

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

**Third Year Pediatric Clerkship Syllabus  
2017-2018**



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## Message from the Chair

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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

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 with 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 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.

With warmest regards,

**Scott A. Rivkees, M.D.**  
Nemours Eminent Scholar  
Professor and Chair  
Department of Pediatrics  
University of Florida

# Goals and Objectives

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Welcome to your 3<sup>rd</sup> 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.

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*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

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## *Administration*

### **Department Chair:**

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### **Clerkship Directors:**

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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: 1<sup>st</sup> Floor, East Entrance**

**Pediatric Wards (Green, Orange, Blue, Cardio, GI): 4<sup>th</sup> Floor, 4200, 4400, 4500 wings**

**Newborn Nursery: 3<sup>rd</sup> Floor**

### *Outpatient*

#### **UF Health at Children's Medical Services (CMS) Clinic – DO NOT PARK AT CMS**

1701 SW 16<sup>th</sup> Avenue

Gainesville, FL 32608

(352) 334-0206

**Endo Clinic** at either CMS (address above – DO NOT PARK AT CMS) or Med Plaza (MP), 2<sup>nd</sup> Floor

Pediatric Specialty Clinics - 2000 SW Archer Road off Gale Lemerand Drive

#### **UF Health at Tower Square (TS) Clinic**

7046 Archer Road

Gainesville, FL 32607

(352) 373-1770

#### **UF Health at Magnolia Park Clinic**

4740 NW 39<sup>th</sup> Place, Suite B

Gainesville, FL 32606

(352) 594-7337



# Pediatric Experience

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## *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 (2 Weeks): General, Pulmonary, Renal, Neurology, Immuno-deficiencies **or**
  - Orange Team (2 Weeks): General, Cardiology, Endocrinology, Genetics, GI/Liver patients **and**
  - Green Team (2 Weeks): Hematology/Oncology/Immunology/Rheumatology **or**
  - Gold Team (2 Weeks): Cardiology **or**
  - Silver Team (2 Weeks): Gastroenterology
  - Emergency Room (1 Week)
  - Newborn (1 Week)
- Outpatient Clinical Experience (2 Weeks)
  - Primary Care
  - Endocrinology
  - Adolescents
  - Acute Care

## *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 at least 48 hours prior to 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. Pediatric Observed History and Physical: During your time in Gainesville, you will be video-taped performing a well-child exam at the Anaclerio Learning and Assessment Center. Upon completion, you will review your video with a designated faculty member for formative feedback. The date and time of both the taping and review cannot be changed. To help you prepare, there is a module in Canvas with resources and an example video.
4. Tobacco Case Module: During Week 1, 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 the Monday of week 2.**

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. Patient Log: 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. CLIPP Cases (<http://www.med-u.org/>): Of the 32 cases available online, **8 must be completed by the end of week 8.** It is anticipated each case will take approximately 45 minutes to complete and it is recommended that you complete at least one self-assigned case each week. CLIPP cases can be paired with lecture topics. To access, go to the home page and click ‘CLIPP Pediatric Cases’ on the left, and it will take you to the CLIPP Case List page. Select “Cases” in the upper right. Click the “register here” link, and on the user data page, enter your personal information and submit. You will get a system-generated email with a verification link. The link will take you to your login page. Enter your user id (email address) and password. The case selection page will appear. Click a case to open it.
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. Parent Evaluation: During the Pediatric Clerkship one parent or patient must complete this evaluation. Upload to Canvas **by the end of week 8.**
12. Evaluations: You are required to complete 22 evaluations **by the end of Week 8.** These evaluations include an aggregate of 10 lecture, 6 faculty, 5 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. Students who fail this exam receive an “Incomplete” as their final grade and will be required to re-take the exam until a passing score (> 6%) is achieved. All shelf scores will then be averaged to calculate the final score in the summative clerkship evaluation. There are plenty of resources to help you prepare including the online CLIPP cases, practice CLIPP Exam, books available for check-out in the Pediatric Medical Education Office (HD-408), a book of prep questions, 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. In general, failure on an exam is remediated by retaking the exam and achieving a passing score. 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><b>Week One:</b></p> <ul style="list-style-type: none"><li>• Orientation</li><li>• Rotation begins</li><li>• Call Schedule begins</li><li>• Begin Reading for Tobacco Case</li></ul> <p><b>Week Two:</b></p> <ul style="list-style-type: none"><li>• Gator Sessions</li><li>• Question &amp; Answer session</li><li>• Tobacco case module due</li><li>• Harrell Center Video Taping</li></ul> <p><b>Week Three:</b></p> <ul style="list-style-type: none"><li>• Gator Sessions</li><li>• Case Conferences begin</li><li>• Ethics Conference</li></ul> <p><b>Week Four:</b></p> <ul style="list-style-type: none"><li>• Gator Sessions</li><li>• Case conference</li><li>• Safety Presentation</li><li>• Week 4 Progress Report</li></ul>	<p><b>Week Five:</b></p> <ul style="list-style-type: none"><li>• Gainesville/Jacksonville switch</li><li>• Gator Sessions</li><li>• Case Conference</li><li>• Ethics Conference</li></ul> <p><b>Week Six:</b></p> <ul style="list-style-type: none"><li>• Gator Sessions</li><li>• Question &amp; Answer session</li><li>• Case Conference</li><li>• Harrell Center Video Taping</li><li>• Shelf Review</li></ul> <p><b>Week Seven:</b></p> <ul style="list-style-type: none"><li>• Gator Sessions</li><li>• Case Conference</li><li>• Ethics Conference</li><li>• Week 7 Progress Report</li></ul> <p><b>Week Eight:</b></p> <ul style="list-style-type: none"><li>• Gator Sessions</li><li>• Case Conference</li><li>• Safety Presentation</li><li>• Shelf Exam</li><li>• Clerkship Debriefing</li></ul>
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## *Gator 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.

2	Tuesday, May 16, 2017	12:00-1:00 Immunizations - Dr. Eitzman	HMEB 460
		1:00-1:30 Clerkship Check-In #1 - Dr. Kelly & Meghan Lopez	
		1:30-2:30 Fluids and Electrolytes - Dr. Kelly	
		2:30-3:30 Case Conference - Dr. Kelly	
		3:30-4:30 Child Abuse - Dr. Rosenthal	
	Wednesday, May 17, 2017	3:30-5:00 Group A Ethics Case Conference	MSB N1-02

Physician schedules change constantly and therefore this schedule is subject to change to accommodate their schedules. Please ensure preparedness by checking Canvas weekly for an update. You will **NOT** be emailed every time there is a change. The responsibility is on you.

## *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 the Clerkship Administrator at 352-273-8594 or by email at [clerkship@peds.ufl.edu](mailto: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	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.

### Late Stay Schedule

When you are inpatient, the chief residents will create a late stay schedule for you. Expect to be on late stay approximately every fourth night until check-out, around 7pm. During this time you will be on the wards helping admit patients, solving acute problems, and following up on various patient care issues discussed during check-out rounds. Late stay shifts are taken during your inpatient ward experience or immediately after it. You are on late stay with the team you are assigned to, as color-coded on the schedule.

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
July 2 Shan	3 Raymond	4 Pashuck	5	6	7 Shan	8 Raymond

## Attendance & Absences

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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. For further information regarding policies and procedures, please refer to the website at

<http://osa.sites.medinfo.ufl.edu/files/2014/10/Policies-and-Procedures-Handbook-2015.pdf>

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.

### Unplanned Absences

Gainesville: In the event of a single-day, unexpected absence due to illness, you **MUST** notify the Pediatric Medical Education office preferably by email ([clerkship@peds.ufl.edu](mailto: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 notified in addition to the Pediatric Medical Education office. COMCEC can be reached at (352) 273-8575.

Jacksonville: In the event of a single day, unexpected absence due to illness or an unexpected absence lasting more than one day, the Pediatric Medical Education office, COMCEC office, and Jacksonville Clerkship office (904) 244-3050 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 Clerkship begins. In the event of such request, an alternate assignment or arrangement may be provided to the student 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

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## *Inpatient Ward Services (4 Weeks Total)*

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

## *Expectations*

- Adhere to the late stay schedule and take these shifts as scheduled. Students are expected to stay until ward team check-out to night float, typically call ends around 7 pm.
- 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.
- Admit at least one patient during late stay.
- 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.
- To work-up one patient per night while on late stay, as well as 4-5 additional patients per week. This means each student should work-up patients with his/her intern on inpatient ward team on non-late stay and in addition to late stay shifts. The formal write-up must be in the patient's chart within 24 hours of admission.
- 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. No templates are allowed, this is your opportunity to learn. Progress notes must be in a SOAP format.
- 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 Friday 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.
- Adhere to schedule of working at least one weekend day.

### *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. 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 and upload signed Endo evaluation form to Canvas.
- 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 3<sup>rd</sup>-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.
- The Chief Residents will create call schedules for students rotating in Inpatient Wards.

## Disaster Guidelines

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EMERGENCY/DISASTER PREPAREDNESS: UF has a system wide alert system, and students should review/update their cell phone information through myUFL system. Students will automatically receive notifications about any emergencies on UF campus, but should also select to receive alerts from UF Health Shands Hospital in Gainesville. Additionally, emergency and disaster plans at the University of Florida-Gainesville, University of Florida-Jacksonville, UF Health Shands Hospital and at the VA Medical Center are available through the following sites.

- UF Emergency Management site: <https://emergency.ufl.edu/emergency-management-plans/>
- UF Health Shands Hospital: <https://bridge.ufhealth.org/shands-emergency-operations-plan/>
- VA Medical Center:  
[http://vawww.visn8.portal.va.gov/northflorida/adlc/publicaffairs/EmergencyPreparedness/Emergency%20Management%20Program/NFSG%20Emergency%20Operations%20Plan/NFSG\\_Emergency\\_Operations\\_Plan.pdf](http://vawww.visn8.portal.va.gov/northflorida/adlc/publicaffairs/EmergencyPreparedness/Emergency%20Management%20Program/NFSG%20Emergency%20Operations%20Plan/NFSG_Emergency_Operations_Plan.pdf)
- UF Jacksonville: <http://1b-esx-infonet.umc.ufl.edu/Emergency-Preparedness/Lists/CEMP/AllItems.aspx>

Specific instructions in case of emergency or disaster will be emailed to you and will vary per situation and your location.

# Example: Independent Learning Plan

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## 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](http://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 4<sup>th</sup> 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)

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## Pediatrics Medical Student Self-Evaluation of Competencies

Student Name: \_\_\_\_\_ Rotation: \_\_\_\_\_ Year: \_\_\_\_\_

My Overall Strengths:

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My Overall Weaknesses:

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Strategies for Improvement:

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Please complete the following sentences regarding progress towards completion of ILP and CLIPP Cases:

I have reviewed my ILP with my mentor: Yes \_\_\_\_\_ No \_\_\_\_\_

I have completed \_\_\_ CLIPP Cases out of the 8 required.

**1. Primary Area of Clerkship at time of Self Assessment (select all that apply):**

Inpatient Wards     Emergency Department     Outpatient Clinics     Newborn Nursery

**2. Professionalism (20%)**

**I. Respectfulness**

- Always Respectful
- Minor lapse in respectfulness
- Areas of concern (describe in comments section)

**II. Work Ethic/Dependability**

- Consistently takes initiative and follows through
- Sometimes requires prompting but always follows through
- Area of concern (describe in comments section)

**III. Honesty**

- Honest even when it entails personal risk (e.g. admits mistake, gives credit to others, etc.)
- There were no concerns
- Area of concern (describe in comments section)

Competency Category	<u>Below</u> expected performance for a UF COM student (* < 3 requires commentary)	<u>At the level</u> of performance expected for a UF COM student	<u>Above</u> expected performance for a UF COM student (* > 7 requires commentary)
	1 2 3	4 5 6	7 8 9
<b>3. PATIENT CARE</b>			
A. History Taking (5%)	2= Despite faculty efforts to address this skill, still not able to conduct a history at expected level. Ability to take a history and retrieve medical information is often incomplete, inaccurate and/or chronology unclear.	5= Almost always identifies and characterizes the needed information with accurate chronology, depth and accuracy. Usually reports most important data from records, and diagnostic tests	8= Consistently performs a complete, accurate and efficient history. Elaborates key subtleties. Chronology absolutely clear. Consistently obtains pertinent information from record and relevant results from diagnostic tests.
B. Physical Exam (10%)	2= Despite faculty efforts to address this, deficiencies exist in exam and/or student utilizes less than optimal technique.	5= Physical exam is appropriate for patient complaint and very good technique is utilized.	8= Technique and knowledge of physical exam well beyond level expected. Links history and physical consistently well.
C. Clinical Judgment/Decision-making/ Problem Solving (10%)	2= Despite faculty guidance, student had difficulties with one or more of the following: 1) Insufficient ability to interpret clinical information; 2) Difficulty prioritizing diagnoses/ problems; 3) Difficulty elaborating a basic differential diagnosis	5= Reasonable analysis of clinical information. For routine problems, able to elaborate a reasonable differential diagnosis and basic management plan	8= Insightful analysis of information and excellent approach to diagnosis and treatment. Able to apply basic science knowledge to clinical situations. Accurately interprets and weighs conflicting information.
D. Preventative Care/Health Maintenance (5%)	2= Insufficient knowledge of, interest in, and/or incorporation of health maintenance, immunization and/or disease prevention strategies.	5= Shows awareness of and considers prevention and health maintenance when appropriate. Able to make reasonable recommendations for most patients using the health supervision and immunization resources.	8= Health maintenance and disease prevention is a priority in patient care. Able to weigh patient preferences, national recommendations and controversies to make balanced recommendations for patients.
<b>4. INTERPERSONAL COMMUNICATION</b>			
A. Patient/Family (10%)	2= Despite guidance, student had difficulties with one or more of the following: 1) ability to establish rapport with patients/families; 2) using medical jargon during family centered rounding or other patient/ family communications; 3) Not recognizing or appropriately responding to significant patient/family responses.	5= Demonstrated the ability to establish effective rapport with nearly all patients/families. Expresses self clearly and at a level that patients can understand. Does not lapse into medical jargon during family-centered patient presentations or patient/family communications.	8= Extremely effective at establishing rapport and communicating with patients and families. Aware of the relevance of psychosocial factors, cultural diversity and support systems when communicating with patients/families. Judgment and insight into communicating with others, including more difficult patients.
B. Oral Presentation (10%)	2= Despite guidance, oral presentations are disorganized, inaccurate or incomplete. Student may be unable to incorporate appropriate diagnostic data in presentation.	5= Presentations are organized, accurate and concise. Able to incorporate appropriate diagnostic data into presentation.	8= Outstanding MODEL presentations. Complete yet concise, very well organized with polished delivery. Assessments comprehensive and systematic, including use of diagnostic data.
C. Written Medical Record (10%)	2= Despite feedback, medical record entries, progress notes or H&P's are one of the following: disorganized, inaccurate or incomplete.	5= Medical record entries, progress notes, and H&P's are organized, legible, accurate and concise. Able to incorporate appropriate diagnostic data into record entry.	8= MODEL medical record entries, progress notes and H&P's. Complete yet concise, very well organized and very clearly communicated. Assessments comprehensive and systematic, including use of diagnostic data.
<b>5. PRACTICE-BASED LEARNING AND IMPROVEMENT (10%)</b>			
	2= Despite feedback, concerns exist for one or more of the following: 1) Does not show evidence of consistent reading 2) Is not able to readily access on-line sources of medical information, 3) Cannot adequately apply factual knowledge to the care of patients. 4) Does not learn from previous errors; makes the same mistakes repetitively	5= Demonstrates initiative in increasing knowledge, applies EBM in practice, and progressively learns from previous errors rarely making the same mistake twice.	8= Exceptional initiative in increasing knowledge, applying EBM or learning from previous experience. This model student will demonstrate initiative in in-depth reading about current clinical problems, great facility in accessing on-line sources of medical information, ability to evaluate medical articles in a critical manner, skillful application of cognitive knowledge to the care of patients. This students learns rapidly from previous errors.
<b>6. SYSTEM-BASED PRACTICE (10%)</b>			
	2= Despite feedback, effectiveness, reliability, and organization in working with the health care team and guiding patient management are a source of concern. Often passive in patient management requiring much direction.	5= A cooperative, organized, and effective member of the team. Handles day-to-day responsibilities well. Shows initiative regarding patient management issues.	8= Handles complex tasks well. Consistently seeks responsibilities and does whatever it takes to fulfill them. Takes initiative in patient responsibilities and actively engages non-MD health care professionals & providers.

# Example: Summative Evaluation Form (do not submit)

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## Pediatrics Medical Student Competency Evaluation

Student Name: \_\_\_\_\_ Rotation: \_\_\_\_\_ Year: \_\_\_\_\_

Evaluator Name (place in sealed envelope for anonymity): \_\_\_\_\_

Student's Overall Strengths:

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Student's Overall Weaknesses:

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Suggested Strategies for Student Improvement:

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**1. Primary Area of Clerkship at time of Assessment (select all that apply):**

- Inpatient Wards     Emergency Department     Outpatient Clinics     Newborn Nursery

**2. Professionalism (20%)**

**I. Respectfulness**

- Always Respectful  
 Minor lapse in respectfulness  
 Areas of concern (describe in comments section)

**II. Work Ethic/Dependability**

- Consistently takes initiative and follows through  
 Sometimes requires prompting but always follows through  
 Area of concern (describe in comments section)

**III. Honesty**

- Honest even when it entails personal risk (e.g. admits mistake, gives credit to others, etc.)  
 There were no concerns  
 Area of concern (describe in comments section)

**\*\*\*\*\* EXAMPLE ONLY – not to be submitted\*\*\*\*\***

Competency Category	Below expected performance for a UF COM student (*< 3 requires commentary)	At the level of performance expected for a UF COM student	Above expected performance for a UF COM student (*> 7 requires commentary)	Did Not Observe
<b>3. PATIENT CARE</b>				
<b>A. History Taking (5%)</b>	1 2 3 2= Despite faculty efforts to address this skill, still not able to conduct a history at expected level. Ability to take a history and retrieve medical information is often incomplete, inaccurate and/or chronology unclear.	4 5 6 5= Almost always identifies and characterizes the needed information with accurate chronology, depth and accuracy. Usually reports most important data from records, and diagnostic tests	7 8 9 8= Consistently performs a complete, accurate and efficient history. Elaborates key subtleties. Chronology absolutely clear. Consistently obtains pertinent information from record and relevant results from diagnostic tests.	DNO
<b>B. Physical Exam (10%)</b>	1 2 3 2= Despite faculty efforts to address this, deficiencies exist in exam and/or student utilizes less than optimal technique.	4 5 6 5= Physical exam is appropriate for patient complaint and very good technique is utilized.	7 8 9 8= Technique and knowledge of physical exam well beyond level expected. Links history and physical consistently well.	DNO
<b>C. Clinical Judgment/Decision-making/ Problem Solving (10%)</b>	1 2 3 2= Despite faculty guidance, student had difficulties with one or more of the following: 1) Insufficient ability to interpret clinical information; 2) Difficulty prioritizing diagnoses/problems; 3) Difficulty elaborating a basic differential diagnosis	4 5 6 5= Reasonable analysis of clinical information. For routine problems, able to elaborate a reasonable differential diagnosis and basic management plan	7 8 9 8= Insightful analysis of information and excellent approach to diagnosis and treatment. Able to apply basic science knowledge to clinical situations. Accurately interprets and weighs conflicting information.	DNO
<b>D. Preventative Care/Health Maintenance (5%)</b>	1 2 3 2= Insufficient knowledge of, interest in, and/or incorporation of health maintenance, immunization and/or disease prevention strategies.	4 5 6 5= Shows awareness of and considers prevention and health maintenance when appropriate. Able to make reasonable recommendations for most patients using the health supervision and immunization resources.	7 8 9 8= Health maintenance and disease prevention is a priority in patient care. Able to weigh patient preferences, national recommendations and controversies to make balanced recommendations for patients.	DNO
<b>4. INTERPERSONAL COMMUNICATION</b>				
<b>A. Patient/Family (10%)</b>	1 2 3 2= Despite guidance, student had difficulties with one or more of the following: 1) ability to establish rapport with patients/families; 2) using medical jargon during family centered rounding or other patient/family communications; 3) Not recognizing or appropriately responding to significant patient/family responses.	4 5 6 5= Demonstrated the ability to establish effective rapport with nearly all patients/families. Expresses self clearly and at a level that patients can understand. Does not lapse into medical jargon during family-centered patient presentations or patient/family communications.	7 8 9 8= Extremely effective at establishing rapport and communicating with patients and families. Aware of the relevance of psychosocial factors, cultural diversity and support systems when communicating with patients/families. Judgment and insight into communicating with others, including more difficult patients.	DNO
<b>B. Oral Presentation (10%)</b>	1 2 3 2= Despite guidance, oral presentations are disorganized, inaccurate or incomplete. Student may be unable to incorporate appropriate diagnostic data in presentation.	4 5 6 5= Presentations are organized, accurate and concise. Able to incorporate appropriate diagnostic data into presentation.	7 8 9 8= Outstanding MODEL presentations. Complete yet concise, very well organized with polished delivery. Assessments comprehensive and systematic, including use of diagnostic data.	DNO
<b>C. Written Medical Record (10%)</b>	1 2 3 2= Despite feedback, medical record entries, progress notes or H&P's are one of the following: disorganized, inaccurate or incomplete.	4 5 6 5= Medical record entries, progress notes, and H&P's are organized, legible, accurate and concise. Able to incorporate appropriate diagnostic data into record entry.	7 8 9 8= MODEL medical record entries, progress notes and H&P's. Complete yet concise, very well organized and very clearly communicated. Assessments comprehensive and systematic, including use of diagnostic data.	DNO
<b>5. PRACTICE-BASED LEARNING AND IMPROVEMENT (10%)</b>	1 2 3 2= Despite feedback, concerns exist for one or more of the following: 1) Does not show evidence of consistent reading 2) Is not able to readily access on-line sources of medical information, 3) Cannot adequately apply factual knowledge to the care of patients. 4) Does not learn from previous errors; makes the same mistakes repetitively	4 5 6 5= Demonstrates initiative in increasing knowledge, applies EBM in practice, and progressively learns from previous errors rarely making the same mistake twice.	7 8 9 8= Exceptional initiative in increasing knowledge, applying EBM or learning from previous experience. This model student will demonstrate initiative in in-depth reading about current clinical problems, great facility in accessing on-line sources of medical information, ability to evaluate medical articles in a critical manner, skillful application of cognitive knowledge to the care of patients. This student learns rapidly from previous errors.	DNO
<b>6. SYSTEM-BASED PRACTICE (10%)</b>	1 2 3 2= Despite feedback, effectiveness, reliability, and organization in working with the health care team and guiding patient management are a source of concern. Often passive in patient management requiring much direction.	4 5 6 5= A cooperative, organized, and effective member of the team. Handles day-to-day responsibilities well. Shows initiative regarding patient management issues.	7 8 9 8= Handles complex tasks well. Consistently seeks responsibilities and does whatever it takes to fulfill them. Takes initiative in patient responsibilities and actively engages non-MD health care professionals & providers.	DNO
<b>OVERALL, I WOULD RATE THIS MEDICAL STUDENT'S PERFORMANCE AMONG THE:</b>				
<input type="checkbox"/> Bottom 1/3 of their peers <input type="checkbox"/> Middle 1/3 of their peers <input type="checkbox"/> Top 1/3 of their peers				

\*\*\*\*\* EXAMPLE ONLY – not to be submitted\*\*\*\*\*

# Example: History & Physical Write Up

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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 tachypnic 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, 4<sup>th</sup> 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 NaHCO<sub>3</sub> can be discontinued. Will continue to monitor urine output to determine hydration status. Zofran

# Example: Patient Caretaker Evaluation Form (do not submit)

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## 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:

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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	