### 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 is designed to help students identify areas they may wish to improve on. The CCA will also be a preparation exercise for the USMLE Step 2CS. The CCA is designed to be similar to the USMLE Step 2CS exam, but it will not be identical. 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 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 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 write 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. You may be asked to include a treatment plan (this may include a therapeutic trial of medication).

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 would normally encounter while training in a residency program. 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 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
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 an 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, 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.

Sample Case

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 history taking checklist includes all of the key inquiries you are expected to make in the course of taking the patient’s history for a particular case. 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.

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 History Taking Checklist (Sample Items)**

<table>
<thead>
<tr>
<th>HISTORY</th>
<th>Did the student ask:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>1.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
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<td>3.</td>
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<td>4.</td>
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<td>5.</td>
<td></td>
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<tr>
<td>6.</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td></td>
</tr>
</tbody>
</table>
Standardized Patient Physical Examination Checklist (Sample Items)

<table>
<thead>
<tr>
<th>Done</th>
<th>Done Incorrectly</th>
<th>Not Done</th>
</tr>
</thead>
</table>

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.

Sample Case

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.

A blank patient note is provided on page 11, followed by two examples of completed notes. 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.

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 five of them.

Diagnostic Workup

Write your immediate plans for further diagnostic workup and/or initial treatment. A therapeutic trial of medication can also be used. 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.”
Clinical Competency Assessment
AY 2008-09
Patient Note on: Theresa Bower

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

_________________________________________________________________________________________

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

_________________________________________________________________________________________

DIFFERENTIAL DIAGNOSIS - In order of likelihood, write no more than 5 differential diagnoses for this patient's current problems.

| 1. |
| 2. |
| 3. |
| 4. |
| 5. |

DIAGNOSTIC WORKUP & INITIAL TREATMENT - Immediate plans for no more than 5 further diagnostic studies or initial treatments.

| 1. |
| 2. |
| 3. |
| 4. |
| 5. |

Have you seen this SP before? If so, rank impact on your performance

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decreased Performance</td>
<td>None</td>
<td>Improved Performance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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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. The note is written in cursive script, but it is legible.
HISTORY - Include significant positives and negatives from history of present illness, past medical history, review of system(s), social history and family history.

45 year old 8% chest pain. Began 1.5 hrs ago. Pain is described as substernal, non-radiating, 1/5 on VAS, and diaphoretic. Pain resolved after 30 mins without treatment. No pain. Has had several similar episodes over past 5-6 mos, is after heavy meal or exertion with some relief by antacids. Has no other related complaints but no specific treatment. Sleeps 6-7 hrs weekly. Ex-smoker x 18 yrs (3 cigarettes usual stress, alcohol, tobacco and breathing) unknown heard problem. No HTN, DM, but has recent MD x 2 yrs.

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

No obvious distress. Minimizing symptoms, auditory BP of 160/80 mmHg.

Chest - No tenderness, clear BS unilaterally without a murmur.

Heart - Normal impulse not displaced, regular rhythm no murmurs.

Abdomen - Non-tender, BS(E) no masses or organomegaly.

Hepatomegaly is palpable in epigastrium without rebound.

DIFFERENTIAL DIAGNOSIS - In order of likelihood, write no more than 5 differential diagnoses for this patient's current problems.

1. Esophageal reflux disease
2. Hepatic failure
3. Coronary artery disease
4. Aortic dissection

DIAGNOSTIC WORKUP - Immediate plans for no more than 5 further diagnostic studies.

1. Stand for CB
2. EKG
3. CXR
4. Endoscopy
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. This note is printed throughout, although a mixture of cursive script and printing would also be acceptable, provided both were legible.
Patient Note Example Two

CCA 2003-94

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

Hx Yo CC - Chest pain x 30 mins

History after heavy meal
- No use of 8"c
- Slight sweating, SOS
- Reduced spontaneous
- Similar episodes over last 2-3 mos., after heavy meals or exertion
- No aches, chest pain while playing tennis, pivotal
- Purely intermittent

PHNA - cholesterol, no treatment, no HTN or DM habits - similar

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

BP 100/60 - appears comfortable
Chest - clear BS BILAT no creriticles
Heart - no rhythm no R or L8 Clear S1, S2

ABD - no sounds no masses, no tenderness liver not enlarged
Extremes - no edema, pulses intact

DIFFERENTIAL DIAGNOSIS - In order of likelihood, write no more than 5 differential diagnoses for this patient's current problems.

1. Myocardial infarction
2. Acid reflux
3. Muscle strain
4. Anxiety reaction

DIAGNOSTIC WORKUP - Immediate plans for no more than 5 further diagnostic studies

1. EKG
2. Cardiac enzymes
3. Ultrasound of gallbladder
4. Upper GI series
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, including draping technique;
  - 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, 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:** Easily read with little effort required.

Your final PN score is the average of your PN scores for the eight 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 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 July 9, 2009).

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.
Sample SP Comments

Student: Doe, John
Date: 5/30/2009

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.
Student: Doe, Jane

Your performance on the Clinical Competency Assessment is reported in terms of standard scores. The individual cases have a mean of 97.28 and standard deviation of 28.34. For example, a standard score of 125.62 would indicate that your performance was one standard deviation above the class mean. Alternatively, a standard score of 83.11 would show that your performance was one-half standard deviation below the mean. (Note: Each case and clinical skill score are standardized separately, as is the total examination score. Hence, the total examination score is not a mere average of the case or clinical skill scores.)

<table>
<thead>
<tr>
<th>Case</th>
<th>Standard Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Michael Thomas</td>
<td>99.25</td>
</tr>
<tr>
<td>Francine Morgan</td>
<td>145.82</td>
</tr>
<tr>
<td>James Martin</td>
<td>68.91</td>
</tr>
<tr>
<td>Richard Kirby</td>
<td>139.01</td>
</tr>
<tr>
<td>Barbara Andrews</td>
<td>98.29</td>
</tr>
<tr>
<td>Larry Garfield</td>
<td>137.85</td>
</tr>
<tr>
<td>Margaret Pennington</td>
<td>115.82</td>
</tr>
<tr>
<td>Daniel Bowman</td>
<td>120.78</td>
</tr>
<tr>
<td>Andrea Blake</td>
<td>79.85</td>
</tr>
<tr>
<td>Melissa Howell</td>
<td>126.97</td>
</tr>
</tbody>
</table>

Clinical Skills

- History taking (Average: 66.51; Mean: 13.31) 87.13
- Physical Exam (Average: 57.68; Mean: 18.28) 72.25
- Interpersonal Skills (Average: 84.59; Mean: 11.91) 87.38
- Note writing (Average: 84.26; Mean: 11.34) 85.64
- Non-note exercises (Average: 61.62; Mean: 20.21) 72.95
- TOTAL ASSESSMENT (Average: 94.04; Mean: 10.91) 109.47

Your overall performance (Total Assessment) was in the top quarter relative to your class.
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. Perhaps 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 your 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.
Write legibly.
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 earlier than thirty 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. The only pieces of medical equipment you need to bring are your stethoscope, otoscope and ophthalmoscope. 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. 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 each CCA day 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://www.pitt.edu/~omed/. An email announcement will be sent to your SOM account to notify you when the site will open for scheduling. If you have any questions or would like further information, please feel free to call Valerie Fulmer at 412-648-8702.

You must schedule your assessment date by Friday, March 13, 2009, otherwise you will be assigned a date to take the CCA. There will be numerous dates offered between May and July. Your scheduled date will be confirmed by email.

Winter Institute for Simulation Education and Research (WISER) Center Location
The CCA is 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.