PEDIATRICS ROTATION SYLLABUS

Level of Training
PGY1, PGY2, PGY3

Preceptors’/Attendings’ Name(s) and Titles
FMC Faculty Contacts:
Paul Robinson, M.D., FAAP
Ronald Machado, M.D.

Thomas Truman, M.D. Pager: 850-657-0350
John Jackson, M.D.
Nora Peebles, M.D.
Several Locum Tenens Doctors

Location(s) of the Rotation
TMH Pediatric Services

Emergency Room: Main: 10915 Unit II: 10922
Pediatric/Adolescent Wing: 2nd floor-North Wing
Phone: 431-2294

Mother Baby Unit: 3rd Floor – Women’s Pavilion
Phone: 10297

Labor & Delivery Triage 2nd Floor – Women’s Pavilion
Phone: 10151

Case Management 3rd Floor – Women’s Pavilion
Phone: 10040, 10042, 10038

Schedule:
A sample schedule for the PGY2 block rotation is shown at the end of this document as Attachment 2.
Description of the Rotation

During the Pediatric inpatient rotation, the resident assumes the following responsibilities:

1. **Emergency Room**

Residents are responsible for seeing pediatric patients in the emergency department that have been referred to them for admission or consultation by emergency physicians. The resident is responsible for obtaining a complete and accurate history and physical examination and formulating an assessment and treatment plan for each pediatric patient. The resident’s assessment and decisions must be reviewed with the attending pediatrician or emergency physician before the plan is put into effect. This discussion should be documented. If the patient was initially seen by the emergency physician and a decision has been made to allow the patient to be discharged from the emergency room, then this decision should be discussed with and agreed upon by the responsible emergency physician. This discussion should also be documented. Documented consultations and admissions should be reviewed and signed by a licensed physician. This can take place at a later date. In the event a patient is seen by the resident PRIOR to being seen by any emergency physician, the patient must be discussed with, seen by when appropriate, and documentation signed by, a licensed physician (emergency physician or attending pediatrician). It is recommended that all consultations and admissions performed by residents be dictated, and then forwarded for electronic review and signature by the attending pediatrician.

2. **Pediatric/Adolescent Floor and Pediatric Special Care Unit**

Residents will be working closely with the TMH Hospitalist team led by Dr. Tom Truman. They will admit patients to both inpatient status and observation status at the direction of the hospitalist physician on call for that day. They will also admit patients with a local family physician, Whit Oliver, M.D. The patients admitted by Dr. Oliver will be overseen by Dr. Oliver, not the hospitalist physicians, unless Dr. Oliver requests they do so.

Residents are responsible for performing a complete and accurate history and physical examination and formulating an assessment and plan for each admission. Responsibilities include the careful recording of this information in the patient’s medical record. The assessment, differential diagnosis, and plan must be discussed with and approved by the attending pediatrician before being carried out by the resident. Seek the approval of the attending pediatrician as well for diagnostic and therapeutic procedures. Residents must also keep the attending physicians informed of the patient’s condition, or change in condition, at all times so that appropriate changes in medical management can be discussed and implemented.

Residents are responsible for maintaining the patient’s medical record, dictating a discharge summary, providing supportive care to the families of hospitalized children, and discharge planning.

Any change in the degree of responsibility is determined on an individual basis by the attending pediatricians. Privileges and responsibilities are increased as residents demonstrate their increasing knowledge, ability, and competence.
Documentation of experience and procedures is required. This includes documentation of each patient seen in the Emergency Room and the Normal Nursery. Most patient experiences and procedures may be documented by noting them on the pediatric service list. Any patient encounter or procedure not included on the pediatric service list must be noted on individual documentation cards. The pediatric service list must be turned in to FMC administrative office staff daily (Monday, for weekends). Residents must give their documentation cards to the FMC office staff, as well.

3. Term Nursery

Residents are responsible for all routine newborn care. This includes performing a complete and accurate perinatal history and physical examination, formulating an assessment and plan, including discharge planning, and carefully documenting in the newborn medical record. Documentation of resident experiences and procedures must be documented for the pediatric/adolescent floor and special care unit.

4. Billing

All admissions and procedures should be documented on the pediatric service list. This helps the administration of the residency program keep track of census and patient experiences the residents have had for the Accreditation Council for Graduate Medical Education (ACGME) and the Family Medicine Residency Review Committee.

5. Telephone

The on-call pediatric resident is responsible for handling all after-hours and weekend pediatric telephone calls from FMC patients. Each call must be documented in Allscripts and forwarded to Dr. Robinson for review.

6. Call

The pediatric inpatient call service is run as a night float system. Each of the four residents on the service will spend one week taking night float. During that time the resident will report to the hospital by 7:30 p.m. to take check out and to be ready for new admissions through the night. The resident will check out after rounds the following morning and must have at least a 10-hour rest period between shifts.

The non-night float residents will take call during the day (8 a.m. – 8 p.m.) on an every third day schedule, but will not be asked to stay in the hospital overnight. PGY-II & III residents will do one 24 hour shift per month from 8 a.m. – 8 a.m. PGY-I residents will split Sunday call into two 12 hour shifts – 8 a.m. – 8 p.m. and 8 p.m. – 8 a.m.

7. Continuity of Care for Pediatric Family Medicine Patients

Whenever a resident needs to admit one of his or her patients to a pediatric service, he or she contacts the pediatric resident on call and discusses the case with him or her. The on-call pediatric resident notifies the attending pediatrician of the admission and remains available to help the primary resident coordinate all aspects of the diagnostic and therapeutic plans. The primary resident participates as much as his or her schedule permits, but all aspects of the patient’s care should be discussed with the attending pediatrician and the on-call resident before implementation.
The primary resident is expected to:

- visit and provide appropriate support to the patient and the patient’s family on a daily basis,
- assist with discharge and follow-up plans,
- write orders and round with the pediatric team as schedule permits, but at minimum, discuss plans with one of the pediatric residents on a daily basis, and
- record progress notes in the medical record on a daily basis or more frequently if indicated.

Residents on the pediatric service monitor primary resident participation and document this on the daily pediatric list. Should a resident’s pediatric patient be admitted without that resident’s knowledge, the admitting pediatric resident informs the primary resident as soon as possible (telephone or written message). Involvement in that patient’s care then follows the above outline. Due to the demands of other rotations, office schedules, and vacation/conference times, pediatric residents serve as case coordinators to maximize quality of care. Note that if a disagreement arises over patient management, the attending pediatricians have final authority.

8. Child Protection Team Participation

To provide residents the opportunity to assess potential child abuse cases and the experience of working with the Child Protection Team members, residents may accompany Dr. Moorer and assist in evaluating potential child abuse victims presenting to the emergency room or at his office. Each case is supervised by Dr. Moorer with assistance from the Child Protection Team member on call. A detailed description of the exam technique in suspected child abuse (including sexual abuse) is available on request.

Supervised by Dr. Moorer, the resident may assist in documenting a thorough history and describing all physical findings. Residents are NOT responsible for determining whether or not child abuse has occurred. Disposition following the evaluation is the responsibility of the Child Protection Team. Any resident who evaluates a potential child abuse case in the emergency room or in Dr. Moorer’s office and wishes to follow the case beyond the initial evaluation may arrange to do so by contacting Dr. Moorer.

Whenever the Child Protection Team physician is unavailable and a potential child abuse victim presents to the emergency room, the child will be evaluated by the emergency room physician. If there is a resident on duty on the Emergency Room rotation, the resident may assist with the care. If hospital admission is indicated, the child will be admitted by his or her primary care physician. If the child has no TMH primary care physician, he or she becomes an unassigned patient and is admitted to the Family Medicine Pediatric Service. Once the child is admitted to the service, the on-call Tallahassee Pediatrics pediatrician assumes supervisory and attending roles.

9. Pediatric and Neonatal Resuscitation and Stabilization Course

During the two-week intern orientation to residency, each resident receives the materials needed and obtains certification in Neonatal Resuscitation Program (NRP) course, authored jointly by the American Heart Association and the American Academy of Pediatrics. Residents also complete testing and certification in Pediatric Advanced Life Support (PALS) during orientation. Certification in neonatal resuscitation and pediatric resuscitation are required for graduation from the residency program.
10. Pediatric Core Curriculum and Discussions

The resident will participate in lecture/discussions with Drs. Robinson or one of the hospitalist physicians twice weekly from 7:50 a.m. – 8:30 a.m. in the Doctor’s Dining Room. Outlines, review articles, and other materials will be provided at each session. Handouts will be posted in New Innovations for talks. In addition, Dr. Robinson will post helpful articles about pediatric cases. Topics include:

- Abdominal Pain
- Anemia
- Fluids and Electrolytes
- Neonatal hyperbilirubinemia
- UTI in children
- Meningitis
- Bronchiolitis
- Croup
- Febrile Seizures
- Non-febrile Seizures
- Gastroenteritis
- Failure to thrive
- Problems in the nursery
- Fever in children
- Proteinuria/renal disease in children
- Adolescent Interview and Case Presentation
- Development

Dr. Robinson will also have weekly teaching rounds about an interesting patient on the floor (under development).

Each upper level resident will also be expected to give one presentation on a topic within pediatrics in which he/she is interested once during each rotation. These discussions will be in addition to the core topics listed above.

Apart from lectures, there will be noon conferences addressing pediatric topics. These can be divided into the following learning areas. Didactics that are currently circulating in the conference schedule list the presenting physician. Some overlap of material with lectures is expected.

Learning Goals

PGY-1 Goals

Residents, under the supervision of faculty and upper level residents, will progressively develop competence in the care of Pediatric patients, newborn through adolescent, both inpatient and outpatient, offering care that is evidence-based and professional. They will progress in understanding of the medical system through appropriate patient/parent education and empathy, and through the use of safe, timely, and individualized documentation skills, and communicate effectively with all levels of staff assisting in the care of pediatric patients.
PGY-2 Goals

Competence will advance in the care of pediatric patients, with increasing autonomy and ability to present detailed plans for transition between levels and locations of care. The resident will accomplish further advances in professionalism and knowledge that lead to strong therapeutic relationships between resident and pediatric patients/families.

PGY-3 Goals

The third year resident will develop competence in the care of pediatric patients, newborn through adolescent, with minimal assistance from Attending Physicians, in both the inpatient and outpatient settings. He or she will routinely demonstrate the knowledge and professionalism required to maintain a therapeutic relationship with pediatric patients and families. The third year resident will be a role model for other residents due to his/her advanced knowledge of the care system, ability to communicate within the system and ability to teach lower level residents. The third year resident will be able to independently triage among the various acuity levels of illness among inpatient pediatric patients. (Competency: Patient Care)

Learning Objectives

PGY-1 Objectives

The PGY-1 resident will be able to:

1. Describe and provide routine newborn care, with supervision by the attending, including (Competency: Medical Knowledge, Patient Care):
   a. perinatal history and risk factors
   b. gestational age/size determination
   c. pertinent physical examination
   d. anticipatory guidance for the family

2. Become certified in neonatal resuscitation (NRP)(Competency: Patient Care).

3. List the pertinent diagnostic findings and outline management of children with the following pediatric problems (Competency: Medical Knowledge, Patient Care):
   • attention deficit disorders (outpatient)
   • bronchiolitis
   • croup
   • failure to thrive
   • fever
   • gastroenteritis with dehydration
   • meningitis
   • neonatal hyperbilirubinemia
   • pneumonia
   • reactive airway disease
   • seizures
   • suspected child abuse
   • urinary tract infection
4. Provide appropriate developmental screening at all ages (Competency: Patient Care, Medical Knowledge).

5. List references for determining (Competency: Patient Care, Medical Knowledge, Practice Based Learning):
   - appropriate drug dosing
   - behavioral-developmental standards
   - growth standards
   - normal pediatric laboratory parameters
   - update on treatment of specific pediatric illnesses
   - criteria for evaluating the physically and sexually abused child

6. Assist with the following procedures (Competencies: Interpersonal and Communication Skills, Medical Knowledge, Patient Care):
   - lumbar puncture
   - preparation of children and their families for procedures (including health education, reassurance, restraint, and sedation/analgesia/anesthesia, informed consent)
   - suturing

PGY-2 Objectives
The PGY-2 resident, in addition to the above, will be able to:

1. Provide routine newborn care as above and, in addition be able to recommend management strategies to the attending physician, if requested (Competency: Medical Knowledge, Patient Care):
   - a. describe common congenital malformations and their management
   - b. interpret and treat transcutaneous bilirubin results prior to discharge

2. Demonstrate increased ability with newborn exam (Competency: Patient Care)

3. Advance ability to care for patients with the pertinent diagnostic findings and pediatric problems as listed above (Competency: Patient Care)

4. List approximate timing of 5 major developmental milestones for infants and children aged one month to five years (Competency: Medical Knowledge)

5. Use appropriate developmental screening tools, questions, and resources in the care of patients (Competency: Patient Care, Medical Knowledge)

6. Utilize at least 2 community resources for children with developmental, emotional, or psychiatric care issues. (Competency: Systems-Based Practice)

7. Utilize pertinent Pediatric care references, and teach PGY-1 residents and students in their use. (Competency: Patient Care, Medical Knowledge, Practice Based Learning)

8. Perform the above listed procedures with minimal assistance from attendings. (Competencies: Interpersonal and Communication Skills, Medical Knowledge, Patient Care)
PGY-3 Objectives

The PGY-2 resident, in addition to the above, will be able to:

1. Independently care for children with common pediatric problems as listed above (Competency: Patient Care)

2. Screen, diagnose, and appropriately refer patients with developmental, emotional, or psychiatric care issues (Competency: Patient Care, Interpersonal and Communication Skills, Medical Knowledge, System-Based Practice)

3. Independently perform pediatric procedures as listed above, with supervision only by attending (Competencies: Interpersonal and Communication Skills, Medical Knowledge, Patient Care)

Methodology of Teaching

The resident learns about:

1. Routine newborn care through direct experience as a member of the pediatric team under the supervision of the attending pediatrician. The resident also gathers knowledge from the pediatric core curriculum, a didactic series of informal discussions.

2. Neonatal resuscitation by completing and receiving certification in the AHA/AAP NRP self-study course during the PG1 year.

3. Common pediatric problems through direct experience as a member of the pediatric team under the supervision of the attending pediatrician. The resident also gathers knowledge from the pediatric core curriculum. In addition, the resident learns the evaluation criteria of the physically and sexually abused child through direct experience with the CPT and physician.

4. Developmental and behavioral issues through assigned reading, the pediatric core curriculum and through direct experience with patients on the pediatric services under the supervision of the attending pediatrician.

5. Community resources for pediatric problems by working as a member of the pediatric team under the supervision of the attending pediatrician. Familiarity with community resources is augmented during the community medicine rotation.

6. How to use pediatric literature and references to research patient care questions that arise on the pediatric in-patient and emergency room services. (Attending pediatricians and involved consultants also provide assistance and direction as indicated.)

7. Procedural skills through direct experience, as opportunity arises on the pediatric inpatient and emergency room services, and by informal precepting by pediatric or Family Medicine attendings.
Evaluation

1. Resident performance, including medical record keeping, is reviewed daily by the attending pediatrician who provides feedback as indicated. The resident may request feedback at any time during the rotation.

2. Attending pediatricians complete a competency-based written evaluation of the resident at the end of the rotation (See Appendix D: Pediatrics Rotation Evaluation Form)

Required Reading

1> Pediatrics Helpbook  
2> UpToDate Topics  
   a. Evaluation and Treatment of Otitis Media  
   b. Evaluation and Treatment of Unconjugated Hyperbilirubinemia in newborns  
   c. Fever in the neonate and young infant (<3 months)  
   d. Clinical features, diagnosis, and treatment of Bronchiolitis  
   e. Developmental surveillance and screening in primary care  
   f. Asthma  
   g. Gastroenteritis

Recommended Resources:


2. Up To Date® available to all residents

The following is available in the “curricular references” folder:

1. Child Abuse Examination protocol

The following textbooks are available:


The following textbooks are available in Dr. Robinson’s office:


2. Smith’s. Recognizable Patterns of Human Malformation.


6. Access to FSU COM Medical Library for Ovid Searches, etc.

The following textbooks are available in Dr. Machado’s office:


2. Essential Evidence® online medical resource.

Suggestions to Residents:

♦ Remember to turn in the following paperwork daily to FMC office staff:

1) Completed pediatric service lists: essential for billing and documenting your experience and procedures. Please make sure the forms have all information requested.

2) Primary physicians’ copy of emergency room record: essential for billing, pediatric attending review, and follow-up information.

3) Telephone messages: Forward your documented phone message to Dr. Robinson on Allscripts.

♦ Notify the attending pediatrician of every admission as soon as possible (normal term newborn can wait until the following morning).

♦ Be thoroughly familiar with EVERY patient and newborn on the service regardless of resident-patient assignments.

♦ Notify other family practice residents or faculty promptly whenever one of their patients or newborns is admitted without their knowledge. Continue to keep residents and faculty informed of their patients’ progress.

♦ Be conscientious with communication. On the pediatric inpatient service, BOTH the on-call resident AND the on-call attending change EVERY DAY.

♦ Share questions, concerns, and problems with faculty promptly.
READ about your patients.

You are responsible for admitting patients from the following sources:
1. All FMC pediatric patients
2. Private patients admitted to the Hospital Service
3. Private patients admitted by Whit Oliver, M.D.
4. Unassigned patients (if it is the hospitalist service’s turn to do so).

Addendum to the Pediatric Syllabus:

Resident’s Responsibilities

I. On Call

A. Nursery

When on call (yes, even on the first day of the rotation), you are responsible for all of our newborn exams in the nursery. The babies with the orange stickers on their cribs are our patients. You will be expected to round in the newborn nursery twice daily, in the a.m. with the attending hospitalist for the nursery service, and in the evening to see any babies born during the day or evening. You will not be expected to pre-round in the nursery before attending rounds.

You will likely be making your evening rounds in the mother’s rooms, as the nursery staff expects you to see new babies in the mother’s room. Keep records of the mothers’ room numbers. Talk with the mothers daily about their baby’s health status and any concerns they may have. At discharge, issues to discuss with them include feedings, positioning, cord care, circumcision care (if appropriate), use of car seats, fever, and jaundice. Be sure at discharge that they have a follow-up appointment in the FMRP office or their pediatrician’s office within two days (if discharged at or before 48 hours) or three days.

Make sure that each mother has a copy of the residency’s Baby Tips booklet prior to discharge. Residents on the Pediatrics rotation are responsible for making sure that copies of “the baby book” are available in the nursery. When more copies of the book are needed, ask in the medical records department of our office.

B. Pediatric Ward

Many admissions will be direct admits from local pediatricians. You will be paged when the child arrives and, often, orders are already written. Before admitting anyone to the floor, the case should be discussed with the attending on call. It is necessary to discuss all ED cases with the attending before discharging or admitting a patient. However, any case you have questions about should at least be seen with a backup resident before releasing the patient from the hospital.
II. Post Night Float Call

Resident responsibilities post-call are to pre-round and write progress notes on inpatients prior to morning rounds. He/she should also check out to the resident coming on call before departing. All admissions from the night prior should be documented in the black Pediatrics Book. Phone triages, ER discharges, and FMRP discharges should also be placed here, once they are signed by the attending. It is imperative that the resident indicates whether the patient is to be billed by FMRP, Dr. Truman or Dr. Oliver. This book should be submitted to the Administrative Coordinator’s office before you go home. The resident on call needs to pick up this book from his/her mailbox sometime after lunch.
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A. PATIENT CARE (PC)

2) PC2. Gathering Essential Information
Below Expectations = Often misses and/or misinterprets important information related to symptoms and problems
Meets Expectations = Consistently gathers information relevant to symptoms and problems

3) PC3. Informed Decision Making
Below Expectations = Frequent significant errors in judgment
Meets Expectations = Usually shows good judgment with clinical problems

4) PC4. Presents Patient Cases
Below Expectations = Patient presentations are confusing and/or incomplete
Meets Expectations = Patient presentations are acceptable

5) PC4. Develops adequate differential diagnosis
Below Expectations = Inadequate differential diagnoses for level of training
Meets Expectations = Acceptable differential diagnoses for level of training

6) PC4. Develops and Carries Out Patient Management Plans
Below Expectations = Often does not identify current or past treatment. Treatment plan inappropriate. Does not recognize when urgent treatment is needed.
Meets Expectations = Identifies current and past treatment. Formulates reasonable treatment plans. Consistently recognizes need for urgent treatment

7) PC4. Follows through in Patient Care
   Below Expectations = Forgets to write orders, know patient's condition, know x-ray and lab results or write timely notes.
   Meets Expectations = Patient care follow through is complete regarding orders, knowledge of patient condition and documentation.

8) PC5. Counsels and Educates Patients and Families
   Below Expectations = Often does not counsel or educate patient or family.
   Meets Expectations = Counsels and educates patient and family appropriately.

9) PC6. Uses information technology for Patient Care/Education
   Below Expectations = Cannot use Power Chart or online/PDA resources for patient care/education.
   Meets Expectations = Uses Power Chart easily. Uses online/PDA resources for patient care/education.

10) PC/HA. History/Physical
    Below Expectations = Unacceptable History/Physical for level of training.
    Meets Expectations = Competent to perform an acceptable History/Physical for level of training.

11) PC9. Works with Health Care Team for Patient's Benefit
    Below Expectations = Has difficulty working with team to benefit the patient.
    Meets Expectations = Usually works well with health care team for the patient's benefit.

B. MEDICAL KNOWLEDGE (MK)

12) MK1. Investigative and Analytical Thinking
    Below Expectations = Takes little or no initiative in building knowledge base. Needs constant prompting; Resistant to feedback.
    Meets Expectations = Expected interest in learning. Responds to feedback appropriately.

13) MK2. Knowledge and Application of Basic/Clinical Sciences
    Below Expectations = Major knowledge gaps.
    Meets Expectations = Adequate; expected gaps of knowledge for level of training.

C. PRACTICE BASED LEARNING AND IMPROVEMENT (PBL)

14) PBL2. Locate, Appraise, Associate Evidence from Scientific Studies
    Below Expectations = Can't access or does not use evidence based medicine on patient decisions.
Meets Expectations = Often uses scientific evidence for their patient's care.

15) PBL7. Incorporates Feedback into Practice
   Below Expectations = Resistant to feedback
   Meets Expectations = Incorporates feedback into practice

D. INTERPERSONAL AND COMMUNICATION SKILLS (ICS)

16) ICS1. Creation of Therapeutic Relationship with Patients
   Below Expectations = Periodic patient complaints from more than one patient.
   Meets Expectations = Patients seem pleased with their relationship with physician. Rare patient complaints

17) ICS3. Communication with Health Care Team
   Below Expectations = Subject of complaints from other physicians and ancillary staff about interactions. Others prefer not to work with him/her.
   Meets Expectations = Good rapport with other physicians and staff. Overall feedback regarding interactions is positive.

18) ICS4. Comprehensive, Timely Legible Medical Records
   Below Expectations = Records are either incomplete, untimely or illegible.
   Meets Expectations = Records are complete, legible and timely

E. PROFESSIONALISM (P)

19) P1. Respectful and altruistic.
   Below Expectations = Lacks empathy, cultural sensitivity and/or respect. Puts own interests first.
   Meets Expectations = Consistently demonstrates sensitivity to adverse population, empathy and respect. Consistently puts patients' needs first.

20) P6. Integrity/Department.
   Meets Expectations = Honest and truthful. Acknowledges personal limits. Shows self-control in a variety of circumstances.

F. SYSTEM BASED PRACTICE (SBP)

21) SBP1. Understands interaction of practice with larger system
   Below Expectations = Does not understand how his/her clinical decisions effect patients and the various health care systems in which the patient could be involved. Does not satisfactorily manage/coordinate patient care.
   Meets Expectations = Frequently understands how his/her clinical decisions effect the patient and various health care systems in
which the patient could be involved. Satisfactorily manages/coordinates patient care

G. OVERALL

22) Strengths

Remaining Characters: 5,000

23) Areas for Improvement

Remaining Characters: 5,000

24) Comments

Remaining Characters: 5,000

25) Overall, how would you rank the resident's performance

Below Expectations  Meets Expectations  Above Expectations

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26) Does this resident need to repeat this rotation

Yes  No

O  O

Return to Questionnaire List