Hospital Tutorial Write-up Benchmarks

1. Comprehensive problem list	A prioritized list of all the patient's medical problems (active/inactive/resolved)
2. Identifying information & chief concern	Name & age
	Known medical problems highly relevant to the chief concern (< 4)
	Chief concern and duration of symptoms
3. History of present illness	Background: Health at the time of symptom onset and details of any chronic illness directly related to the chief concern.
	Details of the presenting problem beginning at symptom onset & proceeding sequentially.
	Predisposing conditions & risk factors
	Pertinent negatives
	Optional: Hospital course or evaluation to date
4. Past medical history	All active medical problems and any other problems relevant to evaluation or ongoing management.
	Summarize for each major, active problem: diagnosis, current treatment, control, and complications
5. Medications & allergies	Prescribed medications and doses
	Non-prescription medications and complementary therapies
	Drug allergies and the type of reaction
6. Habits and risk factors	Substance use: Tobacco, alcohol, drugs Preventive health Diet Exposures
7. Family Medical History	Family history of illnesses and causes of death affecting first degree relatives
8. Social history	Full social history, including influences on your patient's health and health care: living situation, social support, occupation and avocation, any financial or other concerns
9. Review of Systems	List all systems and note the presence or absence of each symptom you asked about. For organ system(s) discussed in HPI, write "see HPI"
	Provide details of positive responses to ROS questions
10. Physical exam	General appearance and vital signs
	Document each organ system in order and report all exam findings, both normal and abnormal.
11. Labs and Imaging	Not part of the ICM II write-ups
12. Summary statement	Restate the ID & summarize the key features from the history & physical exam
13. Branching Diagram or Diagnoses Matrix	A visual representation of your clinical reasoning process. Not included in 3rd year and beyond.
14. Assessment	Format determined by clinical context

The purpose of the write-up is:

1. To record your patient's story in a concise, legible and well-organized manner
2. To demonstrate your fund of knowledge and problem-solving skills
3. In subsequent years, your write-up will communicate the important aspects of the patient's presentation, your decision making processes, diagnostic and care plans to the reader. It will also be a legal document about your patient's health care.

On completion of Foundations of Clinical Medicine, students will be able to:

1. Accurately and completely report the history and physical in the standard format.
2. Summarize the important positive and negative findings of a case and articulate a 3-5 item differential diagnosis.
3. Write an assessment articulating how the patient's history and exam findings support or argue against the diagnoses on your differential.

Let's explore each of these further…

1. Comprehensive problem list	A prioritized list of all the patient's medical problems (active/inactive/resolved)

- Usually a separate entry in the electronic chart. It is included in the write-up for practice.
- Format:
    - The first problems should be the reasons for hospitalization
    - Active serious medical problem are listed next, with duration of problem
    - Active, less serious medical problems are then listed, with duration of problem
    - Inactive problems, including past surgeries, are then listed, with date of diagnosis, from most recent to most remote.

2. Identifying information & chief concern (ID/CC)	Name & age
	Known medical problems highly relevant to the chief concern (< 4)
	Chief concern and duration of symptoms

- 1-2 sentences
- Purpose: Sets the stage and gives a brief synopsis of the patient's major problem
- Format:
    - Identify the patient by name and age
    - Include no more than 4 medical problems (sometimes there are zero) that are highly relevant to the chief complaint. List only the diagnoses here & elaborate on them in the HPI or PMH.
- Report the chief concern and duration of symptoms

3. History of present illness	Background: Health at the time of symptom onset and details of any chronic illness directly related to the chief concern.
	Details of the presenting problem beginning at symptom onset & proceeding sequentially.
	Predisposing conditions & risk factors
	Pertinent negatives
	Optional: Hospital course or evaluation to date

- 1-2 pages
- Purpose: Provides a complete account of the presenting problem, including information from the past medical history, family history and social history related to that problem.
- Format: One framework commonly used to structure the HPI is:

<u>Paragraph 1</u> Background

Characterize the patient's health at the time current symptoms began. If the symptoms are related to a chronic illness, give a brief summary of the illness, including when it was diagnosed, treatment, complications, and how well it is controlled.

<u>Paragraph 2</u> Details of the presenting problem

This is an organized and edited version of the patient's narrative, beginning at the onset of symptoms, and proceeding sequentially to the time of presentation. In FCM, your write-ups should use the day of admission as the reference point for time, and should be written as though you were present at the time of admission.

The chief concern should be described completely:

- quality
- attribution
- associated symptoms
- aggravating/alleviating factors
- timing/duration/frequency
- any prior episodes
- severity
- If the presenting concern is pain, also describe position (or location) and radiation

<u>Paragraph 3</u> Predisposing conditions and risk factors (sometimes called 'pertinent positives')

Information from the rest of the history (PMH, medications, habits and risk factors, family history, ROS) that is directly related to the presenting problem. For example, a family history of cirrhosis is pertinent and should be included in the HPI of a patient who presents with jaundice. The same family history of cirrhosis would NOT be pertinent to a patient with dysuria, so would NOT be included in the HPI.

<u>Paragraph 4</u> Pertinent negatives

- Absence of constitutional symptoms & symptoms from the organ system involved
- Negative information from the rest of the history that <u>directly affects</u> your assessment of the patient's problem. For example, "No family history of liver disease" is a pertinent negative in a patient presenting with jaundice.

<u>Optional</u> Hospital course or evalution to date

- Emergency room or hospital course
- Evaluation of concern prior to hospital admission, if applicable.

4. Past medical history (PMH)	All active medical problems and any other problems relevant to evaluation or ongoing management.
	Summarize for each major, active problem: diagnosis, current treatment, control, and complications

- ½ - 1 page
- Purpose: A comprehensive summary of all medical and surgical problems, both current and resolved.
- Format: Use a bulleted list with explanations when appropriate. Include the following subheadings:
- Major childhood illnesses
    - Medical problems, including psychiatric illnesses. List the chronic problems in outline form, even if mentioned in HPI, and include:
        - Date of onset
        - Brief presenting symptoms/ diagnostic test results if known
        - Current management and control
        - Complications
    - Surgeries (type of surgery and date)
    - Traumas
    - Obstetrical history

5. Medications & allergies	Prescribed medications and doses
	Non-prescription medications and complementary therapies
	Drug allergies and the type of reaction

- ¼ page
- List all medications by generic name and doses if possible
    - List over the counter medications
    - List complementary/alternative medicines
    - List medication allergies including the reaction

6. Habits and risk factors	

- Tobacco (in pack years, current amount, and stop date if appropriate)
- Alcohol (past and current amount, stop date if appropriate)
- Drugs (past and current amount, stop date if appropriate)
- Preventive health including: primary care provider, currency of immunizations, currency of appropriate screening (Pap smears, colonoscopy, etc.), diet, exercise, safety

7. Family Medical History	

- ½ page
- List grandparents, parents, siblings and children and major diseases each was affected by, including coronary artery disease, cancer, diabetes, alcoholism, genetic diseases, or major psychiatric illness.

8. Social history	Social influences on your patient's health and health care: living situation, social support, occupation and avocation, any financial or other concerns

- ½ page
- Purpose: To develop rapport and to understand the impact of education, culture, religion, income and social support on the patient's health and health care.
- Format:
    - Occupation and current employment
    - Upbringing, education, and family relationships
    - Current living situation: who the patient lives with, sources of support, financial and insurance issues, stresses, satisfaction, interests
    - Religious/spiritual support
    - Cultural identity

9. Review of Systems	List all systems and note the presence or absence of each symptom you asked about. For organ system(s) discussed in HPI, write "see HPI"
	Provide details of positive responses to ROS questions

- Format:
    - List all the review of symptoms for each system not discussed in HPI—for organ systems relevant to the presenting complaint, write "see HPI"
    - Provide details of positive responses to ROS questions
    - Remember that diagnoses belong in the HPI; symptoms belong in the ROS.

10. Physical exam	General appearance and vital signs
	Document each organ system in order and report all exam findings, both normal and abnormal.

- 1-2 pages
- Purpose: to describe your exam findings highlighting those that support or argue against items on your differential diagnosis.
- Format:
    - Begin with one sentence description of general appearance and comfort level
    - List vital signs: Blood pressure, pulse, respiratory rate, temperature, oxygen saturation (if known)
    - List in outline form a system by system description:
        - Skin; head, ears, eyes, nose, throat (HEENT); neck/thyroid; lymphatics; breast; chest/pulmonary; cardiovascular; abdomen; genital/pelvic/rectal (usually omitted in ICM II); extremities/musculoskeletal; neurologic
    - Be complete: describe what you found, both positive & negative findings. Do not just write "normal".
    - Do not interpret findings. Document only what you see, hear or feel

11. Labs and Imaging	Not part of the ICM II write-ups

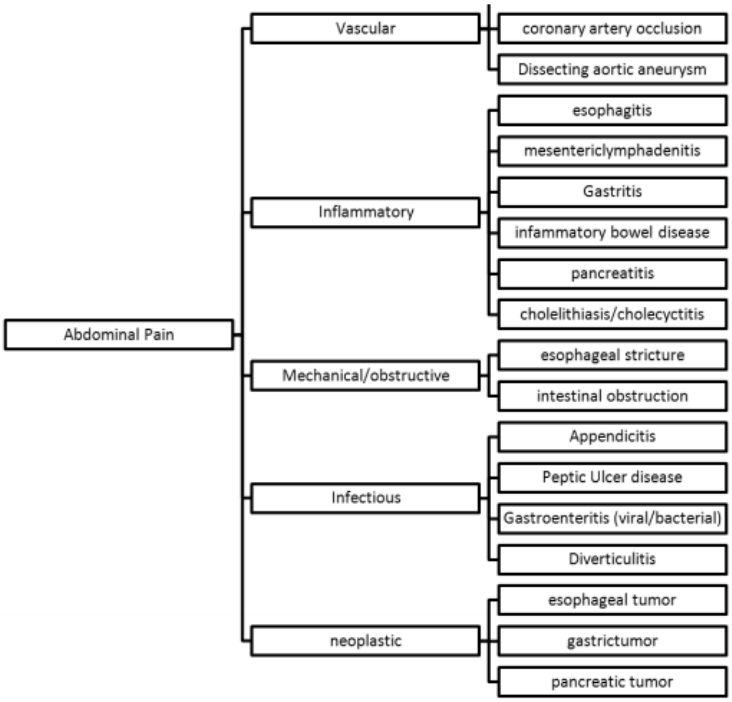
12. Summary statement	Restate the ID & summarize the key features from the history & physical exam

- 1-3 sentences
- Purpose: To synthesize the important history and exam findings, to frame the clinical problem and to lead your listener to your assessment. This is NOT simply a restatement of the ID chief concern.
- Format:
    - Restate the identifying data; summarize key features from the patient's history and physical exam

13. Branching Diagram or Diagnoses Matrix	Visual representation of your clinical reasoning process

Branching diagram

- Purpose: Visual representation of your clinical reasoning process. It helps organize your thinking and develop a complete differential diagnosis for a presenting complaint. *NOT included in 3rd year.*
- Format:
    - Begin with a symptom, physical exam finding, or other interesting feature of the case
    - Link possible causes to the primary symptom/finding/feature in an organized manner. These will become more complete as the year progresses



Diagnosis Matrix

- Purpose: Another tool for organizing your differential diagnosis, comparing the history, risk factor & exam finding of your leading possibilities. Your mentor may ask you to include this in winter and/or spring quarter. *Not included in 3rd year write-ups.*
- Format:
    - Begin with a differential of the 3-5 most likely or "can't miss" causes of the patient's presenting problem
    - Construct a 'matrix' table, with these diagnoses on one axis and "History", "Predisposing conditions and risk factors" and "Physical exam" on the other axis. Record the typical or common findings in each section of the matrix, and bold those present in your patient.

BILATERAL LEG EDEMA	HISTORY OF PRESENT ILLNESS	PREDISPOSING CONDITIONS & RISK FACTORS	PHYSICAL EXAM FEATURES
CHF	• Edema • Dyspnea, orthopnea, PND • Weight gain • Decreased exercise tolerance	• Coronary artery disease • HTN • Severe lung disease • Cardiac risk factors	• Elevated JVP • Enlarged or displaced PMI • S3 • Crackles • Hepatojugular reflux
CIRRHOSIS	• Edema • Increased abdominal girth • Weight gain • Jaundice	• Alcoholism • Viral hepatitis • Injection drug use • FHx of liver disease	• Normal JVP • Ascites • Spider angiomas • Jaundice • Splenomegaly
VENOUS STASIS	• Edema • Skin discoloration or ulceration	• Prior DVT • Obesity	• Hemosiderin deposition in skin • Ulcerations • Normal cardiac exam

14. Assessment	Format determined by clinical context

- Purpose: Explicitly state your clinical reasoning and understanding of your patient after you have read about and study the medical problem.
- Format for a new problem:
    - Begin with a differential of 3-5 possible causes of the patient's problem.
    - Discuss the most likely cause of the patient's problem. Link the features of your patient's history and physical either support or make each diagnosis less likely. Read about the "classic" or "typical" cases, what features are usually seen with the problem. What risk factors make this more/less likely?
    - Next discuss the other 2-4 other diagnoses you are considering (based on your branching diagram or matrix). Again, link the features of your patient's history and physical either support or make each diagnosis less likely
- Format for an exacerbation of a chronic problem
    - Your assessment would address the most likely reasons for the exacerbation, as suggested by your patient's history and exam findings.

Common Problems with the Write-up

The Problem List

Everything on the problem list should be mentioned someplace in the writeup and all important medical issues should be on the problem list.. The problem list should not refer to other sections of the write up - such as "see past medical history". Nor should other parts of the database contain references to "see problem list". The first problem on the problem list is usually the main complaint, or "presenting problem", and therefore is the first problem in the HPI.

The patient has been in the hospital for several days before your interview

Write the HPI as if you were present at the admission. You can add a section at the end of your HPI called "hospital course," summarizing what has occurred since the admission. Your emphasis should be on the patient's symptoms and presentation at the time of the admission as much as this is possible.
In "hospital course" you can include events and testing in the hospital and how the patient is doing now,. Since you will be getting this information from the patient rather than the medical record, you will probably not have all of the details.

Two equally important problems were responsible for the hospital admission

For most patients in the hospital, only one problem led to the admission (HPI), and the rest (even though they're active) are recorded in the PMH. On rare occasions, two problems have required admission. There are two ways to deal with this:

- combine the two problems in the HPI and record all symptoms chronologically; OR
- you can have two separate problems in the HPI. This is often the approach in a clinic patient with more than one active problem. In either case, you will separate the problems in your problem list, and often in the discussion as well.

Unclear chronology

Approach the patient from the standpoint of their history at the time of admission, when they presented for care. Your history is then collected and presented in a chronology organized on the basis of time "prior to admission" (or PTA). You should describe all events as in terms of mins/hours/days/months/years prior to admission or PTA.

Related complaints are discussed separately in the HPI

A patient with worsening ascites, for example, may experience simultaneous dyspnea, abdominal pain and edema. To discuss these 3 symptoms as separate problems in the HPI would be a mistake. When in doubt whether symptoms are related, discuss the case with your College mentor.

Pertinent positives and negatives are missing from the HPI

Deciding which information from the past medical, family and social histories and ROS is a "pertinent positive" or "pertinent negative" can be tough. You need an understanding of the differential diagnosis of a patient's

complaint to correctly identify the pertinents. As a beginning second year, you generally do not have this knowledge going into your interview. You will collect data in the standard sections of the interview, but after discussing and reading about the patient should have a better idea of what is pertinent and should therefore be moved to the HPI.
For the sake of completeness, you should also repeat the data you included as pertinent positives and negatives in the appropriate section of your write up, with the exception of the ROS where you note “see HPI” for the relevant organ systems.

The physical exam shows up in the HPI

Do not put physical exam findings from your examination into the history portion of the database, or historical information into the write up of the physical exam.

Patient with a known diagnosis admitted for routine therapy

If your patient has a known diagnosis with no new symptoms (e.g. a patient with known cancer who is admitted for chemotherapy), there is still a lot you can learn. You can learn about the natural history of the illness - how the disease has progressed over time. You can learn about the psychological and emotional impact of the disease, and the impact on the patient and family. Finally, even if the diagnosis is known, ask yourself what else this might have been, based on the patient's presentation before the diagnosis was known.

You could approach the patient as though the diagnosis had not yet been made, inquiring about the chronology and details of symptoms for an acute problem or an acute exacerbation of a chronic problem. For a patient with a chronic problem without an acute exacerbation, approach the case as a new referral - you need to learn about and understand the details of their illness

Unfamiliar abbreviations

Many abbreviations are used differently in different specialties. In addition, abbreviations are often over used -- "the pt is STH prbm c SOB..." translates to "the patient is said to have a problem with shortness of breath", and is inferior to "the patient became dyspneic...". When in doubt, spell out the word. Unfamiliar abbreviations will only bewilder your reader, and many are not allowed because of patient safety issues.

Mixing up the ROS and the PE

The ROS is part of the "subjective" portion of the medical database, along with the HPI and Past Medical History. This subjective information is given by the patient, or family or caregivers. The PE is part of the "objective" portion, reflecting your own findings and observations. Next year, the ‘objective’ section will also include labs and other testing, after the PE. Never mix the "subjective" and "objective" portions of the database

Insufficient detail

Be specific in your descriptions of abnormalities. A "soft systolic murmur" is inferior to "a 2/6 midsystolic murmur at the left lower sternal border, without radiation”

Long narrative descriptions of physical signs in the physical exam section

This prevents your reader from finding a particular sign at a glance.

NOT-SO-GOOD EXAMPLE:

Cardiac - neck veins at 6 cm of water, PMI- well-localized 5th ICS, 9 cm from midsternal line. Radial, brachial, femoral pulses 2+. Left popliteal not felt. Right femoral bruit. Posttibial and dorsalis pedis pulses 1+. S1 single, S2 physiologic split.. 2/6 midsystolic murmur at LLSB and apex.

BETTER EXAMPLE:

JVP: 6cm water
PMI: well localized, 5th intercostals space, at midclavicular line
Ausc: S1 single, S2 physiologic split. 2/6 midsystolic murmur at lower left sternal border and apex,

Pulses:	DP	PT	F	R	C
Right	1+	1+	2+	2+	2+
Left	1+	1+	2+	2+	2+

Recording a "diagnosis" instead of a "finding" in your physical examination

In your write up of the physical exam, you describe in detail the patient's history and physical examination. Diagnoses are reserved for your assessment and plan. Writing "findings consistent with RLL pneumonia" is inferior to “Chest: symmetric excursion, increased tactile fremitus right posterior base; no crepitus/ tenderness to palpation; dullness to percussion at right posterior base; bronchial breath sounds with occasional mid-inspiration crackles right posterior base on auscultation.”