**Course Objectives**

**Overall Course Goal:**

To enable students to develop core clinical skills on which they can build to become caring, competent clinicians.

This section defines the overall objectives, and also splits them up by term or pecialty.

**Overall Course Objectives**:

At the end of the pre-clerkship Clinical Skills course a student will be able to demonstrate:

* Professional attitudes and behaviours that promote respectful relationships with patients and members of the health care team.
* Insight into his/her abilities and willingness to use feedback and self-reflection to improve as a clinician
* Communication skills that promote a therapeutic doctor-patient relationship and effective information-sharing
* Interviewing skills that elicit the important elements in a patient’s medical history, including the patient’s illness experience
* Physical examination skills that respect the patient’s comfort and dignity and are correctly selected, performed and interpreted relative to the clinical situation.
* Clinical reasoning that integrates information acquired from the clinical encounter with other sources of knowledge, including that derived from self-directed learning, to arrive at diagnostic hypotheses and therapeutic plans.
* The ability to prepare written and verbal reports that accurately and efficiently convey relevant clinical information according to current standards for medical records.
* The correct performance of basic technical skills that reflects knowledge regarding patient preparation, risks and attention to infection precautions.

**Specific Objectives**

Professional Attitudes and Behaviours

The student shall be able to:

1. Describe the key elements of an effective doctor patient relationship.
2. Describe and appreciate the difference between disease and the patient’s experience of illness
3. Demonstrate insight into his/her skills as a physician and practise self-reflection as a means of developing clinical skills
4. Demonstrate effective, respectful interactions with colleagues and health care professionals including preparation and participation in group activities, and the ability to provide and utilize effective feedback.
5. Practice confidentiality regarding patient information.
6. Demonstrate consideration for the privacy, comfort and safety of the patient at all times.
7. Demonstrate a spirit of enquiry in broadening his/her clinical knowledge.

**Communication Skills**

The student shall be able to:

1. Establish rapport with a patient and involved family member.
2. Show compassion, interest and understanding for the patient as a person.
3. Demonstrate patience, and a non-judgmental attitude toward a patient.
4. Demonstrate effective verbal and non-verbal communication skills that indicate he/she is actively listening to the patient.
5. Use effective questioning techniques including:
	* appropriate use of open- and closed-ended questions
	* transitional statements
	* summary statements
	* allowing the patient to complete the answer to the question asked.
6. Use language during the interview that will promote patient understanding, and avoid medical jargon.
7. Apply appropriate communication skills in difficult interviews.

**The Medical Interview**

The student shall be able to:

1. Appreciate the value of a good history in clinical diagnosis.
2. Identify the chief complaint(s) and elicit a complete history of the present illness.
3. Describe major symptoms using the standard (“sacred seven”) qualifiers.
4. Elicit and appreciate the patient’s experience of the illness, utilizing the FIFE (Function, Ideas, Feelings, Expectations) approach.
5. Acquire a complete medical history including history of present illness, medications and allergies, past medical history, family history, life circumstances, and a complete review of systems.
6. Have an organized approach to the interview that establishes the agenda for the visit, follows the patient’s narrative thread while maintaining a logical structure and managing time
7. Within the limits of the student’s knowledge and experience, educate a patient about a clinical problem or plan of care.
8. Within the limits of the student’s knowledge and experience, develop a diagnostic and treatment plan in collaboration with a patient.
9. Complete a thorough interview in less than 30 minutes.

**The Physical Examination**

The student shall be able to:

1. Demonstrate courtesy, respect, and concern for a patient’s privacy and comfort when conducting a physical examination.
2. Drape a patient for appropriate exposure during the examination.
3. Use correct basic physical examination techniques for each system (components as outlined in the Physical Examination Appendix and Queen’s Physical Examination Manual).
4. Use appropriate core and advanced examination techniques to evaluate a specific clinical problem in a focused physical examination.
5. Integrate the examination of multiple systems into an efficient and organized examination.
6. Complete a thorough physical examination in less than 30 minutes.
7. Adapt the physical examination for the ambulatory and non-ambulatory patient.

**Knowledge and Clinical Reasoning**

The student shall be able to:

1. Generate diagnostic hypotheses and refine them during the patient encounter.
2. Identify and prioritize clinical problems.
3. Integrate information from the clinical encounter to achieve a working diagnosis and differential diagnoses for a clinical presentation.
4. Utilize information from self-directed learning to select diagnostic tests to refine common diagnoses.
5. Utilize information from self-directed learning to recommend basic therapies for common conditions.

**Medical Reporting**

The student shall be able to:

1. Prepare an accurate and succinct written report of a clinical encounter that reflects current standards for medical records and includes
	* a problem list
	* the clinical information (components as outlined in the Medical Record Appendix)
	* problem formulation and analysis
	* diagnostic and therapeutic plans.
2. Present an organized and concise (< 5 minute) verbal summary of a clinical encounter that summarizes the information listed in (1).

**Technical Skills**

Please see the Technical Skills section of this report for the specific objectives regarding each procedure.

**Routine Practices and Additional Precautions**

Protecting patients and health care workers by practicing appropriate infection control is a professional responsibility.

All students will be able to:

1. Appreciate the methods and risks of contact and droplet transmission.
2. Describe the importance of hand hygiene in reducing transmission of microorganisms and infection.
3. Demonstrate appropriate hand hygiene techniques in all encounters.
4. Practice correct procedures for preventing blood borne infections during procedures.
5. Describe the principles behind using gloves, gowns and masks to protect from microorganism and infection transmission.
6. Demonstrate the correct sequence of hand hygiene and applying, removing and disposing of gloves, gowns and masks on entering and leaving an isolation room.
7. Demonstrate appropriate technique of a surgical scrub.

**Paediatric Specific Objectives**

The student should be able to:

1. Establish rapport with children of all ages;
2. Involve children in the interview process;
3. Establish rapport with parents.
4. Obtain a comprehensive pediatric interview. Historical data gathered in such an interview includes not only the presenting complaint, history of the present illness and past medical history but also:
	* a detailed prenatal history, birth history and feeding history (where relevant);
	* information related to physical growth and development of secondary sex characteristics;
	* information relating to gross motor, fine motor, cognitive, and social development;
	* information about behavior problems commonly seen in childhood and adolescence;
	* information related to well-child care such as immunizations and hearing and vision screening;
	* a comprehensive review of the child's social situation;
	* a relevant family history;
	* a review of systems appropriate to a pediatric case.
5. Conduct a physical examination on a pediatric patient - this involves:
	* approaching small children in a non-threatening fashion;
	* adapting the physical examination to the age and developmental status of the child;
	* specific skills important to Pediatrics (e.g. measurement of head circumference, Tanner staging).

**Infancy/Perinatal Objectives**

The student should be able to:

1. Assess a normal newborn, and review the immediate care;
2. Review important aspects of the maternal, pregnancy and delivery history, especially with high-risk pregnancies;
3. Review aspects of resuscitation of the newborn, including APGAR scoring in the labour room;
4. Recognize a “sick” neonate;
5. Recognize common neonatal problems including:
	* respiratory distress
	* cyanosis
	* jaundice
	* sepsis
	* problems associated with prematurity.