes (parotid).

In the neck, feel for the lymph nodes in front of and superficial to the sternomastoid muscle, called the superficial cervical nodes (anterior triangle) and then deep to the sternomastoid muscle, the deep cervical nodes (jugular or scalene nodes). The supraclavicular lymph nodes are felt by pressing in the angle between the clavicle and edge of the sternomastoid muscle, helped by asking the patient to shrug their shoulders. Talley and O’Connor (p235) suggest feeling from the front for the supraclavicular lymph nodes but Macleods (59) suggest feeling from behind. To be sure not to miss any supraclavicular lymph nodes, it is best to feel for them from behind and from in front.

For the remainder of the cervical lymph nodes, Macleods (p59) suggest feeling from the front of the patient but Talley and O’Connor (p201) suggest that you still stand at the back of the patient. Feel the post auricular nodes which are behind the ear on a bony part called the mastoid process, the occipital nodes which are at the base of the skull and the posterior cervical nodes (posterior triangle nodes) which are bounded by the sternomastoid muscle at the front and the trapezius muscle behind.
Session 6
Introduction to Clinical Examination C
Introduction to Neurological Examination

By the end of this session, students should be able to:

- To understand the principle of power (strength) testing and the grading system
- Demonstrate power examination on the wrist
- To understand the principles of the techniques of conducting a reflexes examination and the grading system
- Demonstrate ankle reflex testing three different ways

Method
An initial overview of the peripheral neurological examination including the main sections of inspection, tone, power, reflexes, co-ordination and sensation.

Power
The wrist joint will be assessed to highlight the principles of power testing and the grading system. Grading system for power (Ref T & O’C, 6th ed, page 356)

0 Complete paralysis (no movement).
1 Flicker of contraction possible.
2 Movement is possible when gravity excluded.
3 Movement is possible against gravity but not if any further resistance is added.
4- Slight movement against resistance.
4 Moderate movement against resistance.
4+ Submaximal movement against resistance.
5 Normal power.

You will then practice this clinical skill on each other under the supervision of the tutor. You will then mimic a grade of power and your partner will try to determine what this is.

Reflexes
The ankle reflex will be assessed to highlight the techniques used to elicit reflexes including the following:

- How to hold the tendon (patella) hammer i.e. at the end
- Action of the tendon hammer i.e. pendular movement, not a “tapping nor hitting” action
- Checking prior to swinging the tendon hammer the anatomy which one plans to apply the hammer to e.g. location of the achilles tendon when testing the ankle reflex
- Verbal consent from the patient and explanation that it may be a little uncomfortable and it is important for the patient to be relaxed. You may ask the patient to look away or try other distraction techniques if necessary (i.e. in an anxious patient).
- Correct positioning of the limb and this is dependent on the reflex being tested
- Diminution of reflexes if keep repeating them.
- Looking for the muscle contraction. Look primarily at the muscle belly contracting rather than the action of the muscle contraction (eg movement of the foot when testing the ankle reflex)

Ankle reflex specifically:

- Patient lying in bed with the tendon hammer applied to the achilles tendon with the knee flexed and hip externally rotated
- The tendon hammer being applied to the sole of the foot whilst the foot is held in slight dorsiflexion. This is the preferred method.
- With the patient kneeling on a chair/bed the tendon hammer is applied to the achilles tendon.

You need to know how to elicit the reflexes in all of these situations because patients have varying mobility ie not all can kneel on a chair.

Grading system for reflexes (Ref T & O’C, 6th ed, page 358, table 11.10)

0 = absent
+= present but reduced
++ = normal
+++ = increased, possibly normal
++++ = greatly increased, often associated with clonus

You will then practice this clinical skill on each other using the various techniques. The tutor will also show the reinforcement manoeuvres if the reflex is absent (for both upper and lower limbs i.e. teeth clenching and hand grip).

**Summary** (Take home messages)
- When testing power one needs to check to see if the joint/limb/muscle in question has a grade of 3/5 (i.e. antigravity) first and further power grading is assessed from this point.
- When eliciting reflexes the technique is important in order to make an accurate clinical assessment. It is then important to grade the reflexes as this can give vital clues to the clinical problem.
- This has been only an introduction to neurological examination and will be taught extensively in second year.
Session 7:
Vital signs assessment
By the end of this session, all students must be able to
• Demonstrate their ability to accurately perform measurement of temperature, pulse, respirations, blood pressure and oximetry and to document this on the observation chart

Each group will be rostered to come at 30 minute intervals. The session will take 50-60 minutes. Once students have completed designated items in the Blood Pressure quiz, they will come in pairs to the staff members. They will take each other’s pulse, temperature, respiratory rate, oximetry and blood pressure and document this on the observation chart. There will be 20-30 minutes for each pair. If one student is unable to successfully complete the task in the allotted time, they will be given a chance for further practice and be rostered to return the following week to re-do the assessment.
Appendix 1

**FLINDERS UNIVERSITY GEMP**

**CLINICAL SKILLS IN-TRAINING ASSESSMENT**

**STUDENT’S NAME:**

**SEASON ONE, 2010**

**ATTENDANCE AT TUTORIALS** - which is compulsory
Number of tutorials attended ......../14

Sick certificate sighted? Yes or no

**PARTICIPATION IN TUTORIALS** – Students should be involved and interactive with discussions, feedback and role plays
Were there any concerns with the student being not involved or disruptive?

**PROFESSIONAL DEMEANOUR** - punctuality, courtesy, personal presentation
Did the student show major difficulties in acting in a professional way?

<table>
<thead>
<tr>
<th>Assessment Items</th>
<th>Tick if completed</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward Safety</td>
<td></td>
<td>Tutorial 3</td>
</tr>
<tr>
<td>Interview 1</td>
<td></td>
<td>Tutorial 4</td>
</tr>
<tr>
<td>CE1</td>
<td></td>
<td>Tutorial 5</td>
</tr>
<tr>
<td>CE2</td>
<td></td>
<td>Tutorial 8</td>
</tr>
<tr>
<td>Interview 2</td>
<td></td>
<td>Tutorial 10</td>
</tr>
<tr>
<td>CE3</td>
<td></td>
<td>Tutorial 12</td>
</tr>
<tr>
<td>Interview 3</td>
<td></td>
<td>Tutorial 14</td>
</tr>
</tbody>
</table>

**TUTOR’S COMMENTS on STUDENT’S PROGRESS THROUGH SEMESTER 1**

**STUDENT’S COMMENTS on THEIR PROGRESS THROUGH SEMESTER 1**

If all assessment completed satisfactorily, please tick □
If not completed satisfactorily, please tick □
and contact Clinical skills staff for handover for further session/s

Signed ...........................................Tutor's name..........................date................

Signed ...........................................Student's name.....................date..............

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# Appendix 2 Glossary of Common Abbreviations
For convenience, many clinical symptoms, signs and conditions are abbreviated. The following is a list of common abbreviations which you may come across in this handbook and in patient's medical records.

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td># - Fracture</td>
<td>Fracture</td>
</tr>
<tr>
<td># NOF - NOF</td>
<td>Fractured Neck of Femur</td>
</tr>
<tr>
<td>AF - AF</td>
<td>Atrial Fibrillation</td>
</tr>
<tr>
<td>AKA - AKA</td>
<td>Above Knee Amputation</td>
</tr>
<tr>
<td>ARF - ARF</td>
<td>Acute Renal Failure</td>
</tr>
<tr>
<td>BKA - BKA</td>
<td>Below Knee Amputation</td>
</tr>
<tr>
<td>Code Blue</td>
<td>Cardiorespiratory arrest</td>
</tr>
<tr>
<td>CAB/CABG - CAB/CABG</td>
<td>Coronary Artery Bypass Grafting (&quot;Cabbage&quot;)</td>
</tr>
<tr>
<td>CAD - CAD</td>
<td>Coronary Artery Disease</td>
</tr>
<tr>
<td>CCF - CCF</td>
<td>Congestive Cardiac Failure</td>
</tr>
<tr>
<td>COAD/COPD - COAD/COPD</td>
<td>Chronic Obstructive Airways Disease/Chronic Obstructive Pulmonary Disease</td>
</tr>
<tr>
<td>CPAP - CPAP</td>
<td>Continuous Positive Airways Pressure</td>
</tr>
<tr>
<td>CPR - CPR</td>
<td>Cardiopulmonary Resuscitation</td>
</tr>
<tr>
<td>CRF - CRF</td>
<td>Chronic Renal Failure</td>
</tr>
<tr>
<td>CT /CAT scan</td>
<td>Computerised Tomography/Computerised Axial Tomography</td>
</tr>
<tr>
<td>CVA - CVA</td>
<td>Cerebrovascular Accident</td>
</tr>
<tr>
<td>CVS - CVS</td>
<td>Cardiovascular System</td>
</tr>
<tr>
<td>CXR - CXR</td>
<td>Chest Xray</td>
</tr>
<tr>
<td>DRE - DRE</td>
<td>Digital Rectal Examination</td>
</tr>
<tr>
<td>DU - DU</td>
<td>Duodenal Ulcer</td>
</tr>
<tr>
<td>DVT - DVT</td>
<td>Deep Vein Thrombosis</td>
</tr>
<tr>
<td>FBE - FBE</td>
<td>Full Blood Examination</td>
</tr>
<tr>
<td>FH - FH</td>
<td>Family History</td>
</tr>
<tr>
<td>GA - GA</td>
<td>General Anaesthetic</td>
</tr>
<tr>
<td>GORD - GORD</td>
<td>Gastro-oesophageal reflux disease</td>
</tr>
<tr>
<td>GU - GU</td>
<td>Gastric Ulcer</td>
</tr>
<tr>
<td>HRT - HRT</td>
<td>Hormone Replacement Therapy</td>
</tr>
<tr>
<td>HT - HT</td>
<td>Hypertension</td>
</tr>
<tr>
<td>IBS - IBS</td>
<td>Irritable Bowel Syndrome</td>
</tr>
<tr>
<td>IDDM - IDDM</td>
<td>Insulin Dependent Diabetes Mellitus</td>
</tr>
<tr>
<td>IHD - IHD</td>
<td>Ischaemic Heart Disease</td>
</tr>
<tr>
<td>IM - IM</td>
<td>Intramuscular</td>
</tr>
<tr>
<td>IV - IV</td>
<td>Intravenous</td>
</tr>
<tr>
<td>JVP - JVP</td>
<td>Jugular Venous Pressure</td>
</tr>
<tr>
<td>LA - LA</td>
<td>Local anaesthetic</td>
</tr>
<tr>
<td>LBO - LBO</td>
<td>Large Bowel Obstruction</td>
</tr>
<tr>
<td>LFT - LFT</td>
<td>Liver Function Tests</td>
</tr>
<tr>
<td>LIF - LIF</td>
<td>Left iliac fossa</td>
</tr>
<tr>
<td>LMO - LMO</td>
<td>Local Medical Officer (General Practitioner)</td>
</tr>
<tr>
<td>LMP - LMP</td>
<td>Last menstrual period</td>
</tr>
<tr>
<td>LRTI - LRTI</td>
<td>Lower Respiratory Tract Infection</td>
</tr>
<tr>
<td>LUQ - LUQ</td>
<td>Left Upper Quadrant (of abdomen)</td>
</tr>
<tr>
<td>LUTS - LUTS</td>
<td>Lower Urinary Tract Symptoms</td>
</tr>
<tr>
<td>LV - LV</td>
<td>Left Ventricular</td>
</tr>
<tr>
<td>LVF - LVF</td>
<td>Left Ventricular Failure</td>
</tr>
<tr>
<td>LVH - LVH</td>
<td>Left Ventricular Hypertrophy</td>
</tr>
<tr>
<td>MET - MET</td>
<td>Medical emergency team</td>
</tr>
<tr>
<td>MI - MI</td>
<td>Myocardial Infarction</td>
</tr>
<tr>
<td>MRI - MRI</td>
<td>Magnetic Resonance Imaging</td>
</tr>
<tr>
<td>MS - MS</td>
<td>Multiple Sclerosis</td>
</tr>
<tr>
<td>MVA - MVA</td>
<td>Motor Vehicle Accident</td>
</tr>
<tr>
<td>NAD - NAD</td>
<td>No Abnormality Detected</td>
</tr>
<tr>
<td>NIDDM - NIDDM</td>
<td>Non Insulin Dependent Diabetes Mellitus</td>
</tr>
<tr>
<td>NSAID - NSAID</td>
<td>Non Steroidal Anti-inflammatory Drug</td>
</tr>
</tbody>
</table>
OA - Osteoarthritis
OCP - Oral Contraceptive Pill
OSA - Obstructive Sleep Apnoea
OTC - Over the counter (drugs)
PE - Pulmonary Embolism
PH - Past History
PID - Pelvic Inflammatory Disease
POP - Plaster of Paris or Progesterone Only Pill
PPI - Proton Pump Inhibitor
PR - Per Rectum (Rectal examination)
PU - Peptic Ulcer
PUO - Pyrexia of Unknown Origin
PV - Per Vagina (Vaginal examination)
PVD - Peripheral Vascular Disease
RA - Rheumatoid Arthritis
RF - Rheumatic Fever
RHD - Rheumatic Heart Disease
RIF - Right Iliac Fossa
RMO - Registered Medical Officer
PND - Paroxysmal Nocturnal Dyspnoea or Post-nasal drip
RUQ - Right Upper Quadrant (of abdomen)
RVF - Right Ventricular Failure
SAH - Subarachnoid Haemorrhage
SBE - Subacute Bacterial Endocarditis
SBO - Small Bowel Obstruction
SC - Subcutaneous
SLE - Systemic Lupus Erythematosus
SOA - swelling of ankles
SOB - short of breath/shortness of breath
SOBOE - short of breath on exertion
SSRI - Selective Serotonin Reuptake Inhibitor (Antidepressant)
STD/STI - Sexually Transmitted Disease/Infection
STEMI - ST elevation Myocardial Infarction
SVT - Supraventricular Tachycardia
TB - Tuberculosis
THR - Total Hip Replacement
TIA - Transient ischaemic attack
TKR - Total Knee Replacement
TM - Tympanic Membrane
URTI - Upper Respiratory Tract Infection
US - Ultrasound
UTI - Urinary Tract Infection
VBI - Vertibrobasilar Insufficiency
VF - Ventricular Fibrillation
VT - Ventricular Tachycardia
Appendix 3
Hospital - and how to find your way around it!

There are seven floors in FMC which are colour coded
1st - dark blue
2nd - purple
3rd - yellow
4th - dark green
5th - medium blue
6th - light green
7th - orange
Wards and associated areas are generally as marked by the letters above, from 4th to 6th floors.

**The wards:**

<table>
<thead>
<tr>
<th>Medical</th>
<th>Surgical</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>6A - Respiratory, infectious disease, immunology</td>
<td>5B – Neurosurgical</td>
<td>4A – Antenatal, postnatal, gynae, gynae/oncology</td>
</tr>
<tr>
<td>6B - General Medical</td>
<td>5C - Orthopaedic, plastics, (urology, vascular)</td>
<td>4B - Gynaecology clinics</td>
</tr>
<tr>
<td>6C - General Medical, Aged Care</td>
<td>5D - Short stay surgical (emergency), up to 72 hours</td>
<td>4C - Obstetric / postnatal</td>
</tr>
<tr>
<td>6D - Cardiac, cardiothoracic surgery, thoracic surgery</td>
<td>5E - Hepatobiliary, colorectal, gastroenterology</td>
<td>4E - Paediatrics</td>
</tr>
<tr>
<td>6G - Renal, general medical (post ICU), endocrine, dermatology, (rheumatology/)</td>
<td>5F - High dependency medical and surgical</td>
<td>4G - Psychiatry</td>
</tr>
<tr>
<td>5A - Neurology, Stroke unit, neurosurgical, rehabilitation</td>
<td></td>
<td>4G – “Medical” – Short stay surgical (elective), mostly overnight – no students please</td>
</tr>
<tr>
<td>5G - Oncology, haematology, Oncology Day Unit, ENT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4D – Acute Assessment Unit (Medical), from emergency, 24-48hr stays</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 – CCU</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 – A&amp;E, Emergency Extended Care Unit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 – CCMU (ICU)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 – Radiology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 – Clinics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 – Theatre</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 – Neonatology</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 4

Health Care Roles
There are various roles in the health care system:

**Medical:**
Consultant (A qualified medical specialist): a doctor that have finished their specialist college training
General Practitioner (GP consultants)
Registrar (A medical specialist in training): is a doctor that has been accepted into a college training program
RMO (Registered/Resident Medical Officer): is a doctor that is doing a year(s) after internship before applying for entry into a training program.
Intern: the mandatory 1 year training program after medical school to be a registered doctor. Administered by the postgraduate medical council of the state you are working in.

**Nursing:**
CSC - Clinical Nurse Consultant (clinical services consultant CSC)
RN - Registered Nurse: have a university degree. Graduate nurses are like interns doing their rotations for year 1 after their nursing degree.
EN - Enrolled Nurse: Have done a TAFE equivalent course. They cannot administer intravenous medications but at Flinders Medical Centre EN’s can administer oral medication after some training.

**Ward Clerks:** are administrative staff that assist with the smooth running of a ward. Their work includes organizing admissions, discharges, a reception role (guiding family members) and ensuring patients attend various investigations and treatments in a timely manner.

**PSAs - Patient support assistants (orderlies):** Help move patients around the hospital.

**Volunteer:** support for patients and families including providing directions in the hospital, staffing the cafeteria, newspaper service and confectionary trolley.

**Allied Health Professionals:**
Physiotherapist (Physio/PT): focuses on mobility, balance and limb strengthening.
Occupational Therapist (OT): can undertake assessment and management of the following: patient’s activities of daily living/ADL’s (e.g. dressing), cognitive assessments, upper limb/hand function and home visits.
Social Worker (SW): provide counselling and support for patients and families and assist with discharge planning (including financial aspects and accommodation)
Speech pathologist (speech therapist): assess and manage swallowing, speech (voice) and communication problems.
Psychologist: counselling and complex cognitive assessments.
Radiographer: performs the medical imaging.

**Other:**
Ward Clerk
Orderly
Volunteer
Appendix 5

Ward visit information

Your tutor will warn you when you are going to the wards as the dress standard is slightly above what you would normally wear for tutorials. Please ensure that you are neat and tidy.

You must always remember to have your name badge (with photo ID) on you. You cannot go on the wards unless you have your ID badge. We have permission for you to go in the first tutorial (even though you do not have your name badges) as you will be accompanied by you tutor who will have one.

All ward CSCs will know that you are going to be coming to the wards and asking for patients.

When you go to the wards, please go in pairs. One student should be the interviewer and the other student should be the observer, and take notes using the CC checklist.

When you are in your tutorials and are discussing what happened on your ward visit, initially the focus is on the process, not on the content.

Always remember to check with the CSC and/or the nurse in charge of that patient before you ask that patient if you can talk with them.

Medical students can spend quite a bit of time sitting at the nurses’ station, waiting for a patient to finish eating, having visitors or being seen by a doctor so that they can take a history from or examine them. If the phone rings and there is no-one there to answer it, it is nice to be helpful and answer the phone. But be careful. There was once a student who picked up the phone in the nurses’ station and, when they were asked “how is Mr B?”, they replied, “you mean the man with AIDS?”. In this situation, the patient’s relatives did not know that he had AIDS and the student was reprimanded for breaking patient confidentiality. The correct response would have been either “I’ll get the nurse” or “I’m just the medical student, let me find you someone who knows him”. Even if you know information about a patient, you may not have been told who this information can be divulged to. In general, make sure you only give information to the nurse or doctor looking after the patient.

Many students are keen to read the case notes to see if they have the story “right”. In my experience, these students then start to check the case notes, rather than check with the patient. When you are learning, try to avoid this. Certainly, a lot can be gained from reading the case notes but learn how to take a good history first! You are allowed to look at case notes but you must have your identification badge. Medical staff obviously have priority over you for use of case notes, so never walk away from the nurses’ station with them.

You can only look at the case notes of the patient you have been interviewing. You cannot look at other patient’s case notes out of interest and, very importantly, you cannot look at case notes of people that you know or think you may know in a social and personal context. For example, if you see on the patient board the name of your neighbour or a former sporting legend, you cannot look at their case notes just to “see what they have”. This is a serious breach of confidentiality and privacy and staff members have sacked and/or punished over situations like this.

While you are a medical student you will, at some point, have to write in the patient’s case notes. Medical records have become increasingly important due to the increase in litigation and the fact that patients now legally have access to their notes. However, it is also important that you write clearly and accurately so that all other health professionals looking after the patient will be able to understand what you have written. When working in a hospital environment, it sometimes becomes a bit of a game to see who can write the cleverest or wittiest comments about a patient or to leave little notes that only your colleagues can understand. However, remembering the legal nature of these notes should discourage any of these practices. You don’t have to write messily just because you are studying medicine – if what you write can’t be read, then error can occur – try to write legibly at all times. Remember to use only well accepted abbreviations

It is important to remember that patients are in hospital to receive the best possible care for their medical problems. Even though this is a teaching hospital, this doesn’t mean that patients have to let you learn
on them. We ask you to please respect patients’ wishes and show courtesy to patients and ward staff at all times.

In the past, there used to be many in-patients who were not seriously ill in teaching hospitals who expected to have medical students take histories from them and examine them. Nowadays, inpatients tend to be sicker and in hospital for shorter periods of time. They are also now aware that they do not have to interact with students if they do not want to.

However, there are many patients on the wards who are bored or lonely who would really appreciate being visited by a friendly medical student who is interested in what has happened to them. Because these interviews have a social aspect to them, they may take longer than a routine history taking session. It is useful to think of it this way, the extra time spent with the patients providing them with some social interaction is in exchange for them providing you with useful practice in taking a history.

Debriefing:
It is important to debrief from work/hospital/ward experiences and that is one of the purposes of your clinical skills tutorials, especially in the first semester of first year. At other times, there is not always enough time to discuss these experiences with your tutors and most students would naturally turn to fellow students, friends and family to talk about people you have met or conditions that patients have had. That is only normal and natural but you must remember not to identify the patient in any way. For example, you can say that you took a history from a patient “who was found in his house after falling on the floor 5 days ago” but you cannot mention his name, his address or any other identifying characteristics.

A final reminder:
IT IS A PRIVILEGE AND NOT A RIGHT FOR STUDENTS TO SEE PATIENTS.
Appendix 6: Examining Each Other

In the past, when medical students learnt examination skills, they practised on patients in teaching hospitals. It is becoming increasing more difficult for this to happen and the reasons for this are as follows:

1. Patients are in hospitals for much shorter periods – and when they are in hospital they are sicker. No longer are patients in hospital for days before their surgery or days waiting for placements – it just costs the government too much money!
2. Patients are more aware of their right to refuse to be practised on. They no longer see that part of getting free treatment in a teaching hospital it is that medical students should be able to practise on them.

There are other options for learning examination skills. The most obvious and convenient is to learn and practise on each other. Practising on other is something that happens in most medical schools in Australia, NZ, US, Canada and UK. (In other parts of the world, patients may be more available or more amenable to having students practise on them).

Surveys from US (Chang and Power, 2000) and UK (O'Neill et al, 1998) reveal that up to 97% of students are happy to practise on each other. However, when asked about mixed pairings (ie male and female practise on each other rather than male-male, female-female), the response was less favourable (Barnette et al, 2000).

In some cultural groups, it is not seen as appropriate that a person of the opposite gender touch them nor is it appropriate for Muslim women to expose parts of their bodies to men.

There are significant advantages on learning and practising examination skills on each other. These include:

- familiarising students with the skill before they encounter patients;
- refining skills so they are less likely to hurt patients and more time to persist till they get it right;
- finding out what it feels like to be examined;
- learning what is normal by examining healthy students before examining patients with abnormal;
- getting feedback.

At Flinders, students have always learnt and practised on each other. It is something that they have done in certain tutorials and for exam practice.

With the new clinical skills lab, we have set up an area where this can happen in a more comfortable and appropriate environment.

So, first, let us set down some rules that we think will make it easier for everyone. We are very happy to add anything more that you may feel is appropriate.

These beds are only to be used for examining each other – not for sleeping off a hangover etc.

Working with pairs: same sex pairings seem to be more acceptable as people tend to be more comfortable with the same gender. This also overcomes cultural and religious hurdles.

Not all groups have equal numbers of males and females. It is important that everyone be given the option. Working in threes with the same gender may be the best solution.

Wear clothes that make it possible for you to practise on each other while maintaining modesty. For example, if you are wearing a thick long sleeved shirt, you cannot have your blood pressure taken unless you actually take you arm out of the shirt. You can always bring clothes to change into (eg shorts for leg examination if it is the middle of winter).

Areas that are “out of bounds”:

Some clinical teachers suggest that, by having students practise intimate examinations on each other, it helps them realise that these examinations should always be “sexless” (Metcalf et al, 1982). A small proportion of students surveyed overseas (Chang and Power, 2000) and Australia (Abraham, 1995) feel
that it is appropriate for them to learn intimate examinations on each other but even less would actually volunteer to do it!

However, at Flinders, we have made the decision that students do not have to learn intimate examinations on each other. Instead, we have set up the teaching so that students learn the basis of these examinations on plastic models and then practise the skills on teaching associates (people who are paid to be examined and give feedback to the students on their technique). The next step is to practise on consenting stable patients at a point where they know the procedure and have already got feedback on their performance from the teaching associate.

There are still some areas that could be regarded as “intimate” that come under the umbrella of “routine” examination.

These include the inspection and/or palpation of the following areas:

- Apex beat – the apex beat is usually at the 5th intercostal space mid clavicular line. In the female, this is where the breast is usually located.
- Lower abdomen – as it tends to be getting near the pubic hair line.
- Femoral region for pulses, lymph nodes and hernia.
- Axillary lymph nodes.

If this is the case, there are several options:

- Try wearing thin t shirts or singlet underneath your outer garments so that it is still possible for your student partner to feel landmarks and hear heart sounds through your clothing.
- Tell your partner that you do not feel comfortable with this.
- Work with a different partner.
Appendix 7: Information Sheet: Clinical Skills – Peer and Standardized Patient (SP) Physical Examination and Videotaping

In our clinical skills teaching, we make great use of students examining each other: Peer Physical Examination (PPE) and also examining standardized patients (SPE).

This is for several reasons:
- Practise on each other first to learn how it feels
- Build skill levels prior to first patient contact
- Get feedback from peers
- Reserving the scarce resources of patients for more senior medical students
- Limited numbers of suitable patients in hospitals

It is important for students to realise several things:
- Students do not learn intimate examination on each other at Flinders
- Students do not learn procedures on each other that are risky or have significant consequences at Flinders
- Learning with peer physical examination is only successful if all students contribute in some way
- Not all students feel comfortable with both examining and being examined for every body part for a range of valid reasons
- Most often, PPE is gender specific (males learn on other males and females learn on other females)
- Students will examine standardized patients (“actors”/SP) for both teaching and for assessment purposes under the supervision of a tutor.

Information for students on the management of detected incidental findings on self, peers and standardized patients (SP):
- Please discuss any abnormal findings you detect on yourself, your peers or an SP during a clinical skills examination session with your tutor in private, with permission of the peer or SP, as necessary.
- If an incidental finding is detected on you, your tutor will advise you (again in private) to see your general practitioner for appropriate follow-up on the incidental finding. A copy of this will also be held in the Simulation Unit in confidence. Your tutor may enquire at a later date as to whether you have attended your appointment. However, the outcome of your medical consultation with your general practitioner does not need to be communicated to the tutor as these are your private health matters.
- In certain situations, it may be necessary for you to discuss in confidence your medical/health conditions when you feel they will have a direct impact on your studies and these should be directed to the clinical skills lecturers Jo Wiese and/or Anna Vnuk.

Video information:
- Teaching in the GEMP involves videotaping the students performing skills – history taking, physical examination, procedures and Basic and Advanced Life Support
- The students will be videotaped performing these skills on Standardised Patients and on manikins. Sometimes more than one student will be present on the video (eg team BLS assessment, year2).
- These videos will be part of your assessment, for reflection and review with your tutor and/or become part of your e-portfolio.
- It is important that students are aware that these videos must only be used for educational purposes for your personal professional development. They are not to be uploaded to YouTube, Facebook, MySpace or other social networking sites. Additionally, the Standardised Patients, who have consented to be part of the teaching, have not consented to have their images displayed in the public arena.
- Please be aware that if some videos are on permanently for security reasons, these will be clearly signed.

Consent and Acknowledgement
Please read the following information about PPE and SPE at Flinders. After reading this, we would like you to sign the information sheet, to record that you have read and understood this information, and then return the confirmation sheet to us.

- The process of peer physical examination and standardized patient physical examination has been explained to me
- I understand peer physical examination involves limited exposure of my own and other people's bodies
- I understand that before commencing any physical examination or procedure on another student, I need to obtain a verbal consent from him/her
- I can choose whom I work with within my Clinical Skills group.
- I understand that I can opt out of particular PPE roles at any time and other students will respect my decision
- I understand that if other students opt out, I will not ask for his/her reasons but respect his/her decision
- Any complaints about the behaviour of students or tutors should be brought to the attention of a member of the clinical skills staff.
- I understand that being examined by other students does not in any way replace an examination or consultation with a health practitioner (doctor) as PPE is for educational purposes only.
- I will discuss any abnormal findings I detect on myself, my peers or a SP during a clinical skills examination session with my tutor in private.

In addition to the above information:

I agree to participate by both examining and being examined during PPE; examining during SPE throughout the medical course.

I will treat any information that I become aware of during PPE and SPE as private and confidential.

I acknowledge that the videotapes of me, other students and standardised patients will be treated as confidential and will only be used for educational purposes for my personal professional development and not broadcast in public sites.

Name

Signature

Date
This handbook was written by Anna Vnuk, Jo Wiese, John Agzarian and Jane Tillett, Caroline Phegan and Clare Fenwick with contributions from Peter Loa, Ashwin Shukla and all the clinical skills tutors. It is based on practice experience and information from the following references:

**References:**


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Lloyd and Bor, Communication Skills for Medicine, 2nd edition, Churchill Livingstone 2004


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INITIATING THE SESSION
Establishing initial rapport
1. Greet patient and obtains patient’s name
2. Introduces self, role and nature of interview; obtains consent if necessary
3. Demonstrates respect and interest, attends to patient’s physical comfort

Identifying the reason(s) for the consultation
4. Identifies the patient’s problems or the issues that the patient wishes to address with appropriate opening question
5. Listens attentively to the patient’s opening statement, without interrupting or directing patient’s response
6. Confirms list and screens for further
7. Negotiates agenda taking both patient’s and physician’s needs into account

GATHERING INFORMATION
Exploration of patient’s problems
8. Encourages patient to tell the story of the problem(s) from when first started to the present in own words (clarifying reason for presenting now)
9. Uses open and closed questioning technique, moving from open to closed
10. Listens attentively, allowing patient to complete statements without interruption and leaving space for patient to think before answering or go on after pausing
11. Facilitates patient’s responses verbally and non-verbally e.g. use of encouragement, silence, repetition, paraphrasing, interpretation
12. Picks up verbal and non-verbal cues (body language, speech, facial expression, affect); checks out and acknowledges as appropriate
13. Clarifies patient’s statements that are unclear or need amplification
14. Periodically summarises to verify own understanding of what the patient has said; invites patient to correct interpretation or provide further information.
15. Uses concise, easily understood questions and comments, avoids or adequately explains jargon
16. Establishes dates and sequence of events

Additional skills for understanding the patient’s perspective
17. Actively determines and appropriately explores:
   • patient’s ideas (i.e. beliefs re cause)
   • patient’s concerns (i.e. worries) regarding each problem
   • patient’s expectations (ie goals, what help the patient had expected for each problem)
   • effects: how each problem affects the patient’s life
18. Encourages patient to express feelings

PROVIDING STRUCTURE
Making organisation overt
19. Summarises at the end of a specific line of inquiry to confirm understanding before moving on to the next section
20. Progresses from one section to another using signposting, transitional statements; includes rationale for next section

Attending to flow
21. Structures interview in logical sequence
22. Attends to timing and keeping interview on task
**CONTENT to be DISCOVERED Bio-medical perspective**

1. Sequence of events
2. Symptom analysis
   - W: WHERE – the location and radiation of a symptom
   - W: WHEN - when it began, fluctuation over time, duration
   - Q: QUALITY – what it feels like
   - Q: QUANTITY – intensity, extent, degree of disability
   - A: AGGRAVATING and ALLEVIATING factors
   - A: ASSOCIATED MANIFESTATION – other symptoms
   - B: BELIEFS – patient’s perspective (already uncovered)
3. Relevant system questions (not required)

**Background information**

1. Past medical history
2. Drug and allergy history
3. Family history
4. Personal and social history (psychosocial)
5. Alcohol/Smoking/Ilicit Drugs
6. Review of systems (not required)

**Building the relationship**

**Using appropriate non-verbal behaviour**

23. Demonstrates appropriate non–verbal behaviour

- eye contact, facial expression
- posture, position & movement
- vocal cues e.g. rate, volume, tone

24. If reads, writes notes or uses computer, does in a manner that does not interfere with dialogue or rapport

25. Demonstrates appropriate confidence

**Developing rapport**

26. Accepts legitimacy of patient’s views and feelings; is not judgmental

27. Uses empathy to communicate understanding and appreciation of the patient’s feelings or predicament; overtly acknowledges patient’s views and feelings

28. Provides support: expresses concern, understanding, willingness to help; acknowledges coping efforts and appropriate self care; offers partnership

29. Deals sensitively with embarrassing and disturbing topics and physical pain, including when associated with physical examination

**Involving the patient**

30. Shares thinking with patient to encourage patient’s involvement

(e.g. “What I’m thinking now is....”)  
(Items 31-34 not required)

**Closing the interview**

35 Encourages patient to discuss any additional points and provides opportunity to do so (e.g. “Are there any questions you’d like to ask or anything at all you’d like to discuss further?”)

36 Summarises session briefly

37 Makes contract with patient re next steps for patient and physician

Radcliffe Medical Press (Oxford)

**Any comments?**

When completed satisfactorily, tutor to tick □
CASE NOTE ENTRY:
Patient Details:

Presenting problem/s

(up to here for assessment 1)
History of the presenting problem (including time sequence, symptom analysis, patient’s perspective)

Past Medical History

Family History:

Medications

Allergies

Alcohol

Smoking

Illicit Drugs

Social history

When completed, tutor to tick □
LEARNING OBJECTIVES:

When completed, tutor to tick ☐

ADDITIONS to the LEARNING OBJECTIVES

Tasks to be completed during review session with tutor
  a) check completion of all tasks above
  b) discussion, feedback from tutor’s checklist of SP interview
  c) discussion feedback on case note entry
  d) review of learning objectives
  e) add to the learning objectives (if necessary)

After discussion with tutor, has assessment been passed?
☐ Interview/reflection/review cycle is complete – sign off below
☐ Interview was not passed but all other tasks were – then complete the form here and refer student to Clinical Skills Staff for review of interview, remedial work and re-interview
☐ Other aspects of the assessment cycle were not passed – then complete the form here and refer to clinical skills staff for review and re-do

Student name: ……………………… Signature ……………………………………. Date: ……….
Tutor name: ……………  .………… Signature ……………………………………. Date: …….

Any other comments: