OBJECTIVES OF THE INTRODUCTORY CLINICAL PROGRAMME
2015/2016 Batch

The following knowledge, attitudes and skills should be acquired by the students during the appointment. The students should:

1. understand the importance of punctuality, courtesy, respect to patients and clean attire. (patient centeredness)
2. get a basic understanding of how the hospitals function
3. be able to interview and examine a patient in a patient centered manner and document the findings
4. know the meaning of clinical problems and have to identify them.
5. understand medical ethics and communication skills

The above is the first step taken to achieve the wider goals of clinicals shown below:

At the end of **all the clinical appointments** the learners should be able to

1. take a full history and do a complete physical examination.
2. formulate a comprehensive summary of the clinical evaluation.
3. indentify the problems based on clinical findings.
4. analyse the clinical findings and arrive at a differential diagnosis/diagnosis
5. plan appropriate investigations for management of the patient
6. perform bed side examination/ procedures under supervision
7. plan and execute (under supervision) appropriate tests and bed side examinations.
8. propose a management plan for the patient and execute the same under supervision.
9. demonstrate a thorough theory knowledge on the common conditions
10. apply the theory knowledge to the care of patient management.
11. carry out emergency management, pending help.

Some hard facts to be known about clinical teaching/learning

The following will give you an understanding about clinical environment and how to learn from it.

Teaching volume will not be uniform across the different units or at different times in the same unit. However, by working in different units during the clinical rotation you will have an ample opportunity to see all types of patients to learn from and around.

Patients are human beings with different attitudes, concepts and different physical and mind frame. They are not duty bound to co-operate with you. You must respect them and try to work along rather than withdrawing from 'difficult' patients.

Busy clinical work may not allow you to have comfortable and protected reading time. So read whenever or wherever possible. Doctors have to work long hours and so would be for medical students. You will have to learn your theory around your patients not solely from the book.

Students should possess the following:

1. Overcoat/Name badge
2. Equipment for proper clinical assessment
   i.e. stethoscope/reflex -hammer/torch/tape etc.
3. Recommended books:

   Hutchinson's Clinical Method

   Hamilton Beily's Physical Signs in Clinical Surgery

   Ten Teachers – for Obstetrics & Gynaecology (section on history taking and examination)
   Illustrated textbook of Paediatrics (Section on history taking examination)

Duration of the course: 03 weeks

Framework

Areas to be covered in a comprehensive, full time, integrated 03 weeks appointment

1. The clinical method a) History & examination
   b) The identification of clinical problems based on above
2. The History taking process

   - Attention to physical environment and introductions and asking opening question, effective listening and summarizing (setting an agenda)

- Gather information according to agenda
    - Presenting complaint and the duration
    - Subsidiary complaints and the duration
    - History of presenting complaints; sequence of events
    - Systems review
    - Past history
    - Family history
    - Drug history, drug allergy
    - Personal Social & Occupational history
    - Patients perspectives (ideas, concerns, emotions, experiences and expectations)

3. Examination

1. General examination
2. Cardiovascular system
3. Respiratory system
4. Abdomen (including genetalia and groin)
5. Nervous system
    - Higher functions
    - Cranial nerves
    - Motor system
    - Sensory system
    - Co-ordination
6. Muscular skeletal examination
7. Mental state & emotional state
8. Special examination-Ulcers, lumps
9. Examination of newborn baby
10. Obstetrics & Gynaecology examination

CONTENT OF THE HISTORY WHAT STUDENT SHOULD RECORD

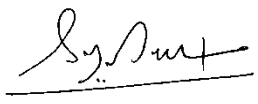
1. Introduction: name, age, gender, occupation, level of education and family background
2. Reasons for the consultation; presenting compliant/s and duration
3. Sequence of events and symptom analysis; history of presenting complaints (according to agenda)
4. Relevant system analysis
5. Patient perspectives (ideas, concerns, experiences, emotions, expectations)
6. Examination findings

    a. General examination (include assessment of height and weight)
    b. Finding of system examination as relevant
    c. Growth and development
    d. Obstetric assessment or gynaecological assessment
    e. *Assessment of mental status*
7. Diagnosis/deferential diagnosis

8. List of problems
    a. Biomedical perspectives
    b. Patient perspectives

9. Plan of management

10. Explanation and planning with patient



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