Foundations of Clinical Medicine – 2

Longitudinal Clinical Experience
(LCE)

Student Handbook

2018-2019
University of Illinois College of Medicine at Urbana-Champaign
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Longitudinal Clinical Experience (LCE)

The Longitudinal Clinical Experience is an opportunity to provide the student with an exposure to an outpatient generalist's practice. The experience is intended to be an avenue to integrate medical knowledge, clinical skills, and professionalism in your journey towards your identity formation as a physician.

You will be assigned an M-2 Primary Care Preceptor and will meet with the preceptor for a total of 10 half-day sessions during the year. Preceptors are located both in urban and rural settings. Some may be in large hospital practices and some in small private clinics. Primary care physicians see a wide variety of patients and patient problems. They represent the disciplines of Family Medicine, General Internal Medicine, and Medicine/Pediatrics.

During each half-day session, you will practice the components of the H&P, observe the clinical responsibilities of a primary care physician, observe the complexities of the medical office system, and correlate basic science knowledge with clinical medicine.

General Goals and Objectives

1. Understand and describe the breadth and depth of the generalist's practice content.

2. Correlate your medical knowledge in the basic sciences with your clinical skills in clinical practice.

3. Describe the clinical and intellectual challenges of the generalist’s practice.

4. Apply the clinical decision-making process in the community practice.

5. Practice history taking and physical examination skills.

6. Understand the principles of disease prevention and health promotion for individuals, families and the community.

7. Articulate the pertinent community health problems unique to their preceptor site.

Session Objectives:

At each session there will be clear objectives for you to complete.

During the year, you will be exposed to a variety of primary care outpatient problems.

Assignments: You will have required write up assignments throughout the year. The majority will be SOAP notes (18 total) of patient encounters that need to be submitted in Benware after each visit. These will be discussed and reviewed by your preceptor as well as your small group faculty. You will also have 4 writing exercises that will be submitted
at 2 intervals in the fall and 2 intervals in the spring. The writing exercises will be evaluated and discussed within your small group sessions.

Submission of all SOAP notes and writing exercises will be required to pass the LCE portion of the FCM 2 course.

**Evaluations:**

Your preceptor will be expected to give you a Professional Attributes Narrative Assessment at mid-term and final. The preceptor will provide feedback of a direct patient encounter utilizing a Modified Mini-CEX Learner Rating Instrument.

If problems arise during any of your LCE sessions, you should contact the LCE coordinator immediately. The coordinator can discuss difficulties you encountered with the preceptor, arrange for an alternate if your preceptor is not available during one of the required sessions, and answer questions related to this experience.
LCE Grade Components:

Total LCE Grade -

- Patient Encounter Notes (18) – 10%
- Reflective Exercises (4) – 4%
- Preceptor Evaluations (2) -

There will be a 1% deduction for each patient encounter note that is submitted into Benware late without excuse. If there are issues that are causing you to not be able to get to your preceptor by the deadline date, please contact your small group faculty member.
VISIT 1/LCE1: Shadowing the preceptor/Professionalism

Visit needs to be completed by **August 31**

*Student’s responsibility to email or call assigned preceptor before August 17 and schedule a time. If the student cannot reach the preceptor the student needs to contact LCE coordinator (Dr. Grace Park) by August 20*

OBJECTIVES:

- Shadowing the preceptor
  - Observe for the following as you shadow your preceptor
    - i. How does your preceptor introduce him/herself?
    - ii. What is an opening question your preceptor asks to the patient?
    - iii. What are ways you see your preceptor remove barriers to communication or ensure comfort for the patient?
  - Professional expectations of the clinic will be reviewed
  - Understand the flow of the office and roles the different staff members have in patient care.
  - Understanding the use of vital signs in the patient examination.

ASSIGNMENTS:

- Arrive promptly for clinic session, dressed in professional clothing with your white coat and stethoscope.
- Coordinate with your preceptor and the M2 calendar to set times for the rest of the fall and spring semester.
  - i. **These dates need to be submitted in LCE1 in Benware for approval**
- Follow 2 patients as they go through the check in process.
- Work with the receptionist as they check a patient in.
- Work with the medical assistant as they take the patient’s vital signs.
  - Need to obtain at least 2 sets of vital signs
    - a. **One set of vital signs needs to be submitted by the student in LCE1 in Benware for approval**
LCG Session #1: Goals

- **Medical Knowledge**
  - Genetics
  - Basic Pathology

- **Clinical Skills**
  - Vital Signs
  - Overview of Medical History and Physical (MHP)

- **Preparedness**
  - LCE sessions to be scheduled for the rest of the semester (LCE 1-6)
VISIT 2/LCE2

Visit needs to be completed by **September 21**

**OBJECTIVES:**
- Student will see at least 2 patients on his/her own (They can see more but that is up to the clinic and preceptor’s schedule.)
- Focus for physical exam will be **Cardiovascular** Examination

**ASSIGNMENT:**
- Student will obtain a chief complaint and complete history then will step out and present the case to the preceptor.
- For physical exam student should look for opportunities to practice the CV examination. Be proactive and ask the preceptor and patient for those opportunities. More normal exams one hears the better one will be able to identify abnormal.
- Student will write patient encounter SOAP note for each patient. This will be submitted to their core faculty in the course. *Preceptor also has the option to require the student to email him/her a copy of student’s SOAP note for feedback.*
  
  **ii. Student will need to submit 2 patient encounter SOAP notes in LCE2 in Benware by September 23.**

Benware Instructions: Enter Case type, Primary Diagnosis and under Comments, the **SOAP NOTE**
LE Session #2 Goals

Medical Knowledge
- IRI
- CFI
- Chest Pain/Arterial CAD
- Congenital Heart Disease
- Dyslipidemia

Clinical Skills
- Cardiovascular Exam
- Neuro
- EKG Reviews

Respect: Student should be working on communication with the patient.
VISIT 3/LCE3

Visit needs to be completed by October 12

OBJECTIVES:

- Student will see at least 2 patients on his/her own. (They can see more but that is up to the clinic and preceptor’s schedule.)
- Focus for physical exam will continue to be Cardiovascular Examination

ASSIGNMENT:

- Student will obtain a chief complaint and complete history then will step out and present the case to you.

- For physical exam student should look for opportunities to practice the CV examination. Be proactive and ask the preceptor and patient for those opportunities. More normal exams one hears the better one will be able to identify abnormal.

- Student will write patient encounter SOAP note for each patient. This will be submitted to their core faculty in the course. Preceptor also has the option to require the student to email him/her a copy of student’s SOAP note for feedback.
  
  iii. Student will need to submit 2 patient encounter SOAP notes in LCE3 in Benware by October 14.

Benware Instructions: Enter Case type, Primary Diagnosis and under Comments, the SOAP NOTE

- Writing exercise will be on topic of PATIENT RAPPORT. Write a thoughtful reflection (at least 1-2 paragraphs) on a patient encounter that you were engaged in or observed where patient rapport was difficult to develop.
  
  o Submit on Benware under LCE 3 Paper by October 14
LCE Session #3 Goals

Medical Knowledge
- Peripheral Vascular Disease
- Atherosclerosis
- Vascular

Clinical Skills
- Cardiovascular Exam
- SIG Reviews

Truthfulness: Student should be working on giving accurate presentation of history gathered

Response Question: Patient Report
Describe an encounter where it was difficult to develop patient rapport. Why did you feel it was difficult? Was it something about yourself, the patient, the situation? How did the encounter make you feel and want to work on for the future.
VISIT 4/LCE4

Visit needs to be completed by **October 26**

OBJECTIVES:
- Student will see at least 2 patients on his/her own (They can see more but that is up to the clinic and preceptor’s schedule.)
- Focus for physical exam will be **Pulmonary Examination**

ASSIGNMENT:
- Student will obtain a chief complaint and complete history then will step out and present the case to you.

- Student will start working on differential diagnosis formation: At this stage, an organ-based approach is helpful. Student should be working on giving at least 3 organ systems that the chief complaint can be originating from. (For example, shortness or breath – student should be able to give possible causes being a Respiratory issue, CV issue, or GI issue).

- For physical exam student should look for opportunities to practice Pulmonary examination. Be proactive and ask the preceptor and patient for those opportunities. More normal exams one does the better one will be able to identify abnormal.

- Student will write patient encounter SOAP note for each patient. This will be submitted to their core faculty in the course. *Preceptor also has the option to require the student to email him/her a copy of student’s SOAP note for feedback.*

  iv. Student will need to submit 2 patient encounter SOAP notes in LCE4 in Benware by October 28.

**Benware Instructions:** Enter Case type, Primary Diagnosis and under Comments, the **SOAP NOTE**
LCE Session #4 Goals

Medical Knowledge
- Dyspnea
- Pneumonia/COPD
- COPD/Asthma
- Restrictive Lung Disease
- Lung Tumors

Clinical Skills
- Respiratory Exam
- Lung Sounds
- ABG and PFTs

Preparedness
Students should start working on differential diagnosis using an organ-system based approach.
Student should be able to give at least 3 organ systems wherever chief complaint may be coming from.
VISIT 5/LCE5

Visit needs to be completed by November 16

OBJECTIVES:

- Student will see at least 2 patients on his/her own. (They can see more but that is up to the clinic and preceptor’s schedule.)
- Focus for physical exam will continue to be HEENT Examination

ASSIGNMENT:

- Student will obtain a chief complaint and complete history then will step out and present the case to you.
- Student will start working on differential diagnosis formation: At this stage, an organ-based approach is helpful. Student should be working on giving at least 3 organ systems that the chief complaint can be originating from. (For example, shortness or breath – student should be able to give possible causes being a Respiratory issue, CV issue, or GI issue).
- For physical exam student should look for opportunities to practice the HEENT examination. Be proactive and ask the preceptor and patient for those opportunities. More normal exams one does the better one will be able to identify abnormal.
- Student will write patient encounter SOAP note for each patient. This will be submitted to their core faculty in the course. Preceptor also has the option to require the student to email him/her a copy of student’s SOAP note for feedback.
  v. Student will need to submit 2 patient encounter SOAP notes in LCE5 in Benware by November 18.

Benware Instructions: Enter Case type, Primary Diagnosis and under Comments, the SOAP NOTE

- Writing exercise will be on topic of HEALTH LITERACY. Write a thoughtful reflection (at least 1-2 paragraphs) on an encounter with a patient where the interaction was affected by low health literacy level.
  o Submit on Benware under LCE5 Paper by November 18
LC E Session #5 Goals

Medical Knowledge
- Sore Throat/Group A Strep
- Gonorrhea/Chlamydia
- Acute and Chronic Renal Disease
- Anemias
- Kidney Stones
- Clothing Disorders
- Lymphomas
- Transfusions

Clinical Skills
- HEENT Exam
- Workup of Fatigue

Respect:
Continue to work on engaging respectfully with staff and patients

Response Question:
Health Literacy
Describe an encounter with a patient where there was a low level of health literacy. How did you determine that? How did the patient’s literacy level affect the patient’s ability to receive and participate in their healthcare? Was the literacy level of the patient addressed by the preceptor?
VISIT 6/LCE6: Mid-Term Evaluation/Professionalism

Visit needs to be completed by December 7

OBJECTIVES:

- Mid-term Evaluations and Feedback for patient interviewing and physical exam skills
- Student will see at least 2 patients on his/her own. (They can see more but that is up to your clinic and your schedule.)
- Focus for physical exam will be MSK (if applicable)

ASSIGNMENT:

- Student will obtain a chief complaint and complete History then will step out and present the case to you. Students will work on giving you at least 3 differential diagnosis.

- For physical exam student should look for opportunities to practice the MSK exams if applicable. The student should also look for opportunities to continue practicing prior physical exam skills (i.e. Vitals, CV, Respiratory, HEENT exam)

- Student will write patient encounter SOAP note for each patient. This will be submitted to their core faculty in the course. Preceptor also has the option to require the student to email him/her a copy of student’s SOAP note for feedback.

  vi. Student will need to submit 2 patient encounter SOAP notes in LCE6 in Benware by December 9.

  Benware Instructions: Enter Case type, Primary Diagnosis and under Comments, the SOAP NOTE

  - Student will ask the preceptor to directly observe him/her doing a history or physical exam and submit a Mini-CEX evaluation.

  - “Professionalism Attributes” Narrative form will also need to be filled out by the preceptor and reviewed with the preceptor. Remind your preceptor at the beginning of the session that you need to sit down and work on the evaluations.

  - Please spend time with your preceptor going over their evaluation and then give evaluations to the student. Student will bring them to their mid-course evaluation session with their core faculty or if the preceptor prefers to directly submit the evaluations you can submit the Mini-CEX and Professionalism evaluation to Kirsten Lawhead (fax number and email is listed on front of handbook)
LCE Session #5 Goals

Medical Knowledge
- Sore Throat/Group A Strep
- Glomerulonephritis
- Acute and Chronic Renal Disease
- Anemias
- Kidney Stones
- Clothing Disorders
- Lymphomas
- Transfusions

Clinical Skills
- ENT Exam
- Workup of Fatigue

Respect
- Continue to work on engaging respectfully with staff and patients

Response Question: Health Literacy
- Describe an encounter with a patient where there was a low level of health literacy. How did you determine that? How did the patient’s literacy level affect the patient’s ability to receive and participate in their health care? Was the literacy level of the patient addressed by the preceptor?
VISIT 7/LCE7

Visit needs to be completed by **February 15**

**OBJECTIVES:**

- Student will see at least 2 patients on his/her own. (They can see more but that is up to the clinic and preceptor’s schedule.)
- Focus for physical exam will continue to be **Female/Male Exam and Abdominal** Examination

**ASSIGNMENT:**

- Student will obtain a chief complaint and complete history then will step out and present the case to you.

- Student will start working on differential diagnosis formation: At this stage, an organ-based approach is helpful. Student should be working on giving at least 3 organ systems that the chief complaint can be originating from. (For example, shortness or breath – student should be able to give possible causes being a Respiratory issue, CV issue, or GI issue).

- For physical exam student should look for opportunities to practice the Abdominal, Female/Male examination. (if applicable). The student should also look for opportunities to continue practicing prior physical exam skills (i.e. Vitals, CV, Respiratory, HEENT exam)

- Student will write patient encounter SOAP note for each patient. This will be submitted to their core faculty in the course. **Preceptor also has the option to require the student to email him/her a copy of student’s SOAP note for feedback.**

  vii. Student will need to submit 2 patient encounter SOAP notes in LCE7 in Benware by February 17.

**Benware Instructions:** Enter Case type, Primary Diagnosis and under Comments, the SOAP NOTE

- Writing exercise will be on topic of **OBSTACLES TO CARE.** Write a thoughtful reflection (at least 1-2 paragraphs) on an encounter where there were barriers to care. Were they physical obstacles (location/transportation); administrative obstacles (patient appointment availability; language barriers); social obstacles (health disparities; health literacy); patient obstacles (noncompliance, attitude)?
  - Submit on Benware under LCE 7 Paper by February 15.
LCE Session #7 Goals

Medical Knowledge
- Women’s Health (Breast Diseases & Cancer, GU tumors and disease)
- Male GU disease and cancer
- Cystitis/Pyelonephritis
- STDs
- Upper diarrhea
- Infectious Diarrhea

Competent/Un Consuming: Continue to work on critical thinking in developing differential diagnosis.

Client Skills
- Female breast and pelvic exam
- Male rectal and digital exam
- Abdominal examination
- Workup of GI bleed, abdominal pain, breast nodules, dysuria

Response Question: OBSTACLE TO CARE
Describe a situation in which there were obstacles for a patient to receive quality care. Were they physical obstacles (location/transportation), administrative obstacles (patient appointment availability, language barriers), social and economic obstacles (health disparities, health literacy), or patient obstacles (noncompliance, attitude).
VISIT 8/LCE8

Visit needs to be completed by **March 15**

OBJECTIVES:

- **Final Evaluations and Feedback for patient interviewing and physical exam skills**
- Student will see at least 2 patients on his/her own. (They can see more but that is up to your clinic and your schedule.)

ASSIGNMENT:

- Student will obtain a chief complaint and complete History then will step out and present the case to you. Students will work on giving you at least 3 differential diagnosis.

- Student will write patient encounter SOAP note for each patient. This will be submitted to their core faculty in the course. *Preceptor also has the option to require the student to email him/her a copy of student’s SOAP note for feedback.*
  - **Student will need to submit 2 patient encounter SOAP notes in LCE8 in Benware by March 17.**
    - **Benware Instructions:** Enter Case type, Primary Diagnosis and under Comments, the **SOAP NOTE**
      - Student will ask the preceptor to directly observe him/her doing a history or physical exam and submit a **Mini-CEX evaluation.**
      - **“Professionalism Attributes” Narrative form** will also need to be filled out by the preceptor and reviewed with the preceptor. Remind your preceptor at the beginning of the session that you need to sit down and work on the evaluations.
      - Please spend time with your preceptor going over their evaluation and then give evaluations to the student. Student will bring them to their mid-course evaluation session with their core faculty or if the preceptor prefers to directly submit the evaluations you can submit the Mini-CEX and Professionalism evaluation to Kirsten Lawhead (fax number and email is listed on front of handbook)
LCE Session #8 Goals

Medical Knowledge
- Hepatitis
- Jaundice
- HIV/Epithelial Disease
- Malabsorption
- Inflammatory Bowel Disease
- Irritable bowel disease
- Mood disorder (anxiety)
- Dissociative Disorders

Clinical Skills
- Abdominal Exam
- Workup of Weight Loss, Diarrhea
- Liver Function Tests

Respect: Continued work in developing patient rapport and communication
VISIT 9-10/LCE 9 Inpatient Session(s)

Visit needs to be completed by **April 13** - you will be assigned a date to do your inpatient session

OBJECTIVES:

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ASSIGNMENT:

- Student will obtain a complete History and Physical and then will step out and present the case to you. Students will work on giving you at least 3 differential diagnosis.

- Student will write patient encounter SOAP note for each patient. This will be submitted to their core faculty in the course. *Preceptor also has the option to require the student to email him/her a copy of student’s SOAP note for feedback.*
  - Student will need to submit 2 patient encounter SOAP notes in LCE9 in Benware by March 27.

Benware Instructions: Enter Case type, Primary Diagnosis and under Comments, the **SOAP NOTE**

**TEMPLATE for LCE Patient Encounter SOAP Notes:**
Chief Complaint (CC): The Chief Complaint should be written in the patient's own words, or paraphrased as accurately as possible. Can use quotations.

History of Present Illness (HPI): Begin with a brief description of the patient. Using both the description of the symptoms given by the patient in the patient-centered HPI as well as the other key findings you elicited in the clinician-centered HPI, write a descriptive paragraph detailing the information obtained. Utilize OLDCARTS.

Medications:

Allergies:

Past Medical History (PMH)

Social History (SH): Write as a descriptive narrative, not bullet points.

Family History (FH): May do as a genogram or as bullet points

Review of Systems (ROS):
Organ System approach
General/Constitutional:
HEENT:
CV:
Resp:
GI:
GU:
Endo:
Heme/Onc:
MSK:
Derm:
Neuro:
Psych:
List all positives and negatives
List all the positives first then the negatives
Avoid
"No problems with heart"
"Negative ROS"
"All Normal"

Physical Exam:
Vital Signs:
General Appearance:
Cardiovascular:
Pulmonary:
Breast/Pelvic (if applicable):
Abdomen:
Male GU (if applicable)
MSK: (if applicable)
Derm: (if applicable)
Neuro:

Differential Diagnosis:
Differential Diagnosis: What are the top 3 possibilities? Can be based by actual diagnosis or organ system involvement. What in the history and physical supports each possibility and what makes the possibility less likely?

1. + (reasons that support from History and Physical)/-(reasons that do not support)
2. +/-
3. +/-

Should’ve Section: What are things you should’ve asked or examined that you had missed?
HISTORY TAKING KEY CONCEPTS:
What are Patient-Centered Chief Complaint and HPI?

Patients seek medical attention because of a specific concern. That main issue is the patient's chief complaint. This is usually established by an open-ended question, such as, "What brought you in today?" or "What seems to be the matter?"

Other examples of initial questions used to elicit the chief complaint
- "What brings you into the hospital (office)?"
- "Tell me what has been bothering you."
- "What seems to be the matter?"

Elicit the Symptom Story: Using open-ended questions guide the patient to tell his/her story of the symptom.

- Use skills of echoing what the patient said (Repeat patient’s words)
- Requests – “Tell me more about it”
- Summarizing/Paraphrasing

Elicit the Personal Concern: Expanding your understanding of the patient as a person

Elicit Emotional Context

- Inquiring about impact: “How has this symptom affected your life?”
- Eliciting beliefs/attributions: “What do you think is causing the problem?”
- Demonstrating understanding through self-disclosure: “I think that if that happened to me I would feel upset.”

Triggers: Determining why the patient is seeking care at this precise time. “What made you decide to see me today for this symptoms?”

What is a clinician-centered HPI?
Obtain a chronological description of the history of present illness (HPI)

1. OLDCARTS
   (describe the symptom that the patient has already brought up)
   2. Ask about symptoms in the same organ system, as the chief complaint that patient has not brought up yet.
   3. Think about what other organ systems that are around or associated with the one described in the HPI that could be the cause of the chief complaint.
      a. Ask about symptoms related to those organ systems

Use the 7 Descriptors of Symptoms (OLDCARTS)
O: Onset
   - “When did it begin?”
L: Location and radiation
   - “Where is it located?” (have the patient point with one finger)
   - “Does it travel anywhere?”
D – Duration
  - “How long does it last?”
  - “How long have you had this symptoms?”
C – Character
  - “What is it like?”
  - “Have you noticed anything else that occurs with it?”
A – Aggravating Factors
  - “What brings it on?”
  - “What makes it worse?”
R – Relieving Factors
  - “What makes it better?”
T – Timing
  - “How often does it happen?”
  - “How long does it last?”
S – Severity
  - “How bad is it?”
  - “On a scale of 1 to 10, with 1 being no pain and 10 being the worst pain you can imagine, what number would you give your pain?”

**What are the Ancillary History Components?**

*Past Medical History*
The past medical history is a summary of the current and past illnesses, general state of health.

Components include general state of health and past illnesses.

Ask open-ended question first. “Do you have any other medical problems?”

Then ask more specific questions about the following:

Childhood Illnesses
Adult Illnesses/Diagnosis
Past injuries/accidents/procedures/tests
Past psychological problems
Past hospitalizations – when and why
Review immunizations during childhood and as an adult
Inquire about status of age-appropriate preventive screening (i.e. Mammograms, colonoscopies, lab testings)
Obtain female patient’s OB/Gyne history (Age of menarche or menopause, Number of pregnancies/complications or types of deliveries)

For any problem identified, note its time of onset, course of the disease, any special diagnostic testing, complications of the illness, etc.

*Medications* (dosage and route)
- Inquire about OTC and herbal supplements

**Allergies** (clarify if allergy or intolerance)
- Identify the specific type of reaction
  - Environmental
  - Medications
  - Foods

**Family History**
A Family History is very important because many medical problems have a genetic component.

It is never appropriate to state, “Family history was non-contributory”

Start with a General Inquiry. Begin with a screening open-ended question. “Tell me about any illnesses or other problems that run in your family.”

Inquire about age and health (or cause of death) of first-degree relatives. “How is your father’s health?” “Mother’s health?” Etc.

Then list specific diseases that tend to run in families. (See Table 5-6, page 123 for details)

**Social history**
The social history provides insight into the individual's values, attitudes, habits, and support systems.

Components: See Table 5-5, page 109 for details

Occupation
Diet/Physical Activity
Functional Status
Safety
Exposures (pets, travel, illness, STI)
Substance use
Personal
  - Living arrangements “Who do you live with at home?”
  - Sexuality (orientation, practices, difficulty)
  - Intimate partner violence/abuse “Do you feel safe?”
  - Life stress
  - Mood
  - Spirituality/Religion
  - Cultural Identity/Background
Health Screening/May have been covered in PMH
Health Literacy/Educational background

**What is a Review of Systems?**
The ROS is a structured series of questions covering all aspects of the patient's health status. It is utilized in the HPI as a means of obtaining pertinent positives and negatives, at the end of the history to avoid omissions, and as a mechanism for discovery of an unrecognized illness.

The ROS involves mainly symptoms not diagnoses. It is not necessary to repeat items covered in another area of the history. During this course, you will be expected to ask all questions within the ROS. As you become more familiar with the process and advance in your career, you may elect to ask key questions under each heading and only ask the detailed questions when a positive response occurs to a key item. For example, you may ask a general question, "Have you had any problems with your eyes?" If the response is negative, you can move on to the next set of questions. If the response is positive, further specific questions should be asked. This is referred to as branching. Branching can lead to omissions if the patient needs prompting to recall a specific issue.

*Each positive answer needs to be developed fully (as a mini HPI).* All of the pertinent information should be obtained on that response, before another system is addressed.

**Overview**
- Comprehensive review
- Head-to-toe evaluation

**Purpose**
- Identify the status of each organ system (General/Constitutional, HEENT, CV, Resp, GI, GU, MSK/Derm, Neuro, Heme/Onc, Psych)
  - Past
  - Present
  - Identify co-existing illness
- A double check for omissions in the HPI
- A list of questions, which can be used in the HPI

Includes positives and negatives

**Utilization (When do you use the ROS?)**
- During the HPI
  - Use components related to the Chief Complaint (patient-centered open-ended interviewing phase)
  - Use during clinician-centered closed-ended interviewing phase
    - Late in the interview
    - Identify omissions
- As a separate subsection of the Medical History
  - Comprehensive list of questions
  - Exhaustive search for other problems
    - Utilize most of the questions [see ROS list later in this text]
- General Concepts
  - Move from general to specific
  - Initial use of open-ended questions
- Avoid leading questions
- Avoid a long stream of yes/no questions
- Avoid medical jargon
- Avoid repeat questions
  - Those that fall in multiple categories
  - Those asked during the HPI
- Don't dwell on ancient history
  - Symptoms that were resolved years ago
  - Focus the patient's time frame
- Develop each positive response to its fullest
  - OLDCARTS [see HPI]
  - Associated symptoms
- Can be performed during the physical exam
  - Saves time
  - But may be confusing as
    - difficult to remember
    - patient may have more difficulty answering
    - May create concern on the patient's part
      - it may draw concern when there is no specific worry on your part

- The patient with a positive review of systems
  - Definition
    - The patient answers yes to nearly everything
  - Solution
    - Emphasize severity
    - Limit time frame
    - Reduce items to bare minimum

Branching Method
Definition: Broad question with follow-up questions for positive responses
Examples
  - “Have you had any problems with your eyes?”
    - Yes
      - “What kind of problems?”
      - Problems with vision, diplopia, flashing lights, photophobia, increased or decreased tearing, etc.
    - No
      - Move on with other systems
  - Benefits of branching questions a.
    - Saves time if there is no problem
  - Risk of branching
    - Missing data
**How to end an interview?**

Orient the patient to the end of the interview and ask for permission to begin discussion. For example, “We have about 5 minutes left; I’d like to share my thoughts about what may be causing your symptoms and then discuss where to go from here. Is that all right with you?”

Bringing the patient into the discussion and asking permission gives patients more receptivity to your thoughts on their symptoms/condition.

Reference:
Adaptations from UIC-COM- Peoria ICM Handbook