

CLINICAL COMPETENCY ASSESSMENT

Orientation Information for Fourth Year Medical Students

Performance-Based Assessment Task Force



UNIVERSITY OF PITTSBURGH SCHOOL OF MEDICINE

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ABOUT THIS PUBLICATION

This *Student Orientation Manual* is intended to provide relevant and useful information for medical students who will take the Clinical Competency Assessment (CCA). In the pages that follow, there is general information and a description of the CCA, its components and the method by which scores are derived. Also included is practical information on preparing to take the CCA.

The information contained in this manual is subject to change, but it is our intent to provide you with as much information as possible, as early as possible.

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GENERAL INFORMATION

Purpose of the CCA

Under the direction of the Curriculum Committee, the Performance-Based Assessment Task Force designed the CCA to ensure that the graduating UPSOM students can gather and interpret clinical patient data and communicate in an effective manner. The CCA will also be a preparation exercise for the USMLE Step 2 Clinical Skills (CS). The CCA is designed to be similar to the USMLE Step 2CS exam, but it will not be identical and will attempt to address areas upon which students may wish to improve. In addition, the CCA is used to assess certain areas of the UPSOM curriculum.

An Introduction to Taking the CCA

The elements of the CCA, including the patients, medical presentations, and the practice rooms either at Scaife or the Winter Institute for Simulation Education and Research (WISER) Center, simulate common medical practice in clinics, physicians' offices and emergency departments. The CCA is used to assess your ability to consider reasonable diagnostic possibilities by presenting a set of common clinical scenarios. In addition, you must demonstrate an acceptable level of professionalism and rapport, as well as written communication skills.

By gathering a relevant medical history and performing a focused physical examination, you will be demonstrating your ability to collect information unique to the presentation of each patient. Taking a relevant medical history means that it relates specifically to the chief complaint of the patient. A focused physical examination consists of maneuvers that reveal information in direct relation to the same patient's chief complaint, age and gender, and medical history. You will be required to type a legible patient note indicating the pertinent positive and negative historical and physical findings that relate to your potential diagnoses. Once you list the possible differential diagnoses that relate to the patient's complaint, you will also list the diagnostic studies that you would use to pursue these diagnoses.

When you take the CCA, you will have the same opportunity as all other students to demonstrate your clinical skills proficiency. The assessment is standardized so that upon asking the same or similar questions, all candidates receive the same information from each patient. An ongoing mechanism of quality control is employed to ensure that the assessment is fair to all. A videotape monitoring system documents each encounter and ensures the safety of the patients and candidates, and is an additional quality control procedure.

CCA Case Development

Practicing physicians and medical educators write and review cases to ensure that they are fair and valid. These cases represent the kinds of patients and problems you have seen during your medical school training and are representative of the cases you will see on the Step 2 Clinical Skills exam. The cases are designed to elicit a process of history taking and physical examination that demonstrates your ability to list and pursue various possible diagnoses.

The cases that make up each administration of the CCA reflect a balance of presenting complaints as well as a mix of acute, sub-acute and chronic problems.

CCA Case Content Selection

The CCA case content is designed to represent common patient scenarios that could be encountered in the eight core clinical clerkships.

- Combined Ambulatory Medicine and Pediatrics

- Family Medicine
- Adult Inpatient Medicine
- Neurology/Psychiatry
- Obstetrics/Gynecology
- Inpatient Pediatrics
- Surgery/Anesthesia
- Specialty Care

The selection of cases is also guided by specifications relating to acuity, age, gender, and type of physical findings presented in each case.

DESCRIPTION OF THE CCA

During the CCA you will have 10 patient encounters. Before entering each examination room, you will have an opportunity to review information posted at the examination room door. This information gives you specific instructions and indicates the patient's name, age, gender, and reason for visiting the doctor. It also indicates his or her vital signs, including heart rate, blood pressure, temperature and respiratory rate. You can accept these as accurate and do not need to repeat them unless you believe the case specifically requires it.

When you enter each room, you will encounter a standardized patient (SP). By asking this patient the relevant questions and performing a focused physical examination, you will be able to gather enough information to develop preliminary differential diagnoses and a diagnostic workup plan. You will also be expected to communicate with the patients in a professional and empathetic manner. You should answer any questions they have, tell them what diagnoses you are considering, and advise them on what tests and studies you will order to clarify their diagnoses.

The kinds of medical problems that your patients will portray are those you would commonly encounter in a clinic, doctor's office or emergency department. There are no young children presenting as SPs. However, there may be cases dealing with pediatric issues in which you may encounter a sick child's parent or caretaker. In such cases, physical examination is obviously not possible and will not be expected.

The elements of medical history you need to obtain in each case will be determined by the nature of the patient's problems. Not every part of the history needs to be taken for every patient. Some patients may have acute problems, while others may have more chronic ones. You probably will not have time to do a complete physical examination on every patient, nor will it be necessary to do so. Pursue the relevant parts of the examination, based on the patient's problems and other information you obtain during the history taking.

The key to interacting with the SPs is to relate to them exactly as you would to any patients that you may see with similar problems. The only exception is that certain parts of the physical examination must not be done: rectal, pelvic, genitourinary, female breast, gag or corneal reflex examinations. If you believe one or more of these are indicated, you may include them in your proposed diagnostic workup.

You will have fifteen minutes for each patient encounter. The patient encounter begins with your review of the doorway information. An announcement will tell you when to begin the encounter, when there are five minutes remaining, and when the encounter is over. In some cases you may complete the encounter in fewer than fifteen minutes. If so, you may leave the examination room early, but you are not permitted to re-enter. **Be certain that you have obtained all of the necessary information before leaving the examination room.**

Immediately following each encounter, you will have nine minutes to complete an interstation exercise/patient note. If you leave the encounter early, you may use the additional time for the patient note. You will be asked to write a patient note similar to the medical record you would compose after seeing a patient in a clinic, office or emergency department. You should record pertinent medical history and physical examination findings, as well as your initial differential diagnoses. Finally, you will list the diagnostic studies you would order next on that particular patient. If you think a rectal, pelvic, genitourinary, female breast, or corneal reflex examination would have been indicated in the encounter, then list it as part of your diagnostic workup. **Consultations or referrals should not be included in your workup plan.** You may also be asked to interpret data or answer questions as a part of the interstation exercise.

Most cases are designed to present more than one diagnostic possibility. Based on the patient's presenting complaint and the additional information you obtain as you begin taking the history, you should consider all possible diagnoses and explore the relevant ones as time permits. You should perform physical examination maneuvers correctly and expect that there will be positive physical findings in some instances. Some may be simulated, but you should accept them as real and factor them into your evolving differential diagnoses. Be considerate of the patients, and always keep them comfortable and properly draped as you perform the

physical examination. You should always wash your hands before beginning the physical examination.

Sample Opening Scenarios

To give you a better understanding of the typical mixture of cases presented in the CCA, ten sample opening scenarios are listed below. This is the basic information that is posted on the doorway of each examination room prior to your seeing the patient. The scenarios listed below are representative of, but are not the exact cases, you will see in your assessment session.

1. 50 year-old female complaining of chest pain
Blood Pressure = 138/92 Heart Rate = 80 Respirations = 18 Temperature = 98.6
2. 35 year-old female complaining of abdominal pain
Blood Pressure = 146/88 Heart Rate = 92 Respirations = 20 Temperature = 99.1
3. 75 year-old male brought to see you because of a fall
Blood Pressure = 155/75 Heart Rate = 68 Respirations = 14 Temperature = 98.2
4. Mother of 1 year-old child with diarrhea
(child not available for physical examination)
5. 46 year-old male complaining that he has no energy for the past three months
Blood Pressure = 122/70 Heart Rate = 70 Respirations = 12 Temperature = 98.7
6. 18 year-old female complaining of vaginal bleeding for two days
Blood Pressure = 95/65 Heart Rate = 84 Respirations = 14 Temperature = 98.6
7. 63 year-old male with history of diabetes; new to your practice; here for medication refill
Blood Pressure = 140/75 Heart Rate = 76 Respirations = 18 Temperature = 99.0
8. 24 year-old female brought in by colleagues because of a seizure at work
Blood Pressure = 155/85 Heart Rate = 100 Respirations = 24 Temperature = 99.2
9. 59 year-old male complaining of blurry vision
Blood Pressure = 138/82 Heart Rate = 88 Respirations = 14 Temperature = 98.6
10. 79 year-old female complaining of shortness of breath since last night
Blood Pressure = 158/90 Heart Rate = 92 Respirations = 20 Temperature = 98.6

Doorway Information (Presenting Information)

Before entering the examination rooms, you will be given some basic information. This **presenting information** is posted on each examination room door and is similar to a triage note that a nurse normally gives a physician. Reviewing the doorway information is part of the timed, fifteen-minute patient encounter.

Before seeing the patient, read the information carefully, because it will tell you his or her name, gender, age, presenting complaint and the tasks you are to complete. You should accept the presenting information as accurate, though in some cases reexamination of vital signs may be appropriate. Most CCA stations will have the same types of tasks listed, but some may include specific, unique tasks.

For your convenience, there will be a second copy of the presenting information in the examination room. Please do not remove the doorway information from the examination room.

Presenting Information (Sample)

1. Opening Scenario

Jolene Brown, a 48 year-old female, comes to the Emergency Department complaining of chest pain.

2. Vital Signs

BP: 160/80

Temp: 99.5°F (37.5°C)

RR: 16/minute

HR: 95/minute, regular

3. Examinee Tasks

- Obtain a focused history.
- Perform a relevant physical examination
(**Do not perform rectal, pelvic, genitourinary, female breast, or corneal reflex examinations**).
- Discuss your initial diagnostic impression and your workup plan with the patient.
- After leaving the room, complete your patient note on the form provided.

History Taking and Physical Examination Checklists

Standardized patients document your actions during the encounter, and they are trained to do so in a fair and consistent manner. Each patient fills out checklists that document the inquiries you make and maneuvers you perform during the encounter. The checklist focuses on interpersonal skills and patient communication in the domains of fostering the patient relationship, gathering information, providing information, basic decision making, and supporting emotions. Patients also use a **physical examination checklist** that includes all of the key maneuvers you should perform during the course of a physical examination for the particular case. Your technique in doing these maneuvers is also taken into account by the patient. He or she marks those items

you asked or performed, for which you receive credit. It is important that you closely document the history, however, in order to complete a post-encounter note.

Since the cases are broad, your history taking should consider multiple possible diagnoses. Do not prematurely close your history taking on a single diagnosis, and do not attempt a complete history. During your physical examination of the patient, you should attempt to elicit important positive and negative signs. The fifteen minutes you have with the patient does not permit a complete history taking or physical examination, but only a gathering of relevant data. Make sure you discuss with the patient your initial diagnostic impression and workup plan. The patients are instructed to ask very specific questions concerning their complaints. These inquiries are intended to challenge you, so you should address each patient's concern as you would do normally in a clinical setting.

All physical examination maneuvers, including exposing and draping the patient, should be done as you would do them normally in regular practice. For abdominal examination, however, you should be able to obtain the information you need without extremely deep or forceful palpation.

Additionally, if you determine that a rectal, pelvic, genitourinary, female breast or corneal reflex examination is necessary for treating the patient, put it as part of the diagnostic workup. Your score is based on what you look for in the encounter and the technique you employ while going about it.

The sample checklist items below are examples of examinee questions and physical examination maneuvers that might be expected in a particular case. However, the listed questions and maneuvers are not exact representations of complete history taking and physical examination checklists.

Standardized Patient Interpersonal Skills Checklist (Sample Items)

YES	NO

Place check mark in appropriate column

1. Did the student introduce him/herself to me?
[Must give **last name**]
2. Did the student address me as Ms., Mrs., or Mr. and my surname, OR asked how I wanted to be addressed?

Standardized Patient Physical Examination Checklist (Sample Items)

Done	Done Incorrectly	Not Done

Place check mark in column to show that the item was done, or was done incorrectly, or was not done.

The student:

1. Auscultated the lungs.
2. Auscultated the precordium in at least 2 positions.
3. Palpated the abdomen, at least epigastric or right upper quadrant.

Patient Note

After leaving the encounter, you will have nine minutes to complete the patient note. In an actual practice setting, the patient note would be used to communicate with other health professionals. Keep in mind that once you leave the patient to complete your patient note, you cannot re-enter the examination room. Blank paper will be provided for note taking in the examination room. For security reasons, the sheets of blank paper must be returned with your completed patient note for each encounter.

These sheets are not scored.

Two examples of completed notes follow on page 11. There are several styles of writing patient notes that are acceptable. The two examples are presented to demonstrate some of the variations in style. They are not meant to represent ideal or perfect patient notes, nor should they be assumed to be complete or accurate with respect to content. Both formats and styles, however, would be considered acceptable, despite their differences.

You will type the note on a computer stationed outside of the patient room. Handwritten notes will be allowed only in the event of a computer failure. If this should happen, please raise your hand immediately to let a proctor know and paper will be provided for you. You will be instructed on the use of the computer station prior to beginning the exam.

History

Make note of significant positives and negatives from the history taking. The following history categories may yield important information, although **not all will necessarily be pertinent to every case:**

- Chief complaint (CC)
- History of present illness (HPI)
- Past medical history (PMH)
- Review of systems (ROS)
- Social history (SH)
- Family history (FH)

Physical Examination

List **pertinent** positive and negative findings from the physical examination.

Differential Diagnosis

Consider a range of possible diagnoses, and list up to three of them. For each possible diagnosis, please list the pertinent history and physical exam findings that support the diagnosis.

Diagnostic Workup

Write your immediate plans for further diagnostic workup. If you think rectal, pelvic, genitourinary, female breast, or corneal reflex examinations should be done as part of the evaluation for that specific patient, you may include them in your diagnostic workup plan on the patient note. Do **not** include hospitalization, consultations, or referrals.

You should order fundamental first line tests that will help point you in a diagnostic direction. These requested tests must also be specific. For example, if you suspect hypothyroidism, you might order "T4 and TSH," but not "Thyroid studies" or "Thyroid panel." Do not order "SMA-20," "Chemistry panel," or "Liver profile," but rather, the specific component tests you are interested in, e.g., "BUN, glucose, Na, K."

Patient Note Example One

The patient note on the following page is written primarily in a narrative style. The History is written in full or nearly full sentences, and the Physical Examination also has fairly complete phrases. Note that there are only four studies ordered under the Diagnostic Workup section; this is acceptable. There are some abbreviations that are common enough to be recognizable by the practicing physicians rating the notes. Only abbreviations accepted by the USMLE and provided to you will be accepted. All others should be completely written.

Patient Note Example One

Patient Note (ISN)

1. HISTORY - Include significant positives and negatives from history of present illness, past medical history, review of system(s), social history, and family history.

48 yo female chest pain. Begin 1.5 hours ago, pain is burning in character, no radiation, slight SOB, st N/and diaphoresis. Pain resolved after 20 mins without treatment. No pain now. Has had several episodes over past 2-3 mos. Usually after a heavy meal or exertion with some relief with antacids. Has Hx of elevated cholesterol but no follow-up or treatment. Plays tennis weekly, ex-smoker x 3years (30 pack/years) Denies unusual stress. Mother with NIDDM, brother with unkown heart problems. No Hx HTN, DM but has not seen MD in x 2 yrs.

2. PHYSICAL EXAMINATION - Indicate only pertinent positive and negative findings related to patient's chief complaint.

No obvious distress, minimizing symptoms, anxious to leave.
BP of 160/80 noted.
Chest - no tenderness, clear BS bilaterally without wheezes, crackles or rales.
Heart - apical impulse, not displaced, regular rythm, no M or rubs.
Abdomen - nondistended, BS+, no masses or organomegaly, tenderness in epigastrium, without rebound

Data Interpretation: Based on what you have learned from the history and physical examination, list up to 3 diagnoses that might explain this patient's complaint (s). List your diagnoses from most to least likely. For some cases, fewer than 3 diagnoses will be appropriate. Then, enter the positive or negative findings from the history and they physical examination (if present) that support each diagnosis. Lastly, list initial diagnostic studies (if any) you would order for each listed diagnosis (e.g. laboratory tests, imaging, ECG, etc.).

Diagnosis 1 (ISN)

3. Diagnosis # 1	esophogial reflux disease
4. Please list the relevant History Findings that support this diagnosis.	chest pain related to meal, relieved by antacids under the history part,
5. Please list the relevant Phsyical Findings that support this diagnosis.	no physical exam to support

Diagnosis 2 (ISN)

6. Diagnosis # 2	peptic ulcer	
7. Please list the relevant History Findings that support this diagnosis.	some nausea and relieved by antacids,	
8. Please list the relevant Physical Findings that support this diagnosis.	no rebound or guarding on exam pain	

Diagnosis 3 (ISN)

9. Diagnosis # 2	angina
10. Please list the relevant History Findings that support this diagnosis.	has high cholesterol untreated, Family history of diabetes, pain is slightly atypical but common in females
11. Please list the relevant Physical Findings that support this diagnosis.	hypertension, no abdominal finding

DIAGNOSTIC WORKUP (ISN)

12. DIAGNOSTIC WORKUP: Immediate plans for no more than 5 further diagnostic studies.	<ol style="list-style-type: none">1. stool for OB2. EKG3. CXR4. upper GI endoscopy5.
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Patient Note Example Two

This patient note is written in more of a telegraphic or “bullet” style. There are no complete sentences, although there are some phrases where appropriate. In some parts of the History in particular, there are one or two words that stand alone. The writer of this note has chosen to transcribe the patient’s blood pressure from the doorway information. You may wish to include vital signs if they are particularly relevant to the case. In this note only four items are listed in both the Differential Diagnosis and in the Diagnostic Workup sections; again this is acceptable. This sample also has some abbreviations or symbols that are generally recognizable.

Patient Note Example Two

Patient Note (ISN)

1. HISTORY - Include significant positives and negatives from history of present illness, past medical history, review of system(s), social history, and family history.

48 yo female - chest pain x 90 mins

HPI

- burning
- no radiation
- slight SOB
- sl N/and diaphoresis
- resolved spontaneously
- similar to episodes over past 2-3 mos. after heavy meal or exertion

PMH

- some relief with antacids
- elevated cholesterol, no follow-up or treatment
- tennis weekly
- smoked 30 pack/years, stopped 3 years ago
- no unusual stress
- Mother with NIDDM, brother with unkown heart problems
- No Hx HTN, DM but has not seen MD in x 2 yrs

2. PHYSICAL EXAMINATION - Indicate only pertinent positive and negative findings related to patient's chief complaint.

BP 160/80 No obvious distress, anxious to leave.

Chest - non-tender, clear BS bilat no wheezes, crackles or rales.

Heart - PMI non-displaced, regular rythm, no M or rubs.

Abdomen - BS+ nondistended, no masses or organomegaly tenderness in epigastrium, without rebound

Data Interpretation: Based on what you have learned from the history and physical examination, list up to 3 diagnoses that might explain this patient's complaint (s). List your diagnoses from most to least likely. For some cases, fewer than 3 diagnoses will be appropriate. Then, enter the positive or negative findings from the history and they physical examination (if present) that support each diagnosis. Lastly, list initial diagnostic studies (if any) you would order for each listed diagnosis (e.g. laboratory tests, imaging, ECG, etc.).

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Doctor-Patient Communication

Standardized patients undergo extensive and continuous training to rate your doctor-patient communication skills. This method of rating results in fair, valid, and reliable data. During the encounters, the patients will evaluate your doctor-patient communication skills based on the following criteria:

➤ Skills in interviewing and collecting information

- ◆ the clarity of your questions;
- ◆ the effectiveness of your questioning techniques;
- ◆ the use of language the patients can understand;
- ◆ your verification and summarization of information with the patients;
- ◆ the effectiveness of your transitions between different parts of the interview.

➤ Skills in counseling and delivering information

- ◆ the clarity of the information you give;
- ◆ the thoroughness of the encounter closure;
- ◆ the clarity and appropriateness of your speech;
- ◆ the effectiveness of your summarization of information and how you link various information together.

➤ Rapport (connection between doctor and patient)

- ◆ your attentiveness to the patients;
- ◆ the appropriateness of your body language;
- ◆ the level of empathy and support you show the patients.

➤ Personal manner

- ◆ your manner of introducing yourself to the patients;
- ◆ the appropriateness of your demeanor;
- ◆ your confidence level and attitude;
- ◆ your manner while conducting physical examinations
- ◆ the appropriateness of how you expose and drape the patients.

General Information on Scoring and Score Reporting

Overview

Your scores will be analyzed in a few different ways. There is an individual sub-score for each of the cases and their associated interstation exercises. There is also a cumulative sub-score for history taking, physical examination, interpersonal skills, and the interstation exercises. Data for these four parameters will be combined to arrive at an overall Total Assessment score.

Scoring Methods

Individual Case Sub-score

You will receive an overall score for each case. This score is calculated by adding the percentage of points you received on the history, physical exam, and interpersonal skill checklists with the score on the progress note. The different components will be weighted so that the history, physical exam, and interpersonal skills items will each comprise 30% of the case sub-score. The remaining 10% will be from the interstation exercises/progress notes.

History Taking Skills

Using the history taking checklists, each SP documents your ability to gather history data relevant to the clinical encounter. Your history score will be the sum of the history scores on each individual case note, giving an overall score for your history taking skills.

Physical Exam Skills

Identically to the history taking skills score, using the physical exam checklists, your physical exam score will be the sum of the physical exam scores on each individual case, giving an overall score for your physical exam skills.

Progress Note (PN)

Following the encounter with the SP, you will be required to complete a progress note. Physicians are trained to rate these notes based on predefined criteria that include:

- **Organization:** Presentation of a clear portrayal of the patient's complaint; reasonable order of assessment and diagnostic workup.
- **Quality of Information:** Information is presented with appropriate detail including documentation of significant positive and negative elements of the history and physical examination.
- **Interpretation of Data:** Interpretation of data gathered is reflected in reasonable differential diagnoses.
- **Egregious/dangerous actions:** Avoids diagnostic workup plans that could result in harm; avoids expensive, non-indicated diagnostic tests.
- **Legibility:** In the event you would need to write a note, it must be legible or will not count.

Your final PN score is the average of your PN scores for the scored encounters.

Interpersonal Skills (IS)

Following each encounter, the SP will also evaluate your doctor-patient communication skills along at least four dimensions:

- Interviewing;
- Counseling and delivering information;
- Rapport;
- Personal manner

For each of these dimensions, the SP assigns a score. The SPs make these evaluations according to a scoring system that is fair, consistent and objective. Your IS score for the encounter is the sum of the four IS dimension scores. Your final score for the Interpersonal Skills component is the average of these scores for the encounters. In addition, the SP's are trained to provide comments on the overall experience of being interviewed and examined by you. They will have the opportunity to write these comments at the end of the encounter. The comments will not be scored, they are for your information only.

Score Reporting

All scores are calculated using a percentage of possible points. Please note, if you arrive late and fail to complete a station you will receive zero points for that station (this will count against your score).

Within two to three weeks of your assessment, you will receive a composite listing of the comments from the SPs. This time is necessary to transcribe and their comments. An example of this is on page 18. Your overall score will be reported to you within two weeks after the entire class has completed the CCA (currently, the last scheduled testing date is early-June 2016).

The scores will be reported to you on each station, as well as a composite score of the History elements, a composite score of the Physical Exam elements, and Interpersonal Skills. An example of the score report is on page 19.

These scores will be available on the Advanced Clinical Education Center's standardized patient encounter data management site, CAE LearningSpace. You will receive information on how to access the site, including your username and password, closer to the actual exam. Please note that the formatting of some reports delivered through LearningSpace will be different than presented in this handbook; however, the content will remain the same.

We do know that students who struggle on the CCA also tend to have difficulty on Step 2 CS. For this reason, if your score on this exam identifies you as someone at risk of having difficulty on the national exam, you will be expected to attend the tutorial sessions later this summer/early fall to help you prepare for the national exam. All scheduling will be made to avoid significant conflicts and with the approval of any elective/course director that is needed.

Sample SP Comments

Student: Doe, John

Date: 5/30/2012

In an attempt to give you more information and feedback about your performance on the Clinical Competency Assessment, we have attached excerpts from the comments that the patients made after your interaction with them. This is meant to give you more specific feedback on your performance. These comments were not incorporated into the overall score.

Case

Michael Thomas

Polite. Seemed OK with my asking questions. Good communication skills.

Francine Morgan

John was focused and attentive. He asked good questions, but he didn't ask many. He seemed concerned and was comfortable to be with. I trusted him.

James Martin

John was empathetic and warm. He showed concern throughout the interview and exam. His questions were concise and easy to answer. I was comfortable with him.

Richard Kirby

John was a bit distant, and detached. He seemed to be following a list of things to ask, and I felt like he didn't really see ME. Didn't look at me when he was asking a lot of the questions.

Barbara Andrews

I felt awkward during this interview. The student moved back and forth in the chair. I felt that he felt uncomfortable. He introduced himself using only his first name.

Larry Garfield

Lets his voice volume drop off at the end of sentences. Should practice not letting that happen. It makes him appear uncertain.

Margaret Pennington

Good eye contact. Poor posture, hands between knees. Seemed a little vague. Did not spend much time with me.

Sample Score Reports

Student: Doe, Jane

- Grade Report

Event: CCA Summer 2010 AY 10-11, Class of 2011 - Student: Doe, Jane

Station 01 - Michael Thomas

Section	Student Score	Class Average	Class StDev	Percentile	Box Plot
Introduction	100.00%	85.71%	34.99%	100%	
History	44.44%	61.75%	16.04%	22%	
Physical Exam	37.50%	32.23%	14.97%	79%	
Patient/Physician Interaction	80.00%	69.59%	13.23%	86%	
Patient Note	21.31%	28.96%	7.24%	17%	
History, Physical, and Note	25.64%	33.13%	7.27%	18%	
Interpersonal	80.95%	70.36%	12.90%	86%	
Weighted Average	47.77%	48.02%	7.17%	51%	

Examination Competencies	Your Score	Class Average	Class StDev	Percentile Score	Box Plot
Introduction, Patient/Physician Interaction (IP)	87.45%	76.29%	12.43%	85%	
History (Hx)	58.54%	64.14%	6.49%	20%	
Physical Exam (Px)	57.86%	52.78%	7.97%	71%	
Patient Note (ISN)	45.21%	43.74%	6.02%	56%	
Data Interpretation Exercise (Evidence Based Medicine), Dermatology, Heart Sounds Interstation, X-Ray Interstation (IS)	68.76%	59.75%	11.54%	76%	

Preparing for the CCA

History taking, physical examination, written communication, and interpersonal behavior are all skills that can be improved by training, practice, and critique. You can refer to the multiple texts and other media sources that address these skills. The best preparation is to see actual patients in a real clinical setting, especially if this is done under the supervision and/or review of a competent clinical teacher. The CCA is designed to simulate an actual clinical experience, so the more clinical experience you have, the more comfortable you will feel during the examination.

Strategies for the Encounters

General Comments

- Greet the patient and state your name.
- Elicit or confirm the patient's name.
- Never attempt to communicate with the patient other than as a physician to a patient.
- Feel free to take notes during the encounter. (Blank paper will be provided.)
- Don't make assumptions about what you will see in each encounter.
- There may be more than one case testing related or similar clinical entities.
- Concentrate on the case on which you are working.
- Notify proctors of any problems.

History Taking

- Begin with broad questions, and then focus your inquiries.
- Don't ask double questions, "do you drink or smoke?".
- Don't rush the patient's answers.
- Don't cut the patient's answer off with another question.
- Repeat your questions in different terms, if necessary.
- Ask follow-up questions.

Physical Examination

- Do a focused examination based on the patient's complaint, symptoms, and history.
- Wash your hands between patients, preferably before touching the patient or beginning the physical examination.
- Tell the patient when you are going to begin the physical examination.
- Describe the maneuvers either before or as you do them.
- Always use patient gowns and drapes appropriately to maintain patient modesty and comfort, but never examine through the gown.
- Use the examination table extension when the patient reclines.
- If you ask a patient to get off the examination table, offer to assist him or her.
- Look for physical findings.
- Do not perform rectal, pelvic, genitourinary, female breast, or corneal reflex examinations.

Concluding the Encounter

- Note that there will be a time warning when there are five minutes remaining in the encounter.
- Tell the patient your initial impressions and your plan for the diagnostic workup.
- Ask for and answer any additional questions.
- Close the encounter when the "End of Encounter" signal is given.

Doctor-Patient Communication

- Make eye contact.
- Ask clear questions and speak understandably.

- If you use medical terms, explain yourself.
- Be direct and honest, but also be sensitive.
- If you don't know the answer to an SP's question, say so.
- Don't give false reassurance or a premature diagnosis.
- Acknowledge the patient's concerns or worries.

Patient Note

- Approach the note as if you are communicating with another health professional.
- Group similar data together.
- Write out information in a logical sequence.
- Be specific.
- Identify critical elements.
- Include pertinent positives and negatives.
- Make sure your plans for further diagnostic workup are reasonable.
- Do not include treatment in your plans for diagnostic workup.

The Day of the Assessment

When you arrive at the WISER Center on the day of your assessment, please arrive no later than twenty minutes prior to your scheduled assessment.

Please bring only necessary personal items with you to the center. Wear comfortable, professional clothing and a white laboratory or clinic coat. You will need to bring a stethoscope, oto/ophthalmoscope, tuning fork, and reflex hammer. All other necessary medical equipment is provided in the examination rooms. Please leave all personal belongings (bags, coats, reference materials, electronic devices, etc.) in either a locker or an area indicated by the event staff, as you will not be allowed to take them into the exam stations with you.

Throughout the assessment day, CCA staff will direct you through the examination. Please follow their instructions at all times.

Each assessment session begins with an on-site orientation. This orientation is in addition to this manual. The orientation will familiarize you with the equipment in each examination room and the nature of typical encounters. It is also intended to inform you about examination procedures.

Prior to the orientation, you will be required to sign the Honor Code and confidentiality agreement. It stipulates that you, as a CCA examinee, will **not** reveal case information to anyone at any time. This agreement is a way to ensure that each examinee has the same opportunity as all others. If you disclose information to other students, there is no guarantee that the information you supply will aid them. In fact, it may confuse subsequent students. In addition to the Honor Code statement and confidentiality agreement, you will be asked to complete feedback and self-assessment questionnaires after the assessment. You will also be asked to sign a consent form for video and participation in research. Research on the CCA process and results is only conducted under IRB approved protocols that provide for confidentiality and other human subject protections, as part of the study of a normal educational practice. If you do not consent, your data will not be used for research purposes. You will, however, be required to take the CCA. The video consent is for use of the tape for educational purposes (training SPs). It will not be made public. If you do not sign the video consent form, your performance will still be taped, in order to maintain a permanent, independent record of your performance, but will not be used for other purposes.

The assessment lasts approximately 5.5 hours, and one break is provided. The break is fifteen minutes long and takes place after the fifth encounter. You may bring your own snack food for the break. No refrigeration or preparation area is available.

Following each complete session there will be a debriefing session with a faculty member. In the debriefing session the group will discuss the appropriate history and physical for each case, and a differential diagnosis and plan.

You cannot, during breaks or at any time, discuss the cases with your fellow students. Examination proctors will be with you to monitor activity. To maintain security and quality assurance, each examination room is equipped with video cameras and microphones to record every encounter.

Scheduling

CCA scheduling will be done via a website where you may review dates and submit your preference. You may schedule your assessment date as soon as you receive notification that the website is available. The email you will receive will contain instructions on how to log in and sign up. To help accommodate individual needs and preferences, each student may select their preferred CCA dates from the list of available sessions. We will make every effort to schedule you on a date you prefer. Due to the finite number of sessions, they will be assigned on a **first come, first served** basis. On most CCA days the exam will run in two separate sessions; the first, from 7:00 a.m. to 12:30 p.m.; and the second, from 12:30 p.m. to 6:00 p.m. (please indicate your preference for AM or PM on the date you request). You will be excused from your elective to participate.

The scheduling website is: <http://spprogram.medschool.pitt.edu>

You must schedule your assessment date by Friday, March 18 2016, otherwise you will be assigned a date to take the CCA. There will be numerous dates offered between May and June. Your scheduled date will be confirmed by email.

Winter Institute for Simulation Education and Research (WISER) Center Location

On all days the CCA will be administered at the WISER Center, 230 McKee Place, 3rd floor.

There is no student parking facility at the WISER building. Nearby on-street and public parking facilities are often full. Please plan your travel to the CCA accordingly.