The Perfect “Encounter”:
A Strategic Approach to Communication & Interpersonal skills

The encounter in a USMLE CS examination is between a non-physician medical educator (SP: Standardized Patient) and an examinee, who may be a medical student or a physician. SPs are defined as "a simulated or real patient who has been taught to present a problem so accurately that the simulation cannot be detected by a skilled clinician." (1)

These SPs will seem like real patients to you and should be treated as such during the USMLE examination. With this in mind, it is important to remember that good communication and interpersonal skills are a top concern for every patient. If you have a pleasing personality, patiently hear all of their dilemmas and concerns, and have good communication skills, it will surely create and maintain long lasting and conducive relationships with your patients.

Before we talk about strategies to delineate an ideal and perfect encounter with a SP, we should know a few facts about the examination.

First, what is the purpose of the examination?

It is very interesting that this examination is structured to test your clinical skill proficiency and not the diagnosis that you arrive at.

Three components of the report score:

One must pass all three components in a single test administration. These three components are as follows:

- ICE (Integrated Clinical Encounter): assess data gathering and data sharing ability. This includes basic clinical skills (history taking and physical examination) along with its documentation as patient note.
- CIS (Communication and Interpersonal Skills): This generally includes overall impact of your personality, your behavior, interaction and communication with the patient.
- SEP (Spoken English Proficiency): This includes an assessment on a scaling system.

Information about exam scoring. How it is scored and who scores this?

Once you finish your encounter, standardized patients (SPs) go thru and check certain items on their computer that is available in the room. There are about 20-23 items in CIS, 9-10 items in physical examination and probably 5-6 items in SEP. The items in history taking are case specific and variable. In addition, they also rate your spoken English proficiency on a scale using a rating system. Don’t forget that a non-physician medical educator or a SP will assess you for an entire encounter, not as another physician. Only patient notes are assessed by physicians.

In the CIS component, 23 items are assessed in every case and you need to score 19-20 every time:

1. Did examinee knock on the door before entering the room?
2. Did examinee appear professionally dressed and presentable?
3. Did examinee introduce him/herself?
4. Did examinee maintain comfortable eye contact?
5. Did examinee use patient last name to address her/him?
6. Did examinee have focused attention on patient?
7. Did he/she express empathy?
8. Did he/she convey nonjudgmental attitude?
9. Did he use appropriate draping techniques?
10. Did he/she use few open ended questions?
11. Did he/she use non leading questions?
12. Did he/she ask multiple questions at a time?
13. Did he/she question without interrupting the patient?
14. Did he/she perform paraphrasing?
15. Did he/she use layman language?
16. Did he/she use transitional phrases?
17. Did he/she give explanation during physical?
18. Did he/she provide appropriate reassurance?
19. Did he/she summarize significant history?
20. Did he/she convey his diagnostic impression in layman terms?
21. Did he/she discuss diagnostic test?
22. Did he/she ask if patient had any questions or concerns?
23. Did he/she offer patient education/suggestions?

A good wrap-up is most important:
It is important to note that if you do a proper counseling and wrap-up, you will cover more than six of the points identified in the CIS as mentioned above.

How to interview a patient:
Before we review, "how to interview a patient," I’d like to quote the “Four habit Model” of highly effective doctors given by Dr. Stein (Article is available in The Permanente Journal).
http://xnet.kp.org/permanentejournal/fall99pi/habits.html

The Four Habits Model of Effective Clinician-Patient Communication is summarized below:

1. Invest in the beginning: As you approach a patient you should create a rapport very quickly. You should be in position to elicit the patient concern as early as possible. Let the patient know "what to expect" from you.

2. Elicit the patient’s perspective: Dig out each and every minute aspect of disease, its presentation, how the patient thinks about it or any specific idea in his mind and also explore the social and professional impact on the patient's life.

3. Demonstrate empathy: Show the patient that I’m here to share your pain and be open to patient’s emotions. Make empathic statements (I’m really sorry to hear that) and convey it nonverbally (facial expressions, pauses, touch on shoulder).

4. Invest in the end: A thorough counseling! Deliver diagnosis, explain investigations and tests, and review next steps. Do not, however, forget to use only and only layman language.

This model of patient interviewing is best understood with visualization of an ideal interview in an American context. I’d firmly recommend watching videos available on the interactive site of Drexel University. These videos beautifully foster learning about complex communication and relationship challenges.

The link for these videos is given below:
http://webcampus.drexelmed.edu/doccom/user/
You may access these video after a free registration which lasts 15 days.

Most common reasons for failing in a USMLE CS:

1. No proper closure or counseling
2. Faking physical examination
3. Hurried the patient
4. Following a set pattern of memorized questions from a book like first aid. Most candidates try to memorize a questionnaire and this in-turn compromises their performance in the CIS, as they are always thinking about the next question. It is important that you frame your next question from the SP's previous answer. It should be extempore and spontaneous. Try to INTERNALIZE these questions without any set pattern or protocol. To do that you need repeated practice with cases with any of your partners. Don’t underestimate the value of live practice. Try to follow hints given by SP’s rather then going through a checklist. Don’t forget to ask PAMHUGSFOSSWA in every case.
5. Lack of practice
6. Lack of confidence shown by lack of eye contact.

Now we are in a position to outline the most successful strategy for the examination:

- CIS is the component where most people (especially IMGs), if they fail, are likely to fail in.
- CIS has 20-23 scoring points, and require meeting 19 to 20 to pass in all encounters.
• Closure itself is 6 points (Vide-supra)
• ICE is one component that has more than 50 different scoring points. (Physical exam plus patient note)
• To deliver your best in communication and interpersonal skills always follow the basic principles of the "Four Habits Model of Effective Clinician-Patient Communication" (as described above).
• Never forget the last component of the Four Habit model: Invest in the end, the counseling!
• If you are running out of time do not compromise counseling and wrapping up of the encounter. If you need to choose between a thorough physical examination and counseling due to scarcity of time, choose to do a proper counseling over the physical examination.
• Wrapping up or counseling is a MUST. Never leave the room without it!
  You didn’t finish Questions or PE, proceed to wrapping up:
  "I’ve got an emergency call on my pager and I need to leave within a few minutes. I’ll get back to you as soon as I return back. However, before leaving I’d like to summarize my findings so far........ (Then start counseling)!

A “ROBOTIC” protocol to deal with an encounter:

We have developed a robotic protocol to deal with an encounter. It should be practiced multiple times in such a way that you do not forget any steps. It can be used in every case with slight modification.

Outside the room:
Minutes before the encounter:
Practice these steps by writing them down (as quickly as possible in 30-40 sec)

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**Introduction:**

*Enter SMILING and shoulders up (relaxed)*

Good Morning/Afternoon/Evening Mr./Ms./Mizz xxxx (SMILE)!
I’m Dr. XXXX. I’m the physician on duty here today.
Nice to meet you!
Is everything fine in this room? (Yes)

**Look into their eyes!**

Please be seated. (If patient is standing)
Let me make you slightly more comfortable. (Pull drape, place drape)

May I sit down?
(Do not move chair closer or away from the patient = 1 meter = This is the comfort zone)
(Stay standing: If it is an emergency case)

Attentive position: Leaning forward 10% with straight head and shoulders up.

Maintain eye contact throughout the encounter. Looking into eyes may disturb you, so look at forehead
(midline just above the nose: patient will think that you are looking into their eyes.)

Facilitate and encourage with sounds (Ah....ha.....yes.....go-on.....I see...ok......excellent..........oh my
goodness.................really.........please continue..........)

Minimize distractions: including writing down notes
Give proper time to SP to explain everything. Do not interrupt.

Tell me, how can I help you?

**Oh! I’m really sorry to know about your problem. (Empathy!)**
I shall try my level best to help you in this regard.

Other ways to show empathy:
- I can see you have been under a lot of stress.
- How you are feeling about that?
- How has it affected you?
- Oh my goodness!
- This must be putting you under considerable strain

Are there any other concerns that you have?.........anything else?

(If multiple problems, then ask:) As you have a number of concerns, what seems more important to you?

Would you please tell me more about it from the beginning?

What made you decide to get it checked now?

I hope you won’t mind if I write down a few notes while we talk?

**History taking:**

O P D S F C A A A (All cases)
O P D S F C L I Q R A A A (pain)
O P D S F C A B C O (vomiting, diarrhea, constipation, cough, vaginal discharge)

**Onset:**
When did it start/when did you first notice?
Was the onset sudden or gradual?

**Progression:**
How did it progress? Did it get better or did it become worse?

**Duration:**
How long have you been having this problem?
**Setting:**
What were you doing when it started?

**Frequency:**
How frequent/often does it occur?
How many episodes of xxx do you have per day?

**Constant v/s intermittent:**
Was it consistently there or did it come and go?

**Location:**
Would you please locate the exact site with your finger?

**Intensity:**
How would you grade your pain on a scale of 1-10, where 10 represents the most severe pain?

**Quality:**
How would you describe the pain? Piercing, burning, throbbing, dull or sharp?

**Radiation:**
Does the pain move/travel anywhere else?

**Alleviating factors:**
Is there any factor which makes the pain better?

**Aggravating factors:**
Is there any factor which makes the pain worse?

**Associated problem:**
Do you have any other associated problem like.....?
Nausea, fever, headache, neck stiffness, limb weakness, numbness or tingling, etc.

*Do you remember any factor or event which could be responsible for it?*

**Amount:**
What was the volume or quantity of blood/cough etc? A cupful, a teaspoon, or a tablespoon?

**Blood:**
Have you noticed any blood in it?

**Color:**
What color was the vomit/discharge/stool?

**Consistency:**
How did it appear? Was it watery, fatty or bloody?

**Content:**
What did it contain?

**Odor:**
How did it smell – any specific odor?

P A M H U G S F O S S W A

Have you had any similar episodes in the past?

What other medical problems do you have?
Blood pressure, diabetes, stroke, heart attack, etc.

Are you allergic to anything? Any foods, pet, fumes or smoke?

Are you taking any medicine or have you taken any?
Have you ever been hospitalized?

Do you have any urinary problem?

Do you have any problem with bowel movement?

How is your sleep?

*The way medicine works; there could be some additional clues in your personal information, which I’d like to ask. Is this okay with you? (Yes) Thanks!*

Does anybody in your family have a similar medical problem?
Are your parents alive?
How did they pass away?
Is there any history of blood pressure, diabetes or cancer in your family?

When did you have your first menstrual period?
Were your menses normal/regular?
When did you have your last menstrual period?
Are you married?
How many kids do you have?
Were they delivered normally?

*Now, I’d like to ask something about your lifestyle. Is this okay with you? (Yes) Thanks. SODA*

Do you smoke?
How long have you been smoking?
How many packs per day?

Do you drink alcohol?
What type of alcohol do you drink?
On an average, how many pegs/beer do you drink per day?
How many days per week?
Have you ever thought to cut down on your drinking?
Have you ever felt annoyed by criticism of your drinking?
Have you ever had a drink first thing in the morning?
Have you ever had guilty feeling about drinking?

Do you take illegal drugs?
How do you take it?
How frequently do you take it?

*Avoid leading questions: For example, "......and you don’t have any fever?" – you need a negative answer from SP!*

What do you do?

*Now I’m going to ask a something very personal, please do not feel embarrassed. All the information will be kept confidential.*

Are you sexually active?
How many partners?
What is your sexual preference? Are you active heterosexually or homosexually or both?
Do you use any contraceptives?
Have you ever been diagnosed with a sexually transmitted disease?
Do you know your HIV status?

Have you noticed any change in your weight?

How is your appetite?

**Summarize:**
*To summarize your history, ".........."*

Is there anything you’d like to tell me or add before I start your physical?
Okay, now I'd like to perform a quick physical examination, is this okay with you? (Yes) Thanks.

**Wash hands:**
Excuse me for a moment, let me wash my hands.
Always engage the SP in a conversation while washing your hands. Don't let him/her feel unattended.

**PE:**
Let me perform a physical examination. May I?
Let me have a quick look at your eyes? (Examine eyes)

P I C K L E: Pallor, icterus, cyanosis, koilonychia, lymphadenopathy and edema

Patient in sitting position over couch:
Examine eyes, oral cavity, neck (thyroid and glands).
Examine thyroid from back also.

Now I need to examine your chest and heart. May I untie your gown?
Simultaneously examine posterior chest. Perform auscultation in all routine cases
"I want to listen to your chest." Keep diaphragm for about 5 seconds at every area. You may utilize this
time to plan for your next strategy.
Also examine tenderness over CVA region or spine.
Now you may bring the gown down to expose front of chest.
"Now I want to listen to your heart and chest."
(Auscultate chest as earlier. Auscultate heart with "quick & dirty examination technique" by placing
diaphragm in Lt parasternal location for 10 sec. (Examine heart in 4 locations with Lt decubitus position if
it is relevant to case)
Let me tie your gown.

Patient is still sitting. Now tell him that you are now observing legs for edema, fingers for any signs of
underlying disease and perform the examination simultaneously.

Now let the patient lie down. Help during the process and pull the foot support out.
Now examine neck for JVP, carotid bruit and tell him that you are watching the blood channels in the neck.
Now perform abdominal examination if required in the case.

If abdominal examination is not required move for the other parts of the examination in a sitting position
e.g. neurological examination.
Never forget to offer basic help and courtesy during the examination. For example, help the patient move
in or out of the bed.

**Conclude:**
"Thanks for your co-operation." (Now be seated on stool and start counseling.)

On the basis of information I gathered from your history and physical examination, it appears that you are
probably having xxxx. However, there are some other possibilities such as xxxxx. To rule out these
possibilities we need to run a few investigations. This will include some routine blood/urine tests, x-rays,
etc.

Once these results are available, please come back to my office and we will discuss the management.

**Counsel:**
Being a concerned physician I must advise you to limit the quantity of alcohol you drink and try to quit
tobacco. Do you have any plan to quit?
(Yes) Excellent!
(No) I understand it is very difficult to quit suddenly.
We have a very well developed support program. Please feel free to contact me anytime for specific steps
we can take, I would be very happy to help you in this regard.

I hope you have understood what we have discussed today?

Do you have any other questions or concerns?
I hope I have answered your questions?

Please feel free to contact me any time, if you require any clarification or help.

It was a pleasure meeting with you.
(Shake hands) Have a good day.

Reference:

**Neurological Examination:**

Mental state
CN
Motor system
Sensory system
Reflexes
Coordination and gait
Special tests

**Q’s to ask:**

Move from head to toe:

**Head:** Headache⇒Blurring of vision⇒ Ear: Dizziness, Lightheadedness, Ear discharge, Hearing problem, Fullness in ear ⇒ Mouth: Speech⇒ Trauma, Fall

**Chest:** Chest pain, cough and palpitation

**Abdomen:** Urination, bowel

**Limbs:** Gait, Weakness/numbness/tingling

**Body:** Shaking of body

**Mood:** How is your mood? How you feel about your life?

**Mental state:**

Where are you Mr. XXX
What date is today?
Who is president of US?

**MMSE:**

What’s your name, Where are you, who is president of US, what day is today?

Can you spell word WORLD backwards for me?

Now I’ll pronounce three words, you have to repeat them immediately and later when I ask you to repeat- Is it okay?

Now I’ll write a command – you have to follow it and perform whatever it says.

What will you do, if you see fire coming out of this dustbin?

MMSE-When running out of time (Five minutes remaining and examination yet not started): Ask the patient what’s your name, Where are you, who is president of US, what day is today?
Describing various tests:

- **MRI** is imaging of body parts by a computerized machine using a large magnet.
- **CT** is imaging of body parts by a computerized machine using X-Rays.
- **Ultrasound** imaging of body parts by a computerized machine using sound waves which we can not hear.
- **Carotid Doppler**: Imaging of large blood vessel conveying blood from heart to brain by a computerized machine using sound waves which we can not hear.
- **ECG**: graphical recording of heart
- **EKG** Graphical recording of rain function
How to evaluate case of fatigue:

Step-1: Follow the principle of “OPD FC AAA”

Onset ➔ Progression ➔ D and F not applicable ➔ Consistent/Any specific time or situation ➔ any factor or event responsible? ➔ Associated problems? (Nausea, vomiting/Fever, chills & night sweat) ➔ Aggravating ➔ Alleviating

Step-2: Follow Head to toe history like Neuro case in a modified manner

Headache/Lightheadedness ➔ Loss of consciousness ➔ Neck (or other parts) glands ➔ Chest pain or cough ➔ Pain any where in tummy ➔ Problem with urination

Step-3: Ask hypothyroid history

ABCD HV
Appetite ➔ Bowel ➔ Cold intolerance ➔ Depression (how is your mood) ➔ Hair fall ➔ Voice

Step-4: Ask about depression questions FACE SLIPS

Do you feel any guilt?
How is your memory and concentration?
How is your energy level?
Do you find any difficulty falling/staying asleep or waking up?
How is your libido?
How is your life? How do you performing in your job?
Do you have any thought to hurting yourself or ending your life? Any plan?
Do you snore?
Do you hear or see anything which others can’t?
Do you hold any idea that others want to control you or harm you?

Step-5: Ask about probable CA’s/Bleeding (Anemia)

Do you have black stools? Or passed blood in your stool?
Have you ever vomited blood?
Do you find any difficulty in swallowing food?
(Chest symptoms already asked)
Have you ever noticed yellowness of skin, dark urine or clay colored stools?

Step-6: PAMHUGSFOS W A-already done with hypothyroid
Evaluation of OA:

Follow **OPDFC** → Then **DPS W**: Deformity, Pain (LIQRAAA, bilateral? worse on which side, during night/resting state), S = Stiffness (When mostly felt?) and sound (any cracking sound? During movement), weakness of muscles around knee

- How long have you been having the osteoarthritis?
- How is it progressing?
- Do you consistently feel pain?
- Is there anything which makes the pain better or worse?
- Is it on both sides? Which side is worse?
- Do you know any specific situation where you feel more pain?
- Do you feel pain during sleep or resting state?(S/o advanced stage)
- Have you noticed any stiffness? When it is seen most of the time?
- Have you noticed any cracking sound during movement?
- Have you noticed any muscular weakness around knee?
- What treatment are you taking for it?
- Did you have any injury of knees anytime?
- Describe your usual activities and exercise routine?
- Do you have similar pain anywhere else –like hip?
- Do you feel pain down your calf or leg?
- Did you have any rash or fever in the recent past?
- When did you have your last menstrual period/ when did you have your menopause?
- Are you taking vit-D and calcium?
- Have you ever tried HRT?

Counseling:

As you know it is a problem of aging and related to wear & tear of joint. The pillars of management are regular exercise, weight reduction and regular pain killer to relieve pain. We may also try heat and cold therapies, joint protection techniques, and surgery or joint replacement in advanced cases. Regular exercise can help manage pain, as well as keep joints moving. Other positive effects include strengthening muscles around joints, increasing energy, improving sleep, controlling weight and strengthening the heart. You may also try local massage with oils and anti-inflammatory ointments
**Chest pain with Sickle cell anemia:**

In addition of routine Q’s about chest pain add:

1. Factors that precipitate sickle cell crisis like dehyadration, diarrhea, fever etc
2. H/o hematuria
3. H/o blood transfusion
4. H/o Blood clot formation (Personal and family)
5. Examination: do not put stethoscope over area of tenderness, examine fingers and calf
6. Counseling:
   - Avoid hypoxemia, dehydration
   - Drinking at least 8 glasses of water every day, especially in warm weather
   - Exercising regularly, but not to the point that you become very tired
   - Limiting the amount of alcohol you drink.
   - Quitting smoking.
   - Contact your doctor if you have any signs of an infection, such as a fever or trouble breathing.
   - Flu shot every year.

**Musculoskeletal Case: Knee pain/Acute arthritis**

**CITRUS HPT**

Chest problem/Cough/Pain
Insect/Tick Bite
Travel/Trauma
Rash
Ulcers in mouth
Stiffness

Hair loss
Photosensitivity
Temperature: Cold reaction? Abnormal reaction/fingers?

**Fever:**

In any case of fever always ask about coexisting night sweats and chills, recent ill-contacts and exposure to anybody with TB?

In a pediatric –phone case of fever we may use “CITRUS” in modified way:

Chest problem/Cough/Pain
Insect/Tick Bite/Exposure to Infection
Travel
Rash
Ulcers in mouth
Stiffness in any limb? (Septic arthritis?)
Challenging questions & situations:

- **Will I pass it to my students? (A teacher with diarrhea)**
  Some of the diarrheas may be transmitted to the other people through contamination of water and food. We are not aware of the type of diarrhea you are having and in order to know about it, I need to run a few investigations. Though being a teacher you might not be handling food and water but to minimize the risk I'll suggest you to maintain toilet hygiene and frequently wash your hands.

- **Crying! (Keep silence for a moment and offer him a tissue. Show empathy on your face. Gently touch his shoulder.)** "I understand you feel sad. Would you please tell me more about it."

**Pediatric Patient: General Questions to ask:**

Begin with birth history:

Alcohol, Tobacco or drugs during preg ➔ Complication during pregnancy ➔ Routine checkups ➔ USG during preg

Complication during delivery ➔ Term? CS or normal?

Complication after delivery ➔ Any infection after birth ➔ First bowel

Milestones:
First smile, first sit-up, talking, walking, dressing up, tying shoe, short sentences, followed two step commands

Breast fed / Diet? Describe typical diet? (What are his eating habits? Can you describe his typical diet?) Solid food, fortified with iron, Multivitamin Immunization, Appetite

Followed by:

- Does he have any symptom like fever, cough, or diarrhea? *(Then ask more about symptom)*
- **ON CALL IDIOT:** (More appropriate for diarrhea/vomiting)
  Onset, Number, Cry, Consistency of stool/Cough, Associated symptoms, Listlessness, Liquids (Urine), Immunization, Diet/Dehydration/Day care, Infection in family, ORS, Travel
- Does he have appetite for non-nutritive substances (e.g., coal, soil, feces, chalk, paper etc)?
- When did he visit physician last time?
- How was the child’s weight gain and growth?
- How is toilet training going?
- Is he a physically active child?
- Is the child safe at home?
- Do you use child proof equipment?
- Do you use child seat in the car when you travel with the child?

**DDX Temper Tantrum v/s ADHD:**

- Is the child distractible?
- Does he have difficulty with concentration and focus?
- How is his memory?
- Does he have any problems organizing ideas and belongings?
- Does he show any impulsivity?
- Does he have weak planning and execution?

**DDX Child not eating well? R/o infective process, lead poisoning, iron def anemia**
Picky Eater

Picky eater telephone case (with constipation)

History taking:

Good Morning, Mrs. Smith. I’m Dr. Xxx; I am an attending physician here at the medical center. How can I help you today? (My son is a picky eater; I am wonder if you could give me some advice on what I should do about it?).

Ok, Mrs. Smith, I’d like to ask a few questions about your son.
How old is your son? (He is 4 years old)
Why do you think that he is a ”picky eater” - does he have any specific preferences for the food? (OK, for example, he only eats some potato chips, candies and drinks fruit He doesn’t like to eat regular meal.)
Does he constantly behave like that?
How long has he been having this problem?
How is it progressing -getting worse or getter better?

Have you ever punished, bribed or rewarded your son to alter his eating behavior?

Does he often drink high calorie drinks like juice, soda or milk?

Do you follow a set schedule of meals?

Do you often offer desserts along with routine meals?

Does he watch TV before mealtime? (Yes, he watches TV sometimes)
Does he have any pain in his belly? (No, he didn’t mention it)
Does he have any problems with his bowel movement? (He has constipation)

How many times a week does he have bowel movements? (2-3 times a week) Constipation = <3 stools per week(problem > 2months =Chronic)

How are the stools? (Are stools hard, dry and unusually large?)

What is the caliber of stool?

Are stools difficult to pass or painful to pass?

What color of the stool is?

Have you noticed any blood in the stools? Was it fresh blood or blood admixed with stools?

Have you ever noticed bright red blood on the toilet tissue after your child has a bowel movement?

When did your child sit on the toilet?

How long does your child sit on the toilet?

Does he avoid the toilet because of his activities or play?

Does he resist toilet training?
Does he have any Stomach pain and bloating?

(Now ask about associated symptom)

Does he have any headaches? a fever? Short of breath? Diarrhea? (No)
(Now ask about PAM HUGS FOSS question)

Did he ever have similar episodes in the past? (No)

Has he ever been diagnosed with any medical illness before? (No)

Does he have any allergies? (No)

Is he taking any medications? (No)

Has he ever been hospitalized? (No)

Does he have any problems with his urination? (No)

Does he have any problem with sleeping?

How many children do you have? (He is the only one)

How much time do parents spend time with him? (A few hours a day, because both of us work)

Who takes care of your child when you are working? (He goes to day care center)

What kind of house do you live? (Very old one)

Then ask Milestones questions (I use IDIOT mnemonic)

Are his immunizations up to date? (Yes)

When was his last well-child check-up? (Six months ago, everything is fine at that time?)

Did he have any infections before? (No)

Did you have any problems with your delivery? (No, everything was fine)

Has your family moved recently? (Yes, we just moved here six months ago)

Sample Closure:

"Mrs. Smith, according to the information you provided me, I feel that your son is probably going through a normal phase of growth. It is a common isolated problem in this age group. Fortunately it responds well to a few behavioral changes. First of all, I’d suggest you to strictly follow a set schedule and offer him a variety of foods at the meal time. Discourage high calorie drinks in between the meals. The children are often moody and they need to offer the same food multiple times before they accept it. The next important thing is the environment at mealtine. It should be conducive and pleasant enough without any distractions. Any argument or watching television should be avoided at the same time. Regarding the constipation, I’d suggest you to provide him high fiber diet like cereals, vegetables etc. You may encourage your child to follow a planned time to sit on toilet by rewarding him. But do not to use food as a reward. However, I’d also require examining him personally and ordering some tests on him to rule out some other possible causes of constipation and behavioral disorders, before I make any definitive diagnosis or give final advices. Does this sound good to you? Hope you understood whatever we discussed today? Do you have any concern or question? Alright then, I will see you once you get to the hospital. Take care."

Differential Diagnosis

1. Low fiber diet
2. Lead poisoning
3. Hypothyroidism
4. Oppositional Defiant Disorder
5. Attention deficit Hyperactivity Disorder

Diagnostic Workup
1. CBC
2. TSH, T3, T4
3. Serum lead level
4. Stool ova and parasitology
5. Serum calcium
**Stridor:**

When did it start?

**What was he doing when it started? (Eating peanuts or playing with toys?)**

Was it sudden in onset or presented in a gradual manner?
(Acute: Foreign body aspiration, infections such as croup and epiglottitis/Chronic: Laryngomalacia)

How is it progressing now—Getting worse or constant?

Is the sound consistently there or does it come and go?

Do you know anything which may have caused it?

Do you know anything which makes it worse or better?
Like feeding, crying, supine position, sleep?

When it is best heard—While inhaling air or while exhaling?

How will you grade its severity?

**Is he able to breath, cough and talk? (Choking?)**

Did you intervene in any manner or tried any treatment?

Does he have any associated problems? Like cough or fever?

Tell me more about cough-Is it barking in nature? Is it productive? Have you seen any blood in cough?

Is he crying? How is he crying? Muffled or weak?

Have you noticed any drooling?

Have you noticed any blueness of skin?

Does he have any difficulty in swallowing food?

Did he have similar episode in the past?

Have you noticed any hoarseness of voice?

Does he snore at night? (Chronic case)

Is there any history of intubation into airway or any other complication at the time or after the delivery?

Is there any history of allergies in the family (Atopy-angioedema?)

Has he suffered any psychological or social stress in the recent past?

How is his growth & development on the whole?

Does he have any pain in his belly? (No, he didn’t mention it)

Does he have any problems with his bowel movement? (He has constipation)

Did he ever have similar episodes in the past? (No)

Has he ever been diagnosed with any medical illness before? (No)

Does he have any allergies? (No)

Is he taking any medications? (No)

Has he ever been hospitalized? (No)
Does he have any problems with his urination? (No)

Does he have any problem with sleeping?

Then ask Milestones questions (I use IDIOT mnemonic)

**Are his immunizations up to date? (Yes)**

When was his last well-child check-up? (Six months ago, everything is fine at that time?)

Did he have any infections before? (No)

**Sample Closure**

Mrs. Wheaton, according to the information I gathered from you, I’m considering a possibility of foreign body aspiration in this case. However, possibility of some infection causing the same problem might not be ruled out. I feel that she needs an emergency medical attention. As you told me that you are not having any transportation, I’d suggest you to immediately Call 911 and bring him to the medical center. Meanwhile I’ll suggest you that please do not put finger in his mouth or perform any blind finger sweep because the foreign body may become more deeply lodged, if it is actually present. In case, if you observe a significant respiratory compromise or choking please perform a Heimlich maneuver by thrusting tummy with sudden pressure. Hope you understood whatever we discussed today? Do you have any concern or question? Alright then, I will see you once you get to the hospital. Take care."

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<table>
<thead>
<tr>
<th><strong>Differential Diagnosis</strong></th>
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<tbody>
<tr>
<td>1. Foreign body aspiration</td>
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<td>2. Croup</td>
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<td>3. Epiglottitis</td>
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<tr>
<td>4. Laryngitis</td>
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<tr>
<td>5. Retropharyngeal abscess</td>
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<td>6. Angioedema</td>
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<table>
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<tr>
<th><strong>Diagnostic Workup</strong></th>
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<tbody>
<tr>
<td>1. Arterial Blood Gases</td>
</tr>
<tr>
<td>2. CBC</td>
</tr>
<tr>
<td>3. X-ray Neck AP and lateral</td>
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<tr>
<td>4. CxR PA in expiration</td>
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</tbody>
</table>
Newly diagnosed case of Diabetes in a child:

When did it diagnose?

How was it diagnosed?

Is he taking any medication/Insulin? (Yes – Insulin)

Tell me about the site of insulin injections? (Thigh: early peak and early fall, chances of hypoglycemia. Abdomen: Preferred)

Is he compliant with the Insulin or taking it regularly?

Is there any side effect of Insulin?

When did you measure his blood glucose last time? What was the level?

Are you measuring blood glucose regularly at your home?

How it has affected the family and child?

Does he have any abnormal thirst or extreme hunger?

Does he feel any weakness or fatigue? Or Depressed?

Is he irritable?

Does he have any problem with vision like blurring of vision?

Has he lost some weight in recent past?

Does he have any tingling or numbness in limbs?

Does he have frequent infections of skin or gums? Or itchy skin?

Have you noticed any skin lesion?

What is his weight and height?

Is he following any specific diet? Would you pls tell me more about his diet schedule?

Does he play? How many hours? At what time? What does he play?

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How is his growth & development on the whole?

Does he have any pain in his belly? (No, he didn't mention it)

Does he have any problems with his bowel movement? (He has constipation)

Has he ever been diagnosed with any medical illness before? (No)

Does he have any allergies? (No)

Is he taking any medications? (No)

Has he ever been hospitalized? (No)

Does he have any problems with his urination? (No)

Does he have any problem with sleeping?
Then ask Milestones questions (I use IDIOT mnemonic)

Are his immunizations up to date? (Yes)

When did he visit his physician last time?

Did he have any infections before? (No)

Did you have any problems with your delivery? (No, everything was fine)

Does anybody in family have similar problem?

**Sample Closure:**

"Mrs. Davidson, I can understand the way you are feeling after your daughter diagnosis of diabetes. Diabetes may alter the dynamics of the entire family and affects everyone. Your life is going to be a little different now but believe me we can mange this disease very well through combination of insulin, balanced diet and regular exercise. First of all, you should understand the disease and know how to manage it? You will need to attend diabetes classes with your daughter. Secondly; everyone including the patient herself should be able to recognize signs of low glucose levels like confusion, disorientation or fainting and should be in position to provide appropriate help. She should always carry glucose tables or juices as an "emergency kit". Her teachers and friends should also be aware of her disease. Hope you understood whatever we discussed today? Do you have any concern or question?"

---

**Differential Diagnosis**

1. Type-1 Diabetes Mellitus
2. Type-2 Diabetes Mellitus
3. Secondary Diabetes
4. Dysmetabolic Syndrome-X
5. Maturity-onset diabetes of youth
6. Prader-Willi syndrome

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**Diagnostic Workup**

1. Fasting glucose
2. Serum electrolytes
3. UA for glucose, ketones, and protein
4. Hb A1c
5. Insulin and C-Peptide levels
6. Islet cell antibodies
Child with Jaundice:

When did you first notice?
(Jaundice within 24 hrs or Color getting deeper after 7 days old or Jaundice is not gone after 14 days of age or Jaundice began or reappeared after 7 days of age require attention)

Are the skin as well as white of eyes both yellow?

Does the Skin appear deep yellow or orange?

Severity according to body part involved?
Vomiting?
Distension abdomen?

How old is your child? (First 24 hrs after birth: Pathological? ABO/Rh)

How is it progressing now-Getting worse?

What’s your blood group?

Do you know the blood groups of your husband?

Have you been pregnant before or aborted earlier?

When did you start breast feeding the child? Is he bottle fed?

Are you adequately breast-feeding him?

Is he sucking well?

Did he pass any stool? What color was stool?

Is he passing urine regularly? How many diapers per day? (< 6/day needs evaluation)

Has he passed urine in last 8 hours (Not =Dehydrated)

What color is urine?

Is your child awake and responsive?

Is he playful, crying and moving well? Or he is lethargic and listless?

Is there any sign of dehydration like very dry mouth, sunken soft spot?

Does he have any fever or low temperature? Did you measure it?

Fever? Cough, pulling ear, runny nose, distended abd, cry when urine is passed?

PAMHUGSF

How is his growth & development on the whole?

Does he have any pain in his belly? (No, he didn’t mention it)

Does he have any problems with his bowel movement? (He has constipation)

Has he ever been diagnosed with any medical illness before? (No)

Does he have any allergies? (No)

Is he taking any medications? (No)

Has he ever been hospitalized? (No)

Does he have any problems with his urination? (No)
Does he have any problem with sleeping?

Then ask Milestones questions (I use IDIOT mnemonic)

Are his immunizations up to date? (Yes)

When did he visit his physician last time?

Did he have any infections before? (No)

Did you have any problems with your delivery? (No, everything was fine)

Does anybody in family have similar problem?

**Sample Closure**

"Mrs. Whitestone, as per the information provided by you, I’m considering a possibility of physiological or natural jaundice. It usually peaks on day 4 or 5 and then gradually disappears over 1-2 weeks. However, there are certain other possibilities like jaundice because of breast feeding or some other pathological conditions or birth defects. I’d suggest you to bring the child to the medical center for further evaluation. Meanwhile I’ll suggest you to feed your baby every 1-2 hours during the day and don’t let him sleep more than 4 hours at night without a feeding. As your child is having less than 3 stools/day, you need to facilitate passage of stools simply by carefully inserting tip of a lubricated thermometer into his anus and slowly moving it from side to side. Improved stool frequency may also lower the pigment levels in the body by excreting it into the stools. Hope you understood whatever we discussed today. Do you have any concern or question?"

**Differential Diagnosis**

1. Physiological Jaundice
2. ABO or Rh incompatibility
3. Neonatal Sepsis
4. Cephalohematoma
5. Breast feeding jaundice
6. Polycythemia

**Diagnostic Workup**

1. Total and indirect bilirubin
2. Blood Typing
3. Direct Coomb’s Test
4. C reactive protein
5. CBC
6. Titers for CMV, toxoplasmosis and rubella (If required)
HALLUCINATIONS

Would you please tell me more about it? What exactly happened?

Was it sudden in onset? (acute: Delirium)

How long have you been having this problem?

Other false perceptions like smell, taste, voices, visual, tactile (Bugs crawling on body). Did you hear a voice? or see something? Or sensation of feeling something or being touched?

When did hallucinations first appear?

How frequent does it occur?

How long did you experience the same?

What were you doing when it was experienced?

Was this first episode? Or did you have similar episode in the past?

Do you know what could be responsible for it?

Was there a known precipitating factor to the symptoms?

At what time of the day are the symptoms worse?

Do you have any fever? Any vomiting?

Is it interfering in daily activities and job?

How is your sleep? Do you find any difficulty falling asleep or staying asleep?

Is your sleep and wake pattern normal?

Is there any relation with sleep like experiencing while falling asleep or waking up?

How is your memory and concentration?

Do you feel depressed?

Do you feel restless and agitated?

Do you have any idea of hurting yourself or others?

Is there any elated feeling of well being?

Are you taking any illegal drugs or have you ever taken the same?

If yes: How long have you been taking this? How frequent? Have you ever taken IV drugs also? Do you know your HIV status?

Do you have any palpitations?
Do you have risk factor for developing stroke like high blood pressure, high cholesterol, diabetes, smoking, family history.

Do you hold any idea that other people want to control you or want to harm you?

Are you suffering from any stress in your personal or professional life?

Is there any traumatic event in the past?

Do you have any problem with law? Have you ever been convicted due to any reason?

How is your relationship with your family members?

Do you have any disability like problem in hearing or vision?

Do you have any headache or history of migraine?

Do you have any problem with speech?

Have you ever been diagnosed with mental illnesses?

Do you have any severe medical illness? like including liver failure, kidney failure etc

History of fall/trauma or LOC ➔ chest problem ➔ pain in belly ➔ Urinary problem ➔ Weakness in limbs ➔ H/o any shaking of body

**PAMHUGSFOSS**

**PE:**

1. MMSE
2. Hearing and vision examination
3. Quick neurological examination
4. Neck stiffness
5. CV+ Chest auscultation

**Counseling:**

- Need to interview close friends and relatives

**W/U:**

1. CBC
2. BMP
3. Urine toxicology and serum alcohol levels
4. TSH
5. CT/MRI
6. EEG
Stress Incontinence:

When did you first notice?

How is it progressing?

How frequent does it occur in a day?

Is it consistently present or is it transient and intermittent?

When do you feel this incontinence? Is there any specific time or situation?

Is there anything which makes it worse or better?

What are the factors which precipitate the event? Like coughing, sneezing or heavy lifting, laugh, or exercise.

Do you leak every time you cough, sneeze, laugh or exercise?

Do you wear absorbent pads?

Does it occur during sexual activity?

How it has affected your activities of daily living and general well being?

How it has affected your interpersonal relationship?

How much liquid or water do you drink every day?

How many times do you urinate every day? (Bothersome urination eight or more times a day or two or more times at night = overactive bladder)

Did you ever notice a sudden and strong need to urinate immediately?

Have you noticed leakage or gushing of urine that follows a sudden, strong urge?

Did you notice it during the sleep? (Urge incontinence?)

Do you have frequent urinary tract infections? Did you notice increased frequency, burning sensation in urine or painful urination?

Do you smoke? Do you have any breathing problem or chronic cough?

Do you have diabetes?

Do you consume excessive caffeine or alcohol?

Do you play any sports like running or tennis?

Did you have any surgeries like prostatic surgery? Or do you have kids? How many? Were they delivered normally? Was it a forceps delivery?

What’s your height and weight? (BMI = Obesity?)

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PE:

Abdomen and genitals
A neurological exam to identify sensory problems
Auscultate chest and heart
PICKLE
Sample Closure:

"Mrs. Andrews, according to the information I gathered from you, I’m considering a possibility of stress incontinence. In this condition the valve mechanism controlling the outlet of your urinary bag becomes weak and an increase of pressure on the bladder may lead to leaking. It is basically a problem with muscles and nerves that help to hold or release urine. However, there are certain other causes like infection in urinary bag or neurologic illnesses which may also lead to similar problem. In order to know more about the problem I need to run a few investigations like routine urine examination and assessment of the quantity of urine retained after voiding. Once the results of these investigations are available we will go over the things in detail and I will tell you more about management and treatment options in detail. Meanwhile I will suggest you to follow a few measures to relieve your symptoms or lessen the frequency of episodes. Please restrict the amount of fluid and strictly avoid caffeinated and alcoholic beverages. Frequently pass urine and wear absorbent pads to avoid embarrassing incidents.

**Differential Diagnosis**

1. Stress incontinence
2. Urge incontinence
3. Functional incontinence
4. Overflow incontinence
5. Mixed incontinence

**Diagnostic Workup**

1. UA
2. US abdomen with Post Void residue
3. Urodynamic Study
4. Cystoscopy
Some common trade names of medications used by SP’s:

Advil: Ibuprofen
Allegra: Fexofenadine
Augmentin: Amoxicillin + Clavulanic acid
Lopressor: Metoprolol
Mylanta: Antacid
Maalox: Antacid
Nexium: Esmoprazole
Peptobismol: Antidiarrheal
Prilosec: Omeprazole
Synthroid: Levothyroxine
Tylenol: Acetaminophen
Zyban: Buprerpion

Commonly asked and very important cases:

All given in first aid-so don’t waste your time in asking cases at xxxx center at various forums.