

**University of Florida College of Medicine
Department of Pediatrics Medical Education**

**Third Year Pediatric Clerkship Syllabus
2020-2021**



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Message from the Chair

College of Medicine
Health Science Center
Department of Pediatrics
Chairman's Office

Box 1000296
Gainesville, Fl. 32610 -0296
352-392-3337
352-392-0481 Fax

Future Physicians

I would like to take this opportunity to welcome you to the Department of Pediatrics. During the next eight weeks, we will introduce you to a specialty which deals with the entire gamut of health care, encompassing preventive medicine, primary care, and critical care. You will be introduced to the pediatric sub-specialties of Neonatology, Pulmonology, Gastroenterology, Nephrology, Cardiology, Endocrinology, Immunology, Genetics, Infectious Diseases, Critical Care, Rheumatology and Hematology-oncology. You will see children cared for in a variety of clinical environments in a family-centered, developmentally appropriate manner where quality of care and concern for the growing child is paramount.

The pandemic has given us to rethink how to best meet the evolving needs of our patients and community, all of whom deserve a high performing organization to serve them. Our Department of Pediatrics is dedicated to the principles and practices of education, and we are committed to providing you with the knowledge and skills, which are the prerequisites for success in your professional career.

Welcome! I look forward to meeting you in the coming weeks.

Sincerely,

Desmond Schatz, M.D.
Professor and Interim Chair of Pediatrics
University of Florida College of Medicine

Goals and Objectives

Welcome to your 3rd year Pediatric Clerkship. During the next eight weeks, the door will be opened to a unique and exciting part of your medical education. We are eager to provide a stimulating educational environment in which you can acquire the knowledge, skills, and attitudes important in the care of infants, children, and adolescents. The Department of Pediatrics places the highest priority on your education. We hope you will display an eagerness to learn, ability to teach yourself and others, and appreciate the special nature of children and their health problems. We have set the following as goals for you to accomplish during this experience:

Goals

- Provide an educational program that helps prepare our students for any residency they may choose as part of the general professional education.
- Prepare students to be exemplary house officers.
- Acquisition of basic knowledge of growth and development (physical, physiologic and psychosocial) and of its clinical application from birth through adolescence.
- Development of communication skills that will facilitate the clinical interaction with children, adolescents, and their families and thus ensure that complete, accurate data are obtained.
- Development of competency in the physical examination of infants, children, and adolescents.
- Acquisition of the knowledge necessary for the diagnosis and initial management of common acute and chronic illnesses.
- Development of clinical problem-solving skills.
- An understanding of the influence of family, community, and society on the child in health and disease.
- Development of strategies for health promotion as well as disease and injury prevention.
- Development of the attitudes and professional behaviors appropriate for clinical practice.
- An understanding of the approach of pediatricians to the health care of children and adolescents.
- Begin to understand an educational plan for continuous learning throughout your medical career (ILP).

Objectives

The Department's expectations of your performance are in line with the College of Medicine's competency based curriculum. There are several objectives, both general and specific. You will experience, be taught, and evaluated specifically in the following competencies:

- **Professionalism (P)**
- **Practice-based learning (PBL)**
- **Patient care (PC)**
- **Interpersonal Communication (IC)**
- **Medical knowledge (MK)**
- **System based practice SBP)**

General:

- Demonstrate the professional conduct necessary for a successful clinical interaction with patients and families (P).
- Demonstrate respect of patient, parent and family differences in attitudes, behaviors and lifestyles paying particular attention to cultural, ethnic, and socioeconomic influences (P).
- Demonstrate intellectual curiosity, initiative, responsibility, honesty, and reliability (P).
- Demonstrate solicitation, acceptance, and action on feedback (P).
- Demonstrate collegiality and respect for all members of the health care team (P).
- Evaluate patients from infancy through adolescence in a variety of clinical settings, establishing rapport with the patient and family in order to obtain a complete history and physical examination (PC).
- Prepare a complete written summary of the history and physical and orally present the case in a focused and chronological manner (PC) (IC).
- Identify clinical problems and outline an initial diagnostic and therapeutic plan (PC).
- Know when hospitalization and diagnostic tests are indicated (PC).

- Select the diagnostic tests which are most likely to be useful and be aware of their costs and limitations (PC) (SBP).
- Effectively communicate information about the diagnosis and treatment to the patient and caregiver (IC).
- Obtain updated information relevant to the diagnosis and treatment of the patient, performing a literature search and critical review of the literature (PBL).

Specific:

Health Supervision (MK, PC, IC)

- Describe the content of a health supervision visit and the factors used to determine the frequency of such visits. Gather health supervision data from a focused history and physical examination.
- Discuss the appropriate use and interpretation of the following screening tests: Neonatal screening, Developmental screening, Hearing and vision screening, Lead screening, Drug screening, Hemoglobin screening, Cholesterol screening, TB testing
- Demonstrate the ability to provide anticipatory guidance: nutrition, behavior, injury prevention, immunizations, pubertal development, sexuality, and substance use and abuse.

Growth (MK, PC)

- Accurately measure height, weight and head circumference and plot the data on an appropriate chart.
- Include an assessment of growth in the patient work-up.
- Identify abnormal growth patterns and explain the initial assessment.
- Outline the initial evaluation of a child with failure to thrive.
- Identify by history, growth pattern and physical findings, the child with hypothyroidism and growth hormone deficiency.

Development (MK, PC)

- Perform appropriate developmental screening on all patients as part of the health maintenance visit or inpatient evaluation.
- Utilize knowledge of the developmental stages in the interaction of the patient and physician in the clinical setting.
- Summarize the main adolescent developmental changes that are important to discuss with parents and adolescents.
- Explain how to perform and assign the sexual maturity rating (Tanner) as part of the examination for adolescent.

Behavior (MK, PC)

- Take a complete and relevant history and perform a pertinent physical examination on a patient who presents with a behavioral problem.
- Elicit age appropriate behavioral concerns during the health supervision visit.
- Distinguish between age-appropriate “normative” behavior and psychiatric illness.

Nutrition (MK, PC)

- Discuss the nutritional advice to provide families regarding breast feeding vs. formula feeding, why and when solids are added to an infant's diet, use of cow's milk
- Discuss how to advise families about the dietary prevention and treatment of common pediatric mineral (iron, fluoride, and calcium) and vitamin deficiencies.
- Obtain a routine diet history on an infant that includes: the type of feeding (breast vs. formula) with amount and frequency, types and approximate amounts of solids, and diet supplements given (vitamins, fluoride, iron).
- Determine whether a formula-fed infant is receiving adequate calories.
- Recognize when nutritional assessment is necessary beyond infancy, and demonstrate how to obtain a daily diet diary.

Prevention of Illness and Injury (MK, PC, IC)

- Assess the immunization status of an infant, child or adolescent during a health care visit. Initiate a discussion about immunizations with the family of an infant, a toddler, a child about to enter school, 7th grade, and college.
- Provide anticipatory guidance about injury prevention to the patient and family of an infant, a toddler, a preschool age child, school age child and adolescent.

Issues Unique to Adolescence (MK, PC, IC)

- Conduct a health maintenance visit on a healthy early, middle and late adolescent incorporating a developmental assessment, risk behavior assessment, and preventive counseling.
- Assign a sexual maturity rating (Tanner stage) during the evaluation of the adolescent in the clinical setting.
- Describe pertinent features of the history, physical examination when evaluating a boy or girl with delayed pubertal development.
- Describe one's approach to counseling a teenager concerned about contraception and sexually transmitted diseases and AIDS, or a youth who engages in high risk behavior

Issues Unique to Newborn (MK, PC, IC)

- Gather appropriate history from parents/guardian and chart; perform a physical exam on a well or ill newborn and describe routine issues for counseling parents.
- Discuss routine admitting orders for the normal newborn.
- Develop a reasonable differential diagnosis and evaluation scheme for newborns with clinical presentations. Diagnoses may include jitteriness or Seizures, Bilious Vomiting, Jaundice, Hypoglycemia, Lethargy or Poor Feeding, Sepsis, Respiratory Distress, Rashes, Cyanosis, Delayed Passage of Meconium, Heart Disease, Pulmonary Disorders.

Medical Genetics and Congenital Malformations (MK, PC, IC, PBL)

- Gather basic data from history/physical exam.
- Consider useful laboratory tests when evaluating a child with a possible common genetic disorder or a congenital malformation.

Chronic Illness (MK, PC, IC, SBP)

- Perform an initial history and physical examination on a new patient who presents with a chronic illness. Include assessment of growth and pubertal development.
- Take an interval history and problem focused exam on a patient seen in follow-up for their chronic disease.
- Interact effectively with other members of a multi-disciplinary team caring for the child with a chronic illness.
- Outline the basic management for a child who presents with the following chronic diseases: allergic rhinitis, chronic urticaria, asthma, sickle cell disease, seizure disorder, insulin dependent diabetes mellitus, cystic fibrosis, hemophilia, childhood malignancies.
- Provide anticipatory guidance to the family of a child with one of the above chronic diseases, alerting them to the clinical symptoms that would signal complication from the disease or its treatment.

Therapeutics (MK, PC, SBP)

- Demonstrate the ability to write a prescription.
- Explain how a drug dose is calculated for infants and pre-pubertal children.
- List the most common generic types of medications used for management of the following uncomplicated conditions: otitis media, asthma, conjunctivitis, allergic rhinitis, urinary tract infection, impetigo, eczema, fever, streptococcal pharyngitis, acne

Fluid and Electrolyte Management (MK, PC, IC)

- Write maintenance fluid orders.
- Obtain historical information to assess state of hydration. Recognize the physical exam findings of dehydration.
- Calculate and write IV orders for initial fluid replacement and maintenance fluids for a patient with dehydration from 1) gastroenteritis, or 2) diabetic ketoacidosis.
- Explain the clinical consequences of electrolyte disturbances, including hypernatremia, hyponatremia, hyperkalemia, and hypokalemia, and discuss the effect of pH on the serum potassium level.
- Explain to parents how to use oral rehydration therapy for mild /moderate dehydration.

Poisoning/Prevention and Treatment (MK, PC, IC, SBP, PBL)

- Provide anticipatory guidance regarding home safety and appropriate techniques to prevent accidental ingestions.
- Demonstrate knowledge about the use of the poison control center and other information resources in the management of the patient with an ingestion.
- Describe the general principles of poison management to include obtaining essential information on the telephone.

Pediatric Emergencies (MK, PC)

- Recognize how the signs of shock in a child differ from those of an adult.
- Provide presentation and initial diagnostic assessment/management for the following: Shock, Ataxia, Seizure, Mental status changes, Respiratory Distress, Apnea

Child Abuse (MK, PC, IC, SBP)

- Know the types of questions to ask in assessment of a child for non-accidental injuries and child abuse.
- Summarize the ethical responsibilities to identify and report child abuse and the obligation placed on reporters by community or state.

Child Advocacy (PC, MK, SBP)

- Describe behaviors preventing children from access to health care.
- Identify the ways that practicing physicians can advocate for children.
- Describe the types of problems that benefit more from a community approach rather than an individual patient approach.

Common Pediatric Illnesses (MK, PC)

- Develop a diagnostic approach to any of the following clinical problems: Cough, Diarrhea (+/-) vomiting, Fever, Dermatitis/Rash, Sore Throat, Wheezing, Otitis/Ear Pain, Eye Trauma, Joint/Limb Problems, Erythema/Swelling, CNS Problems, Abdominal Pain, Muscle Weakness, Rectal bleeding
- Discuss the characteristics of the patient and of the illness that must be considered when making the decision to manage the patient in the outpatient setting or to admit to hospital.
- Explain how the physical manifestations and the evaluation and management of many pediatric illnesses vary with the age of the patient. Give specific examples.
- Discuss in some detail the appropriate uses of these diagnostic tests: chest x-ray, lumbar puncture and CSF examination, EEG, radiologic imaging, echocardiogram.
- Develop a diagnostic approach to any of the clinical signs listed below: Heart Murmur, Lymphadenopathy, Splenomegaly, Hepatomegaly, Abdominal Mass, Impaired Vision, White Pupillary Reflex, Impaired Hearing, Pallor/Anemia, Bleeding (Superficial), Bleeding (deep tissue), Hematuria, Proteinuria.

In 1995 the UF student body enacted an [honor code](https://www.dso.ufl.edu/sccr/process/student-conduct-honor-code/) and voluntarily committed itself to the highest standards of honesty and integrity. When students enroll at the university, they commit themselves to the standard drafted and enacted by students. The entire document may be accessed at <https://www.dso.ufl.edu/sccr/process/student-conduct-honor-code/>

Clerkship Organization & Locations

Administration

Department Chair:

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Gainesville Pediatric Locations

Inpatient

Shands Children's Hospital

1600 SW Archer Road

Gainesville, FL 32610

(800) 749-7424

(352) 265-8000

Emergency Department: 1st Floor, East Entrance

Pediatric Wards (Green, Orange, Blue, Cards) 4th Floor, 4200, 4500, 4400 wings

Newborn Nursery: 3rd Floor

Outpatient

UF Health at Children's Medical Services (CMS) Clinic

1701 SW 16th Avenue -Gainesville, FL 32608

(352) 334-0206 – Medical Director Dr. Lindsay Thompson lathom@ufl.edu

Endo Clinic at either CMS or Med Plaza, 2nd Floor Pediatric Specialty Clinics - 2000 SW Archer Road

UF Health at Tower Square (TS) Clinic

7046 Archer Road - Gainesville, FL 32607

(352) 373-1770 – Medical Director Dr. Carolyn Carter cartcg@shands.ufl.edu

UF Health at Magnolia Park Clinic

4740 NW 39th Place, Suite B - Gainesville, FL 32606

(352) 594-7337 – Medical Director Dr. Maureen Novak – novakmn@ufl.edu

UF Health at Tioga Town Center

133 SW 130th Way, Suite C – Newberry, FL 32669

(352) 733-7337 – Medical Director Dr. Maria Kelly kellymn@peds.ufl.edu

Pediatric Experience

Pandemic Expectations

University of Florida College of Medicine students are part of the healthcare team during clinical rotations, preceptorships, and patient experiences associated with required and elective courses. As members of the healthcare team, students are expected to provide care to all patients within our healthcare system at a level appropriate to their training and with supervision. Students should expect to have appropriate personal protective equipment available based on infection control recommendations in order to safely care for patients. Students will not be expected to care for patients with active SARS-CoV-19, however, they will not be prevented from doing so.

In the event that a student believes they should be exempted from certain clinical duties because of a high risk medical condition, the student will have to work with the Disability Resource Center (DRC) to identify appropriate accommodations. The request for accommodations will then be reviewed by the College of Medicine to ensure the goals and objectives of the clinical curriculum can be met.

In the event that a student is unable to perform the duties that are required to meet the goals and objectives of the course or clerkship, a leave of absence will be required. If the prolonged absence is due to a medical condition that will result in an absence greater than 6 weeks, the student should apply for a medical leave of absence. If a student is unwilling to work in the clinical setting because of concern for their own safety, then they should apply for a personal leave of absence. Please refer to the student handbook for more information about leaves of absence. <https://osa.med.ufl.edu/files/2014/04/Policies-and-Procedures-Handbook.pdf>

If a student feels ill or has a suspected COVID exposure, call the Student Health Blue Team at 352-294-5700 for guidance and testing.

60% Core Competencies

While experiencing the variety of settings that combine to create the field of pediatrics, you will be assessed by the faculty, staff, and some patients that you come in contact with. These assessments are based on five ACGME Core Competencies: Professionalism, Patient Care, Practice-Based Learning, Interpersonal & Communication, and System-Based Practice. Pediatric areas you may experience are:

- Inpatient Experience
 - Blue Team or Orange Team(2 Weeks): General and subspecialty patients
 - Green Team (Heme/Onc and rheum), Endocrinology, Cardiology, or Neurology (2 Weeks)
- Outpatient Clinical Experience (2 Weeks)
 - General Pediatrics – Primary, Acute, Adolescent Care (2 weeks)
 - Newborn Nursery (1 week)
 - Pediatric Emergency Department (1 week)

20% Portfolio Compilation

The intent of the portfolio is to ensure a well-rounded education experience during the Pediatric Clerkship. The following required items are intended to assist in the development of your medical skills by providing opportunities to practice newly acquired skills and attain feedback on your progress. An attempt should be made to finish 50% of the requirements by Week 4 so to ensure completion. Pages 18-28 provide examples of several of the requirements listed below.

1. Ethics Conference: During your time in Gainesville, you will participate in a conference where you bring forth an ethical issue encountered during your time within inpatient wards. A short write-up is required for the conference and **must be submitted to Canvas by Monday at 8 am the week of the conference**
2. Safety Presentations: During your time in Gainesville, you will participate in a conference where you will present a safety issue encountered during your time within inpatient wards. You will receive formative feedback on your team's presentation. This PowerPoint presentation will be presented as a ward team and should be uploaded **on each team member's Canvas Portfolio by the end of week 8.**
3. Structured Clinical Observation Form: Anytime during your rotation, have a faculty or resident observe you perform a full H+P utilizing the SCO form. Afterwards, review with the faculty or resident for feedback.
4. Tobacco Quiz: You will be review the Tobacco Education Curriculum on Canvas. Once finished, and with the use of additional resources, (of your discretion) completely answer questions regarding four cases. These completed cases are **due for submission in Canvas at 11:59 Monday of week 2 of your Pediatric outpatient experience.**
5. Individualized Learning Plan (ILP): One ILP will be written and executed during your clerkship time. The ILP should define learning goals, strategies by which the goals will be achieved, reflection of completion and a method of measuring your outcome. You will review your ILP with an assigned faculty member within a pediatric setting and, at the end of the rotation; your ILP advisor will review your ILP for a summative evaluation. **Upload ILP to Canvas by the end of week 8.**
6. Pediatric Competencies Checklist: Date and initial each category as you complete. **Upload to Canvas end of week 4 and 7 for progress update; completed log due end of week 8.**
7. Self-Assessment of Core Competencies: Complete a self-assessment of your performance utilizing the pediatrics medical student self-assessment form and **upload to Canvas by the end of week 2** of the clerkship. You will receive a mid-rotation feedback and self-assessment report week 5 to compare your self-evaluations to those of clinical faculty and residents.
8. Aquifer Pediatrics Cases (<http://www.aquifer.org>): Of the 32 cases available online, **8 must be completed by the end of week 8.** Cases typically take 30-45 minutes to complete – a good goal is 1 a week, and can be paired with lecture topics or competencies you haven't seen or need more work on. To access, go to the home page and click 'courses' then 'Aquifer Pediatrics'. Login with your gatorlink user name and you will be prompted to create a password, and will then be able to access the cases.
9. Patient History & Physical (H&P) Write-ups: While you are inpatient, you are **required to write-up 4 patients' H&Ps. You must do one formal H&P per week of inpatient experience** and turn them into the ward attending by Thursday each week, review them for feedback to improve and upload to Canvas **by the end of week 8.**
10. Outpatient Clinic Note Write-ups: While you are in the outpatient clinics, you are **required to write-up 2 formal patients' notes and solicit feedback. You must do one formal clinic note per week of outpatient clinic experience** and turn them into the clinic attending, review them for feedback to improve and upload to Canvas **by the end of week 8.**
11. Hand Off Educational Activity and Evaluations: During week 1 of your pediatric inpatient experience, you will review the a Powerpoint on patient hand offs titled "Patient Hand offs" on Canvas. You will then complete a graded quiz on the material **due for submission in Canvas at 11:59 Monday of week 2 of your pediatric inpatient experience.** Following this assignment, you will participate in an evaluation process for patient hand offs as an evaluator and evaluatee. You will expected to complete at least 4 hand off evaluations. You will evaluate a resident performing a patient hand off (at least 2) and then ask a resident or faculty member to evaluate you performing a patient hand off (at least 2). It is your responsibility to supply the evaluation form (in your welcome binder and on Canvas). Your evaluations of the resident should be anonymous (not include their name) but must include their training level. You do not need to share your evaluations with the residents, but they should share their evaluation of you. The purpose of the resident evaluations area for you to identify the

key components for a successful patient hand off. These 4 completed evaluations (2 as evaluator, 2 as evaluatee) should then be **uploaded to your Canvas portfolio no later than Friday 11:59pm, week 8.**

12. **Parent Evaluation:** One parent or patient must complete this evaluation. **Hand in to Meghan or upload to Canvas by the end of week 8.**

13. **Evaluations:** You are required to complete 30 evaluations **by the end of Week 8.** These evaluations include an aggregate of 15 lecture, 7 faculty, 7 resident and 1 program evaluations. **All evaluations are in New Innovations.**

20% Medical Knowledge

Your efforts on the NBME shelf exam, given the last day of rotation, comprise 20% of your total Pediatric Clerkship score. There are plenty of resources to help you prepare including the online Aquifer cases, practice CLIPP Exam and daily prep questions on Canvas, books available for check-out in the Pediatric Medical Education Office (HD-513), and a Shelf Review conducted with the Clerkship Director. We want you to excel in this area so if you are feeling underprepared or overwhelmed, let us know! We're here to help.

Final Grade Determination

The final grade of the Pediatric Clerkship Program is determined by the outcomes of these three sections: Core Competencies, Portfolio Compilation, and Medical Knowledge.

Total Grade (100%) = Core Competencies (60%) + Portfolio (20%) + Medical Knowledge (20%)

Remediation Policy

Students must satisfactorily complete all required components of each clerkship. Students who do not do so will receive an incomplete grade (H) for the clerkship until all components are satisfactorily completed. Students with an unsatisfactory performance in any area should discuss the process and timing of remediation with the clerkship director. Failure to satisfy a clinical or professionalism component is remediated by the satisfactory completion of an individualized plan of remediation. This remediation should be proposed by the clerkship director and approved by the Academic Status Committee.

Rotation Schedules

There are several schedules you will be utilizing while in Pediatrics. We've made every attempt to keep them as simple as possible. There are two types of schedules: academic schedules and clinical schedules.

General Gainesville Academic Schedule

While in Gainesville you are expected to attend Morning Reports M-W and Friday at 8 am in Room 4433. Thursdays you are expected to attend Grand Rounds at 8 am in C1-4. Sample schedule shown below – your rotation may differ:

<p>Week One:</p> <ul style="list-style-type: none"> • Orientation • Rotation begins • Begin Reading for Tobacco Case <p>Week Two:</p> <ul style="list-style-type: none"> • Gator Sessions • Question & Answer session • Case Conferences begin • Tobacco case module due • Harrell Center Video Taping 	<p>Week Five:</p> <ul style="list-style-type: none"> • Gainesville/Jacksonville switch • Gator Sessions • Case Conference • Ethics Conference <p>Week Six:</p> <ul style="list-style-type: none"> • Gator Sessions • Question & Answer session • Case Conference • Harrell Center Video Taping • Shelf Review
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<p>Week Three:</p> <ul style="list-style-type: none"> • Gator Sessions • Ethics Conference <p>Week Four:</p> <ul style="list-style-type: none"> • Gator Sessions • Case conference • Safety Presentation • Week 4 Progress Report 	<p>Week Seven:</p> <ul style="list-style-type: none"> • Gator Sessions • Case Conference • Ethics Conference • Week 7 Progress Report <p>Week Eight:</p> <ul style="list-style-type: none"> • Gator Sessions • Case Conference • Safety Presentation • Shelf Exam/Clerkship Debriefing
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Learning Sessions, Ethics Conferences, Safety Presentations, and Other Responsibilities

This schedule is used primarily for relaying the dates, times, locations, and subject matter for all Gator Sessions and other Pediatric Clerkship activities. If you are in Gainesville, your attendance is required at these weekly Tuesday sessions. Supplemental cases are provided on Canvas. It is **required** that you prepare for Gator Sessions by reading these materials. An example of this schedule is below.

Tue May 21, 2019	 Health Supervision Learning Session - Dr. Parker - HMEB 128 *attend*	due by 12pm
	 Growth and Development Learning Session - Dr. Novak - HMEB 128 *attend*	due by 1pm
	 Clerkship Check-in #1 - Dr. Kelly and Meghan Lopez - HMEB 128 *attend*	due by 2pm
	 Case Conference - Dr. Kelly - HMEB 128 *attend*	due by 2:30pm
	 Hematology Learning Session - Dr. Davis - HMEB 128 *attend*	due by 3:30pm

Physician schedules change constantly and therefore this schedule is subject to change to accommodate their schedules. Please ensure preparedness by checking your Canvas calendar frequently.

Pediatric Observed History and Physical and Review

This schedule determines when you will participate in a video taping of a pediatric observed history and physical. You will participate while in Gainesville, generally either week 3 or week 5. Following the recorded examination at the Anaclerio Learning and Assessment Center, a designated faculty member will review the recording with you in an effort to further your examination and interpersonal communication skills. The dates of both the exam and review are pre-determined and CANNOT be changed, substituted, or switched.

Inpatient/Outpatient Rotation Schedule

Your clinical assignments are provided in the Inpatient/Outpatient Rotation Schedule. This schedule is divided into two parts, the general overview of all eight weeks and then sub-schedules for each rotation. The rotations and their corresponding sub-schedule are color-coded to help with interpretation. If ever there is a question about your Gainesville schedule contact Meghan at 352-273-8594 or by email at clerkship@peds.ufl.edu. Your concern will be addressed promptly.

An example of how to read this schedule is below:

Smith, Tom					JAX OUPT	JAX OUPT	JAX OUPT	JAX OUPT
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Tom has been assigned to orange team (Weeks 1 & 2), Silver -Gastroenterology (Weeks 3 & 4) Below this are the schedules for all rotations. Tom simply must identify the appropriate ones based on the color-coding.

Weeks 1 & 2 Schedule:

Orange Ward	6A-5P	6A-12P/Lectures	6A-5P	6A-5P	6A-5P	OFF	OFF
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Weeks 3 & 4 Schedule:

Heme/Onc Ward	6A-5P	6A-12P/Lectures	6A-5P	6A-5P	6A-5P	OFF	OFF
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During weeks 5-8, he will be in Jacksonville and will receive that schedule from Jacksonville in Week 4.

Attendance & Absences

Attendance is required at all clerkship activities. In the third and fourth year clinical clerkships and electives, daily attendance is required for all aspects of the clinical rotations. During clinical rotations, typical “holidays” are not taken unless specifically mentioned by the clerkship (Christmas and Thanksgiving are exempt from this rule). If you have any unexpected or planned absences, you **MUST** notify those faculty members who supervise your clinical experiences **and** the Pediatric Medical Education Office. The pediatric clerkship adheres to all COM policies and procedures.

On the Pediatrics clerkship, we consider you an integral member of the team with patient care responsibilities. Thus, when you are absent, someone else covers these responsibilities. Unlike an undergraduate course, you cannot "make-up" most assignments. For this reason, on this clerkship, planned absences are strongly discouraged and should be reserved for emergency situations.

In the event of an unplanned absence, you will be required to make-up the time missed in order to ensure adequate clinical experience. This may require an extra call or weekend experience. Failure to adhere to these policies and procedures will result in a lowered professionalism competency score.

Medical Absences

Students are encouraged to maintain their own personal health throughout medical school. This includes their dental, mental and/or physical health. Ideally, students will make every effort to schedule these appointments at dates/times that do not conflict with required education activities. When this is not possible, students must submit their request for an excused absence to the relevant course/clerkship director(s). Upon approval, the director will notify the student of makeup requirements and due date, if appropriate. Additionally, students will not be penalized for absence from class or other scheduled academic activities for medical reasons. This applies to absences for acute illnesses as well as to absences due to regularly scheduled ongoing treatment for dental, mental or physical health. For any questions and/or concerns regarding this policy, students are to consult the Associate Dean for Medical Education or Student Affairs.

Unplanned Absences

Gainesville: In the event of a single-day, unexpected absence due to illness, you **MUST** notify Meghan in the Pediatric Medical Education office preferably by email (clerkship@peds.ufl.edu) but also by phone (352) 273-8594 as soon as physically possible. If unable to reach the Pediatric Medical Education office, contact the UF Office of Student Affairs. If longer than a single day, the COMCEC Staff must be emailed at UFMedEd@ahc.ufl.edu in addition to the Pediatric Medical Education office.

It is essential for students not to come to work if feeling ill and to call the COVID Hotline at 352-265-5550 for assessment and instructions on testing and ability to work in a clinical area.

Jacksonville: In the event of any unexpected absence due to illness or an unexpected absence lasting more than one day, the Pediatric Medical Education office (352-273-8594, clerkship@peds.ufl.edu), COMCEC office (UFMedEd@ahc.ufl.edu), and Jacksonville Clerkship office (904-633-4176, tara.mccormack@jax.ufl.edu; fgenuard@ufl.edu) must each be notified immediately.

Planned Absences

Students must contact the clerkship director as far in advance as possible (these requests **must** be made at least **4 weeks** prior to the beginning of the clerkship) to discuss and obtain the permission of the clerkship director to be absent from assigned responsibilities in the case of planned meetings, events such as weddings or family gatherings, or the observation of a personal religious holiday. If the student is in Jacksonville at the time of the planned absence this request must also be sent to the Jacksonville clerkship director, Dr. Genuardi, in the same time frame. Once permission is obtained for the planned absence, the student must notify COMCEC of the approved dates for the absence.

Holidays

Students are allotted the following holidays: Thanksgiving, Summer Break, and Winter Break. Thanksgiving is defined as beginning 7pm Wednesday and ending 5am Monday. Summer and Winter Break are determined by the UF COM Academic Calendar. The COM recognizes other holidays, both religious and secular, which are of importance to some individuals and groups. Students wishing to observe these holidays must inform the Pediatric Medical Education office before the Clerkship begins. In the event of such request, an alternate assignment or arrangement may be provided to ensure adequate clinical experience. The timing of this make-up work is at the discretion of the Clerkship Director and may fall during other holiday periods when appropriate. Missed days which cannot be completed before clerkship end date results in a grade of "Incomplete".

Clinical Setting Responsibilities

Inpatient Ward Services (4 Weeks Total)

Services include Orange Team, Blue Team, Green Team (Heme/Onc), Gold Team (Cardiology), and Endocrinology Team.

Expectations

- Attend expected work hours of 6:00 am-5 pm, including morning reports, morning rounds, chief and chairman rounds, grand rounds, and any other lecture that is advantageous to understanding the ward experience.
- Complete the Handoff Quiz in Canvas by Monday of week 2 or your inpatient block.
- Complete 4 handoff evaluations (2 evaluations of resident handoffs, 2 resident evaluations of your handoffs) and upload to Canvas or hand in to Meghan..
- Complete 4 H&Ps (1 weekly) and upload into Canvas Portfolio system by week 8.
- Complete a Self-Assessment of Competencies by week 2 (during first 4 weeks only).
- Determine team Safety Presentation topic and be adequately prepared to present.
- Turn in 1 parent/caretaker evaluations (per clerkship) to Meghan, and peer evaluations as assigned in New Innovations.

Roles and Responsibilities

- Complete an EPIC tutorial and have functional username and password before your first day of inpatient wards. The EPIC hotline is (352) 265-EPIC, if help is needed.
- Week's 1-4 students begin inpatient responsibilities immediately following orientation. Weeks 5-8 students report to 4433 at 7:45 am the Monday of Week 5 for a welcome and debriefing by the Chief Residents prior to morning reports.

- It is your responsibility to review and adhere to the standards outlined in the handouts provided by hospitalists on the first Monday of inpatient service.
- Observe a physician (senior resident or attending) perform a pediatric history and physical during Week 1 (or Week 5) and demonstrate a history and physical with a physician present before the end of the rotation.
- Participate fully in a team's activities including patient admission work-ups, rounding, and attending team and ward conferences. Morning report begins promptly at 8 am in 4433 and is immediately followed by work rounds. General Attending-taught rounds are scheduled by the individual attending and are generally held 2-3 times per week.
- Each student is to write progress notes on his/her patients DAILY before rounds. The students should discuss the written progress note daily with his/her intern.
- Follow a minimum of three to five patients concurrently, including both general and sub-specialty patients within your ward team. If more than five admissions are assigned to a student on a particular night, additional patients can be assigned to other students.
- Participate fully in the care of pediatric patients. Assist in performing procedures under the supervision of pediatric housestaff or attendings.

Newborn Nursery (1 Week)

Expectations

- Attend expected work hours of 8 am-5 pm, including morning reports, morning rounds, grand rounds, and any other lecture that is advantageous to understanding the Newborn Nursery experience.
- Participate in labor and delivery call from 8 am-5 pm. If an attended delivery is admitted to the NICU, follow that infant to the NICU and witness complete stabilization of that infant under the supervision of the pediatric residents and/or ARNPs

Roles and Responsibilities

- Complete an EPIC tutorial and have functional username and password before your first day. The EPIC hotline is (352) 265-EPIC, if help is needed.
- Report at 7:30 am for orientation on your first day within Newborn.
- Review the PowerPoint module entitled, "An Introduction to the Nursery" prior to day one of service. This will be emailed the week prior to starting Newborn Nursery and is also available online in Canvas.

Emergency Department (1 Week)

Expectations

- Attend expected work hours that vary from 7 am-11 pm, including morning reports, morning rounds, grand rounds, and any other lecture that is advantageous to understanding the Emergency Department experience.

Roles and Responsibilities

- Complete an EPIC tutorial and have functional username and password before your first day. The EPIC hotline is (352) 265-EPIC, if help is needed.
- Report as scheduled for orientation on your first shift within the ED
- When you rotate in the Emergency Department, you will be under the supervision of your assigned pediatric resident and the ED attending.
- You are expected to complete daily evaluation sheets on yourself and discuss with the ED attending at least 30 minutes prior to shift ending. This form will be emailed to you and is available on Canvas. Forms should be left with the attending to turn in on your behalf.
- You will evaluate and treat all patients felt to be appropriate. Please be sure that all patients are examined by and discussed with your supervisors before discharging them from the ED. At the beginning of the week,

introduce yourself to the residents. At each shift change, introduce yourself to the ED or pediatric attending, or pediatric resident.

Ambulatory Clinic (2 Weeks)

Expectations

- Attend expected work hours of 8 am-6 pm at the location and under supervision of the attending assigned to you by the schedule.
- Experience a variety of clinical settings and participate actively in patient care.
- Complete a self-assessment evaluation of competencies by week 2 and upload to Canvas (during first 4 weeks only).
- Attend 1 endocrinology half-day clinic as assigned.
- Complete 2 formal clinic notes (1 weekly) and upload into Canvas by the end of week 8.
- Turn in 1 parent/caretaker evaluation (per clerkship) to Meghan, and complete newborn peer evaluation as assigned in New Innovations.

Roles and Responsibilities

- Complete an EPIC tutorial and have functional username and password before your first day. The EPIC hotline is (352) 265-EPIC, if help is needed.
- Report at 8 am for orientation at your specified location on your first day within the ambulatory clinic. Most clinics run from 8 am-noon and 1 pm-6 pm. On your first day, introduce yourself to the front office staff. Acquaint yourself with the clinic system.
- Rotate as scheduled to one or more pediatric outpatient care sites staffed by a pediatrician, pediatric specialist and/or pediatric housestaff.
- See patients and present them to the attending.
- Write brief clinic notes on patient encounters within the EPIC system. Ask your attending how they would like to provide feedback on your notes.

Roles and Responsibilities of the General Attending

- The General Attending will distribute their goals and expectations on the first day of the rotation.
- The General Attending shall meet with the students at least 2-3 times per week for one-hour teaching sessions. These can be formal or informal in nature.
- The General Attending shall meet with the students two weeks into their rotation for a review of their progress and performance. They will review and comment on the self-assessment done by the student.
- The General Attending will review all history and physical write-ups, make comments, and then return them to the 3rd-year medical students as promptly as possible in order to facilitate incorporation into their portfolio.

Roles and Responsibilities of the Chief Residents

- The Chief Residents will provide the students with an initial orientation on the first day of the rotation.
- The Chief Residents will meet with the students weekly to discuss teaching cases, interesting patients and/or physical findings of interest during chief rounds.

Disaster Guidelines/Emergency Preparedness

During emergency conditions student safety is a priority.

- College of Medicine educational programs follow the University of Florida policies and procedures regarding the scheduling/cancelling of classes and operations. Adjustments in curriculum delivery will be made depending on the nature and extent of the emergency.
- Students on clinical rotations will be contacted by the clerkship directors regarding clinical operations. If clinical operations are open, students are expected to contact their faculty supervisor to confirm their attendance on inpatient clinical services and outpatient clinics to support patient care.

Students should check e-mail for safety announcement updates from the College of Medicine and University of Florida.

Additional information regarding UF emergency preparedness can be found at the following links.

- <https://emergency.ufl.edu/emergency-management-plans/>
- https://emergency.ufl.edu/wp-content/uploads/2013/08/UF-Basic-Plan_03042014.pdf

Student Services

College of Medicine Policies and Procedures Handbook

<https://osa.med.ufl.edu/policies-procedures/>

Disability Services

The University of Florida is committed to providing academic accommodations for students with disabilities. Students requesting accommodations must first register with the Disability Resource Center (DRC) (352-392-8565, <https://drc.dso.ufl.edu>) by providing appropriate documentation. Once registered, students should present their accommodation letter to the College of Medicine's ADA Representative, Mr. Jim Gorske (jgorske@ufl.edu), who will distribute the accommodation letter to appropriate course and/or clerkship directors, as needed, as well as the testing center. The University encourages students to register with the DRC as soon as they begin medical school or upon the verification of a disability.

Medical Student Mistreatment Policy

Mistreatment is any decision, act, or condition affecting a student that is determined to be illegal or unjust or that has created unnecessary hardship. Mistreatment may take the form of verbal or physical abuse, discrimination for any reason, or a requirement for individual service activity that is independent of requirements for other team members. When such an incident occurs, the student should take steps to address it. The student may first discuss the problem with the individual responsible for the negative action or with the Associate Dean for Medical Education, Associate Dean for Student Affairs, or the Associate or Assistant Dean for Diversity and Health Equity. The dean contacted by the student will then address the concern with the appropriate Course Director or Clinical Clerkship Director who is responsible for the educational activity in which the incident occurred. If the negative action occurred on the Jacksonville Campus, students may also discuss the matter with the Associate Dean for Students Affairs-Jacksonville, who will follow the same plan outlined above. A written record of incidents reported to one of the Associate or Assistant Deans will be maintained by the Associate Dean for Medical Education. Once the allegation of mistreatment is elevated beyond the level of the individual responsible for the incident, the reviewing authority should provide a written response to the student within ten business days of being notified of the incident. If the student is not satisfied with the response of the reviewing official, he/she may appeal first to the Senior Associate Dean for Educational Affairs and,

subsequently, to the Dean of the College of Medicine. At any point in the process outlined above, the student also may address his/her concern about mistreatment with the Director for Student Counseling and Development. This official may provide counseling to the student but is not responsible for attempting to redress the grievance. Students can report concerns in person, phone, email or through an online submission link:

<https://students.med.ufl.edu/about/student-mistreatment-report/>

Example: Independent Learning Plan

ILP project

Learning objective: *Improve my auscultation of pediatric murmurs*

When I first came to medical school, I was pretty set on PM&R as all my background had been as a PT aide with a degree in exercise physiology. I love neuromuscular disorders and I enjoyed my time working with this particular population when I was a PT aide. Therefore to me, it was obvious that as a physician I should treat these patients as well. However that changed when I was lucky enough to spend 1 week with Dr. Saidi during my first year of medical school.

I picked pediatric cardiology as my preceptorship because it seemed difficult to me and I wanted a random challenge to try something new. I found that not only did I love cardiology (especially how the physical exam is instrumental in determining the diagnosis), but that I also loved working with kids. Like most students, I was afraid that I would hurt them or worse yet that they wouldn't like me. That week made me fall in love with pediatrics and with cardiology. Therefore I want to use this project as a means to help me achieve my goal of pursuing pediatric cardiology. I'll start with the basics of identifying heart murmurs and work on really studying both normal physiologic murmurs and the more common pathologic murmurs. Finally, I'll review the 5 T's of cyanotic heart disease.

Strategies to improve:

1. **Uptodate** has several articles that I have found that will be useful.

a. [Cardiac causes of cyanosis in the newborn](#) by Robert L Geggel, MD

b. [Approach to the infant or child with a cardiac murmur](#) by Robert L. Geggel, MD

c. [Physiologic and pharmacologic maneuvers in the differential diagnosis of heart murmurs and sounds](#) by Bernard J Gersh, MB, ChB, Dphil, FRCP, MACC

2. **Blaufuss multimedia** (blaufuss.org) – a resource that briefly explains common cardiac murmurs with a short clip of the murmur. I also used various similar online websites that had audio clips.

3. **Medical literature** – These review articles about pediatric murmurs discussed the nomenclature of murmurs (grade, location) and techniques useful in accentuating particular murmurs that aid in interpreting the clinical finding.

a. Menashe V. Heart Murmurs. *Pediatr Rev.* 2007;28(4):e19-e22. doi:10.1542/pir.28-4-e19

b. Sapin SO. Recognizing Normal Heart Murmurs: A Logic-based Mnemonic. *PEDIATRICS.* 1997;99(4):616-616. doi:10.1542/peds.99.4.616

c. Evaluation and Management of Heart Murmurs in Children - American Family Physician. <http://www.aafp.org/afp/2011/1001/p793.html>. Accessed November 2, 2015

4. **Practice. Practice. Practice.** With feedback!

a. Spend 1 morning with Dr. Saidi at the Congenital Heart Clinic in GNV.

b. Spend 1 day on the inpatient cardiology service in Jacksonville.

5. **Visual study aid** consisting of a chart that organizes the heart murmurs into categories with associated pictures and murmur descriptions. See below.

Assessment of competency at onset of rotation: **Novice**

I feel confident in hearing murmurs, that is hearing S1 and S2 and concentrating on extra abnormal heart sounds, but I consider myself a novice in practically interpreting what I hear. I always ask myself, how does it change when I change the placement of my stethoscope? Is this murmur supposed to radiate to the axilla or up into the neck? How does patient position change affect the murmur? These are all questions that I don't feel confident in answering, and hence this is my goal for this pediatric rotation. I want to build on my basic knowledge of the physiology of heart murmurs and practice applying the maneuvers that manipulate what I hear to help me differentiate the etiologies.

Evidence of completion: **Made progress**

It would be pretty impossible to master auscultation of heart murmurs in 8 weeks, especially since doctors' train for 3+ years in cardiology alone. That being said, I do believe that I made good progress.

Creating this chart gave me another opportunity to review physiologic and pathologic murmurs. It gave me a chance to organize the information in my head and understand the physiology of each of the murmurs. Sometimes just getting back to the basics of medicine is really helpful in a world where we have to learn so much so quickly. Additionally, reviewing the maneuvers that affect murmurs is very useful not only for practical purposes but also because it is frequently questioned on STEP.

I relied heavily on the articles mentioned above and the Uptodate resources to create my chart. To help me understand physiologic murmurs, I found Sapin's article on recognizing normal heart murmurs the most helpful because it explained each murmur in terms of the physics of flow. Often in medicine we are told to memorize a fact and recognize a presentation, but understanding the physics of each flow murmur helped me understand why they were most commonly mid-systolic and could change with time (ex: PPAS is a reflection of the underdeveloped pulmonary trunk that suddenly accepts more blood flow after birth, and over time it begins to expand and develop accordingly which decreases the murmur so it is minimally heard by age 1). On the other hand, the articles from UpToDate were far more useful in helping me understand pathologic murmurs. I believe this is because they were so dense, which normally would be a deterrent, but instead was incredibly helpful because it thoroughly explained each pathology, their associated murmurs (the physics of these murmurs), and how the physiology affect a patient's presentation. I think these nuisances are difficult for students to understand especially when it is quickly taught in class addition to the sheer volume of other information from other topics. Each time going through the details helps make them stick, so this was a good exercise.

I was able to start this project while in the newborn nursery which gave me numerous chances to listen for murmurs. It was very interesting that so many babies had physiologic flow murmurs and I think training my ear to such fast beating hearts made it easier for when I transitioned to outpatient. The most common murmur I came across was the Still's murmur. Students can often mistake a still's murmur for a VSD; since both are systolic murmurs heard best at the LLSB. If you don't isolate S1 and S2 and hear that the still's murmur is purely ejection, then you could misdiagnose a Still's murmur as a VSD. I made this mistake a few times until Dr. Knickerbocker helped me hear enough Still's murmurs to differentiate them from VSDs. I spent a morning at the outpatient cardiology clinic with Dr. Saidi and Dr. Gessner. Coincidentally, there were two patients referred to Dr. Gessner for a VSD rule out, and Dr. Gessner asked me to go see them both. It was interesting because one of them had a Still's murmur while the other had a VSD. The VSD was a much harsher sound and almost covered up the S1, so what I was hearing was a wushh-S2, wushh-S2. The Still's murmur on the other hand was clearly an S1-pause-buzz-pause-S2. Not only was the timing different, but the sound of the murmur was different as well. I got to exam both patients a few times by the time I examined them myself, presented to my resident with whom I examined them again, and then presented to Dr. Gessner with whom I examined them for a third time so it really reinforced what I was hearing and allowed me to compare the characteristics of the murmur. It was a unique learning moment.

In the outpatient clinic I tried to listen carefully to each patient's heart. Though it was rarely pertinent to the CC, having Dr. Stern, Dr. Posa, and Dr. Kelly give me feedback on whether I did hear the correct type of murmur was really useful. A cardiac exam is relatively standard for each patient, so both my outpatient and inpatient rotations gave me a lot of practice. I feel more confident at identifying pulmonary flow murmurs, Still's murmurs, VSDs, fixed split S2s, and mitral valve prolapses, because I heard these the most. By the end of my inpatient rotation, I had become confident in hearing them and was correct in a vast majority of the cases, which is a significant improvement from where I started. I didn't have the opportunity to evaluate any acute cardiac patients or patients with stable congenital heart defects though, so I will have to practice that when I hopefully do a pediatric cardiac rotation fourth year.

My future plans are to continue my training in 4th year by doing a pediatric cardiology rotation. Cardiology is a complicated topic and I know the only way to get better is to increase my exposure. It is one of the few fields where physical exam skills are still critical to the diagnosis. This is something that both intimidates me and draws me to the field, so I am excited to continue learning about it. Physical exam skills can only improve with practice, so that will be my goal: continue to practice and increase my exposure.

Example: Pediatrics Medical Student Self-Assessment Evaluation of Competencies (do not submit)



Subject Name
 Class of —
 Rotation: Location
 Evaluation Dates

Evaluated by: **Evaluator Name**
 Class of —

Pediatric Clerkship Self Evaluation 2019

Professionalism

1* Respectfulness

Areas of Concern	Minor lapse in respectfulness	Always respectful	N/A
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2* Work Ethic and Dependability

Area of concern. Consistently requires prompting and follow-through is questionable.	Passive Student. Occasionally requires prompting but follow-through is reliable.	Proactive student. Consistently takes initiative and follow through is guaranteed.	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

3* Honesty

Area of concern. Has had an episode of dishonesty in communication or patient care.	No concerns for dishonesty.	Student was honest even when it entailed personal risk (e.g. admitting to a mistake, giving due credit elsewhere)	N/A
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Patient Care

4 History Taking

1-3 (below expectations): Unable to conduct a history at a 3rd year student level. Gathers either insufficient or overly exhaustive historical information.
 4-6 (at expectations): Obtains a complete and accurate history in an organized manner. Identifies pertinent historical details in common presenting chief complaints.
 7-9 (above expectations): Obtains a complete and accurate history in an organized and efficient manner with unusual insight. Identifies pertinent historical details in the majority of chief complaints and uses alternative historical sources (PCP, pharmacy).

[1]	2	3]	[4	5	6]	[7	8	9]	N/A
<input type="radio"/>									

5* Physical Exam

1-3 (below expectations): Unable to conduct a pediatric physical exam at a 3rd year student level. Incorrectly performs pediatric physical exam maneuvers. Misses key physical exam findings.
 4-6 (at expectations): Performs a basic pediatric physical exam correctly and recognizes and interprets abnormal findings. May miss subtle findings on occasion.
 7-9 (above expectations): Performs a complete pediatric physical exam in a logical and fluid sequence identifying, describing and documenting even the subtlest abnormal physical exam findings consistently.

[1]	2	3]	[4	5	6]	[7	8	9]	N/A
<input type="radio"/>									

6* Medical Decision Making

1-3 (below expectations): Not able to perform medical decision making at a 3rd year student level. Limited ability to filter, identify and connect pieces of clinical information. Has difficulty elaborating a basic differential diagnosis or management plan.
 4-6 (at expectations): Is able to analyze clinical information in a reasonable manner. Can elaborate a basic differential diagnosis and management plan for routine pediatric problems.
 7-9 (above expectations): Insightful analysis of clinical information. Elaborates a prioritized differential diagnosis and insightful management plan. Integrates emerging information to continuously update the differential diagnosis.

[1]	2	3]	[4	5	6]	[7	8	9]	N/A
<input type="radio"/>									

7* Preventive Care and Health Maintenance

1-3 (below expectations): Demonstrates insufficient knowledge, interest and/or application of pediatric health maintenance and/or disease prevention.
4-6 (at expectations): Actively considers disease prevention and health maintenance when appropriate. Applies evidenced recommendations for health supervision and immunization during most clinical encounters accurately.
7-9 (above expectations): Health maintenance and disease prevention are a priority. Consistently applies evidenced recommendations for health supervision and immunization while weighing patient preferences to make balanced recommendations.

[1	2	3]	[4	5	6]	[7	8	9]	N/A
<input type="radio"/>									

Interpersonal and Communication Skills

8* With Patient and Family

1-3 (below expectations): Ability to establish rapport & communicate with pediatric patients/families is concerning. Utilizes ineffective communication techniques.
4-6 (at expectations): Establishes good rapport with pediatric patients/families & team members. Adapts communication content and style to audience, location and receiver preference in most situations.
7-9 (above expectations): Establishes excellent rapport with pediatric patients/families and team members. Displays excellent judgment adjusting communication content and style to audience, location and receiver preference in all situations.

[1	2	3]	[4	5	6]	[7	8	9]	N/A
<input type="radio"/>									

9* Oral Presentations

1-3 (below expectations): Unable to conduct oral presentations at a 3rd year student level. Oral presentations may be disorganized, inaccurate, incomplete or template rigid. May react defensively when interrupted.
4-6 (at expectations): Filters, synthesizes and prioritizes information resulting in concise, organized, accurate presentations. Adjusts presentations to audience (family friendly) and avoids medical jargon when appropriate.
7-9 (above expectations): Delivers outstanding presentations that are complete yet concise, well-organized and with a polished delivery. Consistently adjusts presentations to audience (family friendly), avoids medical jargon and actively engages patients/families and other team members.

[1	2	3]	[4	5	6]	[7	8	9]	N/A
<input type="radio"/>									

10* Written Medical Record

1-3 (below expectations): Unable to create medical record entries at a 3rd year student level. Documents using a template rigidly without adaption. Documentation is disorganized, inaccurate, incomplete, duplicated (copied) or untimely.
4-6 (at expectations): Creates complete medical record entries without unnecessary details or redundancies. Documentation is organized, accurate and timely for most encounters. Documents clinical reasoning and data interpretation accurately.
7-9 (above expectations): Creates polished medical record entries that are consistently organized, accurate, complete and timely for all encounters. Clinical reasoning documentation is outstanding with insightful interpretation.

[1	2	3]	[4	5	6]	[7	8	9]	N/A
<input type="radio"/>									

Practice-Based Learning and Improvement

11* Practice-based Learning

1-3 (below expectations): Demonstrates limited application of evidence-based medicine and/or inability to form a relevant clinical question. May not solicit feedback and/or be defensive to suggestions for improvement.
4-6 (at expectations): Develops clinical questions and applies a basic understanding of evidence-based medicine to clinical practice. Solicits basic feedback and seeks to improve performance with guidance.
7-9 (above expectations): Develops well formed, focused, pertinent clinical questions with insightful EBM applicability to patient care. Actively solicits specific feedback based on reflections of knowledge/skill deficiencies and actively improves performance.

[1	2	3]	[4	5	6]	[7	8	9]	N/A
<input type="radio"/>									

Systems-Based Practice

12* Health Care Team

1-3 (below expectations): Prioritize own goals over team goals. Limited understanding of team member roles besides physicians. A passive team member that requires direction.
4-6 (at expectations): Active, integrated team member. Prioritizes team goals over own goals. Understands team member roles and actively listens to their recommendations.
7-9 (above expectations): Proactive, integrated, selfless team member. Understands all team member roles, seeks and incorporates their recommendations. Actively engages with patient/family and team members to coordinate care.

[1	2	3]	[4	5	6]	[7	8	9]	N/A
<input type="radio"/>									

13* Areas of Strength:

14* Strategies for Improvement:

Example: History & Physical Write Up

CC: “My son blacked out while we were exercising outside.”

HPI: CC is a 10 year old obese African American male who is being transferred from the PICU for treatment of heat stroke. Two days ago around 5pm the patient and his father were outside alternating jogging with walking on the Hawthorne trail. They went approximately three miles when the patient started feeling short of breath, hot, and thirsty. The patient continued to walk after drinking from a water fountain and after another mile the father noticed the patient shaking all four extremities that lasted 10-20 sec. Then the patient lost consciousness and fell face first to the ground. The father noticed he was non-responsive to his father calling his name and shaking him but he was breathing the entire time. The father thinks the patient was unconscious for about 9 minutes. EMS was called by a passerby on a bicycle and they arrived about 15 minutes after the patient lost consciousness. The patient did not require CPR. During transportation, the patient maintained palpable pulses and experienced altered mental status (confusion/agitation) with tachypnea (gag reflex intact). The initial temperature taken by EMS was 105.9 (rectal) with a GCS of 3 (verbal =1, motor =1, eye=1).

In the ED, the GCS was documented as 12 and the patient was intubated on first attempt without difficulty due to respiratory distress, agitation, and combativeness. He was cooled with stomach and bladder irrigation, evaporation, and cool IV fluid bolus. His EKG showed elevated ST segments. He was tachypneic and tachycardic. He was started on MIVF and IV fentanyl and midazolam and transferred to the PICU. He was extubated yesterday and has been able to maintain respirations.

The patient has no history of chest pain, palpitations, seizures, syncope, arrhythmias, URI symptoms, vomiting, or diarrhea.

History was obtained from mother, father, and patient. However, the patient has no recollection of the events. The last things he remembers is feeling thirsty and then he remembers being in the PICU.

PMH:

Birth history: born at 38 weeks to a 20 year old mom via SVD. There were no complications during pregnancy or delivery. There were no medications used during pregnancy. The patient was discharged after 7 days due to neonatal jaundice that resolved after being treated with 3 days of bililights. The patient’s birth weight was 8lbs 5oz.

Chronic medical conditions: none

Immunizations: up to date per mom

Surgical history: PE tubes at age 4 for recurrent ear infections

Hospitalizations: two ED visits as infant due to URI symptoms. No hospital admissions besides current admission.

Feeding history: enjoys eating pizza, salad, turkey, fruits and veggies, yogurt, grilled chicken. Drinks about 1 glass a week of 1% milk. Drink 2-3 sugary beverages a day (juice, Gatorade, or soda). Parents claim he gets at least three servings of calcium a day between milk, yogurt, cheese, or broccoli.

Bowel/Bladder: BM twice weekly; UOP 2x/day normally.

Sleep/Bedtime routine: goes to bed at 9pm, awakes at 6am. Mom and dad claim patient snores a lot but do not notice any times where patient stops breathing.

Psychomotor/Development: met all age appropriate developmental milestones. Walking at 11 months, first word at 1.5 years.

Medications: no home meds, Zofran and Tylenol PRN in hospital

Allergies: NKDA

Social history:

Home: lives in house in Gainesville with mom and dad
Sick contacts: none recently at school or home
Pets: none
Weapons:none
Smoke exposure: none
PCP: CMS Gainesville
School:Idlywilde Elementary
Grades: AB honor roll, 4th grade

Exercise: exercised at least every other day with father until he quit two weeks ago during spring break. Sunday was his first day back exercising. Does not play any sports.

Family history:

Paternal Grandfather with T2DM, died of heart attack at age 57
Maternal grandfather died of alcoholic cirrhosis

ROS:

Constitutional- negative for fevers, changes in activity
Eyes- negative for drainage, redness
ENT- negative for oral lesions, ear drainage, rhinorrhea, headaches or visual changes
Resp- negative for cough, wheezing, or shortness of breath
Cardiovascular- negative for heart murmur, chest pain, or racing heart
GI- negative for loss of appetite, vomiting, diarrhea, changes in bowel habits, or bloody stools
GU- negative for hematuria or frequent UTIs or decreased UOP
Heme- negative for prolonged bleeding with cuts or scratches or history of anemia
Lymphatic- negative for lymphadenopathy
Skin- negative for rash
MSK- negative for joint pain or swelling
Neuro- negative for seizures, fainting, or headaches
Behavioral- negative for sleep problems
Endocrine- negative for polyuria or polydipsia or skin changes
Allergic/Immunologic- negative for allergies or recurrent infections

Physical Exam:

Vitals- T37.3 (range 37-38), P 81 (range 62-90), RR 20 (range 20-24), BP 119/61 (range 104-129/48-83), O2 sat 97%, weight 80kg (99.85%), height 62in (98.9%)

General- 10 year old obese African American male sleeping comfortably, alert and responsive when awake, NAD

HEENT-normocephalic, no trauma, sclera anicteric with no injection or erythema or discharge, tympanic membranes clear bilaterally, nares patent, moist oral mucosa w/o lesions or dry lips, posterior pharynx clear

Cardiovascular- regular rate and rhythm, normal S1 S2 no rubs, gallops, or murmurs, pulses bilateral and equal (radial, dorsalispedis)

Respiratory- bilateral equal chest expansion with adequate air movement;no wheezing, crackles stridor, nasal flaring or retractions

Abdominal- nondistended, not tender, no gross lesions or trauma, no organomegaly or masses, normal bowel sounds in all four quadrants

Lymphatic- no palpable lymphadenopathy

GU- normal male genitalia, no rashes

Musculoskeletal- muscle tone normal without weakness or atrophy, full ROM of all extremities

Neuro- equal movement of all four extremities, gross strength intact, no focal deficits

Skin- no rashes or erythema, scars or bruises

Labs: most recent CMP, VBG, coags, CBC, tox screen, and UA are wnl except for lactic acid of 3.8, troponin T 0.06, potassium 2.5, AST 233, ALT 403, INR 1.4, CK 2123

Radiology: chest X ray that was taken to evaluate ET tube placement showed normal heart and lungs

Differential diagnosis:

Heat stroke

Electrolyte abnormality

Cardiac arrhythmia

Sepsis

Seizure

Drug overdose

Assessment: 10 year old obese male who lost consciousness while exercising outdoors in hot and humid weather. This is likely heat stroke due to the severity of symptoms, high temperature, loss of consciousness, and altered mental status. An electrolyte abnormality is also possible due to excessive loss during exercise without replacement, however his temperature would not be this high with an electrolyte abnormality. It is possible to have an electrolyte abnormality in addition to heat stroke. A cardiac arrhythmia is possible, but again not likely at the time due to high temperature. Sepsis is a possibility but the patient had no preceding fever or symptoms of illness. It should be kept on the differential in case the patient does not respond to treatment for heat stroke. Although the patient had no history of seizure disorders, the father did witness some shaking. A seizure is a common manifestation of heat stroke, so epilepsy should only be considered if the patient has another episode of shaking and non-responsiveness after current symptoms resolve. A drug overdose is possible but it low on the differential due to lack of substantial history supporting the diagnosis.

Plan:

Heat stroke: will continue to monitor for end organ damage by checking daily liver function tests, coagulation studies, BMP, INR (elevated so will give one dose of PO vitamin K), CK and cardiac enzymes. At this time there is no need to do another EKG because the patient has had an Echo showing normal function and an EKG showing normal sinus rhythm. The patient can continue to get Tylenol as needed for muscle pain or elevated temperature.

FEN/GI: encourage PO fluid intake, consider d/c MIVF if able to keep down PO fluids. Will add potassium to IVF due to potassium of 2.5 today. Urine is negative for myoglobin and BUN and creatinine are trending down so NaHCO₃ can be discontinued. Will continue to monitor urine output to determine hydration status. Zofran

Example: Patient Caretaker Evaluation Form (do not submit)

Parent/Caretaker Evaluation of Medical Student

MEDICAL STUDENT NAME: _____

You have been selected to provide feedback to a medical student that was involved in your child's care. At the University of Florida, we believe that it is very important to train our future doctors to be sensitive and professional. Your responses and suggestions are very important to their training as future doctors. The information is kept confidential. Please put this form in the provided sealed envelope and return it to the student or hospital staff. Thank you for your time.

Please check the box YES or NO

1. The medical student introduced him/herself and their role in the team.

YES NO

2. My child and I were treated with respect.

YES NO

3. The medical student was careful and thorough.

YES NO

4. I understood what the student was asking and saying.

YES NO

5. I was satisfied with the medical student.

YES NO

6. I would let the medical student participate in the care of my child again.

YES NO

Comments and/or suggestions for improvement:

Please contact Meghan Lopez, Medical Student Coordinator, at (352)273-8594 with any questions or concerns.

Example: Pediatric Competencies Checklist (do not submit)

University of Florida Pediatric Clerkship Pediatric Competencies Checklist

	Patient type or Procedure	High-Yield Location: C=Clinic, E=ER, N=Nursery, H=Hospital	Examples of diagnosis or issues addressed	Alternative clinical learning experience	Date accomplished/ Student initials
1	Newborn Health Maintenance History and Physical	C	Newborn (0-1 month) health maintenance or well child visit	CLIPP case 1	
2	Infant/Toddler Health Maintenance History and Physical	C	Infant and Toddler (1-60 months) health maintenance or well child visit	CLIPP case 2, 3	
3	Child Health Maintenance History and Physical	C	School aged (5-12 years) health maintenance or well child visit	CLIPP case 4	
4	Adolescent Health Maintenance History and Physical	C	Adolescent (13-19 years) health maintenance or well child visit	CLIPP case 5, 6	
5	Growth and Nutrition	C,H	Failure to thrive (FTT), poor weight gain, obesity, short stature, constitutional delay, small for gestational age, large for gestational age, nutrition, diet	CLIPP case 26, 18	
6	Development	C	Delayed language, gross motor, fine motor, or social adaptive skills, autism or other forms of pervasive developmental disorders	CLIPP case 28, 29	
7	Behavior	C	Sleep problems, colic, temper tantrums, toilet training, feeding problems, enuresis, ADHD, encopresis, autistic spectrum disorder, eating disorders, head banging, poor school performance	CLIPP case 4	
8	Upper Respiratory Tract	C,E,H	Laryngotracheitis (croup), retropharyngeal abscess, peritonsillar abscess, laryngomalacia, tracheomalacia, foreign body aspiration, tracheitis, anaphylaxis	CLIPP case 14	
9	Lower Respiratory Tract	C,E,H	Bronchiolitis, bronchitis, pneumonia, aspiration, asthma, bronchiectasis, foreign body aspiration, reactive airway disease	CLIPP case 7, 12, 13	
10	Gastrointestinal Tract	C,E,H	Gastroenteritis, giardiasis, pyloric stenosis, appendicitis, HSP, peptic ulcer disease, gastroesophageal reflux disease	CLIPP case 15, 16, 27	
11	Dermatologic system	C	Viral rash, eczema, urticaria, contact dermatitis, toxic shock, thrush, atopic dermatitis, seborrheic dermatitis, acne	CLIPP case 3, 21	
12	Central nervous system	C,E,H	Meningitis, concussion, seizures, ataxia, closed head injury, headache	CLIPP case 9, 20, 24, 28	
13	Emergent Clinical Problem	E,H	Meningitis, shock, testicular torsion, DKA, SIDS, acute life threatening event (ALTE), congestive heart failure, burns, status asthmaticus, status epilepticus, encephalitis, child abuse etc.	CLIPP cases: 7, 23, 25	
14	Chronic medical problem	C,H	Allergies, asthma, cerebral palsy, cystic fibrosis, diabetes mellitus, malignancy, sickle cell disease, epilepsy, atopic dermatitis, obesity, sensory impairment, HIV/AIDS	CLIPP cases: 30, 31	
15	Unique condition: fever without localizing findings	C,E,H	Rule out sepsis; urinary tract infection, systemic viral infection (e.g. EBV), autoimmune diseases	CLIPP case 10	
16	Unique condition: neonatal jaundice	C,N	Hyperbilirubinemia- direct or indirect, breastfeeding or breast milk jaundice, ABO or Rh incompatibility, phototherapy, biliary atresia, cholestasis	CLIPP case 8	
17	Capillary blood draw	C,N	Hemoglobin, cholesterol, glucose or monospot assessment	N/A	
18	Intramuscular injection	C,N	Vaccine or antibiotic administration	N/A	
19	Pediatric Lumbar Puncture	E,H and Anaclerio Learning Center	Fever in infant, assessment of IC pressure, meningitis, encephalitis, oncologic evaluation, altered mental status, simulation experience	N/A	
20	Observed Pediatric H&P	C, E, H and Anaclerio Learning Center	Routine well child visit at ALAC with self-assessment and review with a faculty member	N/A	

Example: I-PASS Structured Handoff Assessment

Pediatric Clerkship I-PASS Structured Handoff Assessment

Evalutee Information:

Name: _____ MS/PGY Level: _____ Date: _____ / _____ / _____
**leave blank if evaluating a resident, but still include PGY level*

Evaluator Information:

Name: _____ MS/PGY Level: _____

Situational Overview (check one):		Yes	No
1	Was a situational overview provided by the learner giving the handoff (e.g. description of the "big picture" of what will need to be prioritized by the receivers of the handoff)		

Indicate the frequency that the specific element of the mnemonic was used throughout the handoff:

I-PASS Mnemonic	Description	Never	Rarely	Sometimes	Usually	Always
2	Illness Severity					
3	Patient Summary					
4	Action List					
5	Situation Awareness/Contingency Planning					
6	Synthesis by Receiver					

Indicate the frequency with which the learner who gave the handoff did the following:

	Never	Rarely	Sometimes	Usually	Always
7					
8					

Rate the frequency with which the learner who gave the handoff did the following:

	N/A	Never	Rarely	Sometimes	Usually	Always
9						
10						
11						

Indicate the phrase that BEST describes the pace of the handoff (circle one):

12	very slow pace/ very inefficient	slow pace/ inefficient	optimally paced/ efficient	fast/ pressured pace	very fast/ very pressured pace	
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13 What was especially effective about the handoff?

14 What aspect(s) of the handoff could be improved?

15 Additional comments:

