Department of Child Health

**PRESENTATION GUIDELINES FOR RESIDENTS, HOUSE OFFICERS AND STUDENTS.**

*At the Bedside clinical round or the clinical case discussion seminars*.

Before presentation follow the following rules

1. You should not present the case if you have not taken the history and examined the patient.
2. Always stand on the right side of the patient and towards the head end of the bed.
3. Stand in front of consultant/senior faculty.
4. Hold the case notes in one hand.
5. Never keep another hand in pocket, do not lean in the bed.
6. Keep smiling.
7. During presentation never become quiet for more than 30 seconds.
8. Speak softly but loud enough to be heard from the foot end of the bed.

   Make an effort to present cases without the aid of the chart, without reading the chart notes verbatim. If there are three or fewer admissions to be presented, then an extemporaneous oral presentation is a reasonable expectation of an intern or resident. A physician should and must have the intellectual capacity to present a case from memory.

9. Follow the following order for presentation:

   Start as: My patient is Pushpa Raj Sharma, aged 8 months from Palpa presented to this hospital three days back with the presenting complaints of fever for 10 days and convulsion for 10 minutes one days back. Pushpa was alright 10 days back when his mother noticed …….
……

- Presentation

  History:

  - Gender(it may be awkward if the child is old enough to understand his/her sex), age, race, place of residence, presenting complaint

(in the chronological order), and relevant HPI (include systemic review), PMH, medications, birth and development history, immunization history, nutritional history (always refer to the calorie: required and received by the child), personal history (school), social history, family history (include contact and consanguinity).

- **Do not** meander randomly from one problem to another in your presentation. If a patient has more than one problem to be included in the present illness, give a full report on just one problem at a time. **Do not** repeat information that was already included in the HPI in PMH.

  Physical exam:

  **Do** start with a general description of the patient's appearance and the degree of distress, if present.

- Present vitals, (in an unconscious patient mention the Glasgow coma scale) anthropometric findings (always relate to the percentiles), and physical exam findings (some times negative findings are equally important).

  **Do** give a particularly **detailed**, **precise,** and **complete** report of the examination of the organ that is involved in the present illness (e.g., Do not state simply that there are creps in the lung in patient admitted for pneumonia; rather specify the quality of breath sounds, and specify the presence or absence of wheeze, crepitations specific to lung fields, percussion notes).

- **Do not** take time to state your interpretation of physical findings while reporting the physical exam. When you are reporting the physical exam, just state the facts. When you are stating your assessment of the patient's problems, then you can give your interpretation of the facts.

- Lab tests and Imaging
  - What was done for the patient upon presentation?
  - Relevant past blood labs and chemistries and images

- Clinical Diagnosis

- Differential diagnosis
  - What (at least) three things may this patient most likely have?
  - What diagnosis can you not miss!
  - Use the presentation, history, labs and images to argue for and against the differential

- Hospital course
    - How was the patient managed for their hospital course?
    - Were there crucial turning points?

- Treatment
    - Medical , referral, psychosocial or behavioral management
    - Follow-up

- Discussion
    - Comment on all aspects on the patient care, paying special attention to areas where there might have been alternative methods of care. You may also engage some of your faculty to comment as to how they might have managed this patient.

- Preventive measures
    - Present known screening and preventive methods
    - This is one of the key sections in this Case Presentation. Use research publications, and references to illustrate your point.
    - Please offer (at least) three suggestions for improving medical care for minorities.

**GUIDELINES FOR THE DISCHARGE SUMMARY**

The following guidelines are directed towards improving the quality of the contents of the discharge summary.

*"DIAGNOSIS"*

1. **Do** list **final diagnosis**. Symptoms, physical signs, and abnormal laboratory values, which should be included among **problems** on your problem list, are not necessarily **diagnoses**. For example, anemia is not a diagnosis. Nutritional iron deficiency anemia is a specific diagnosis. If a patient has an anemia that has eluded explanation, then an appropriate discharge diagnosis is "normocytic anemia of unknown etiology" rather than just "anemia".
2. **Do** list all **active** problems. For example, if an electrolyte imbalance is resolved during the course of the hospitalization, or is present only transiently, then **do not** list it as a final diagnosis.
3. **Do not** use abbreviations in the list of final diagnosis. The list of diagnosis is read and codified by non-medical personnel in the medical records department. Although some abbreviations are readily recognizable, it is easier for everyone if abbreviations are not used for diagnosis. (In general, the use of abbreviations anywhere in the chart should be minimized.)

*"SUMMARY"*

1. **Do** write a **very** brief, cogent history and physical exam. There is, after all, a full admission work-up in the chart, and there is no need to rewrite the history and physical exam in the discharge summary. Often, it is appropriate to just list the relevant findings within the discussion of specific problems, instead of writing a separate abstract of the history and physical exam.
2. **Do** write the summary like a progress note. List each problem separately and write a separate paragraph to describe the hospital course of each problem.

N.B. It is appropriate to include within the text of the written summary discussion of both :final diagnosis" and other significant problems. For example, a patient was admitted for pneumonia, and during the course of his illness developed convulsion that required anticonvulsant therapy for two days, but that resolved by the time of discharge. The final diagnosis should include pneumonia, but **not** seizure disorder. However, the written summary should indicate that the hospitalization was complicated by the need for anticonvulsant therapy (how much, what type of anticonvulsant, etc.) for two days (indicating the presence of hypoxia, for future reference).

3. **Do** list all pertinent tests and their results. Also, list what results, if any, are pending.

4. **Do** specify whether a problem improved, resolved or continued unchanged.
5. **Do** specify the justification for the final diagnosis, unless it is immediately obvious.
6. **Do** list all medications that the patient is being told to take upon discharge.
7. **Do** mention what, if any, follow-up in clinic -- and which clinic-- has been arranged.
8. **Do** make a special effort to be **legible** and **neat**!!! The discharge summary should clearly and easily communicate information. It should not obfuscate information. Remember other hospitals can imagine your knowledge and your hospitals efficiency.

**Remember**: the discharge summary for is extremely important. A good summary provides concise and accurate information and ensures a degree of continuity of care for the patient. A haphazard or nonchalant summary is an unnecessary obstacle. A bad summary forces the reader to take the time to go through the interrogation with the parent and parents may not know the hospital medical events.

A discharge summary should be accomplished before the morning of discharge. It should be a written summary on a specially prepared summary sheet and must be signed by the third year MD resident. If the patient has been hospitalized for more than three days, the summary must be dictated. All summaries must contain:

a. Chief complaint
b. Relevant HPI, PMH, Developmental, medications, birth and development history, immunization history (in brief)
c. Relevant admission physical exam (in brief)
d. Pertinent laboratory data
e. Diagnostic impressions
f. Hospital course
g. Condition on discharge
h. Medications, diet, disposition and allergic reactions
i. Discharge follow-up including the **DATE OF THE NEXT FOLLOW-UP CLINIC**
j. Final diagnoses in order of importance to the patient's hospitalization

**Department of Child Health**

**Student Evaluation**

Date Evaluated:

You may or may not write your name.

For all of the questions below please insert the appropriate number hat best fits your response:

0 = terrible, unacceptable, definitely no
1 = poor, marginal
2 = average, acceptable
3 = good, very satisfactory
4 = superior or excellent, definitely yes

1. Rate the overall quality of this posting:
2. List and evaluate your Faculty:

    a. Dr.
        a. teaching ability
        b. availability
        c. enthusiasm

    b. Dr.
        a. teaching ability
        b. availability
        c. enthusiasm

    c. Dr.
        a. teaching ability
        b. availability
        c. enthusiasm

3. List and evaluate the MD Resident/House Staff with whom you had closest contact:

    a. Dr.
        a. teaching ability
        b. availability
        c. enthusiasm

    b. Dr.
        a. teaching ability
        b. availability

c. enthusiasm

b. Dr.

a. teaching ability
b. availability
c. enthusiasm

4. Rate the MD Resident/house Staff in general regarding:

a. teaching ability
b. availability
c. enthusiasm

5. Rate your interaction with Full-Time Faculty. Explain:

6. Rate the degree of direct supervision regarding review of your history and physical findings, progress notes, etc.

7. Please rate the following:

- Orientation
- Patient Load
- Ambulatory Experience
- Teaching Rounds
- Teaching Conferences
- Degree of cooperation from Full-Time Staff

8. Rate your interest in this field:
   a. before taking this paediatric posting

   b. after taking this paediatric posting

9. Rate the organization of this paediatric posting:

10. Was the method of evaluating your performance explained to you at the beginning of this paediatric posting?

Did you receive adequate feedback on your performance during the course of this posting?

11. What do you consider to be the appropriate length of time for this posting?

12. What did you like least about this posting?

13. What did you like best about this posting?

14. Comment on the lecture series at your hospital site:

15. Do you have any comments or suggestions?

Please return this evaluation to: Prof. Pushpa Raj Sharma, Department of Paediatrics, HLMC.

**GUIDELINES FOR CONDUCT AT BEDSIDE ROUNDS FOR FACULTY**

Bedside rounds, whether during daily morning rounds, ward attending rounds, or consultation rounds, are an integral part of any training program. Bedside rounds, in contrast to sit-down conferences, require particular attention to a code of behavior that can best be labeled "**Professionalism**". The following guidelines are meant to emphasize certain points of professional behavior for all participants of bedside rounds.

1. **Do not** laugh, side chat or discuss other things at the bedside. This is simply "unprofessional" and should never be done.
2. **Do** greet the patients guardian and say “hello to a child”. However the child is small show some gesture so that parent think you are really there to care his/her child. It is very bad form to go to a patient's bed and talk about him or her, but not to him or her. It is inexcusable to not even say, "Namaste".
3. **Never** refer to any patient in disparaging terms in public! What is said in private is a matter of personal conscience, but what is said in public is a matter of professional ethics.
4. Assume that the parent of unresponsive patient, or the patient with an altered mental status could possibly understand what is said at the bedside, and maintain professional decorum in front of all parents.
5. **Do** talk with the older children about their illness. Describe what is his/her illness.
6. **Do** maintain the patient's personal privacy and dignity as much as possible.
7. **Do not** argue at the bedside. If an earnest difference of opinion becomes apparent, continue the discussion outside the room.
8. **Do** use appropriate language at the bedside. Know what to say and what not to say at the bedside. For example, never say "cancer" or "tumor" or “bad prognosis” in front of a patient who has not yet been diagnosed and told of having cancer.
9. **Do** talk to the patient. Before leaving the bedside, translate the medical discussion into an appropriate explanation for the parent.

**Remember**: even if the patient being discussed is not physically present, other patients in the room will hear the discussion and will more than likely talk among themselves, talk to the patient in question, spread rumors, etc. If any parent is within earshot, all the rules of professional behavior apply.

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