GUIDELINES FOR CLERKING

Purpose:

The purpose of the case study is mainly to train the student to take a thorough history and perform a comprehensive physical examination. In addition the student, through this exercise, writes down his/her thoughts about the patient's problem(s) and formulates his/her plan of action to solve it. It helps the students think critically in a problem solving manner. The student can look at the patient's file (chart) and should discuss the case with the treating team as well.

History Taking:

Starting with the patient's demographic data and presenting complaint and its detailed history, the student takes a full history as he is taught to do so and according to the guidelines.

Physical examination:

It is important that the student examines the patient thoroughly as he/she has learned it, and according to the acceptable medical standard. Often times a thoroughly performed physical exam can discover some findings that may or may not be related to the patient's problem. Accordingly, a complete physical examination must be performed or at least attempted. It is wise, however, to do a problem oriented physical examination more in depth to better delineate the patient's problem.

Summary:
A brief summary of the history and physical examination is advisable here.

Problem List:

All the problems that the patient has as obtained by the history and the physical examination need to be listed down at this stage. It is important to put down the most important problems (e.g. most serious, most urgent, or most agonizing to the patient) at the top of the list.
All problems that the patient has especially those that affect his well-being whether organic or psychosocial need to be listed own.

Provisional diagnosis and differential diagnosis:

The provisional diagnosis is the one that best explains the patients' symptoms and signs and encompasses as many of the patients problems as possible.
The differential diagnoses are alternative possibilities that fit the symptoms and signs but to a lesser degree.
Each diagnosis, whether the prime one or the alternatives (differential) ones, needs to have the supportive evidence and negating points mentioned.

Management Plan:

Management includes investigations and treatment:

Investigations:

The student must suggest the investigations required whether hematological, other boy fluids or tissues or radiological. Each investigation suggested must be accompanied by sound reasoning's as to why it should be done. Investigations need to be prioritized.

Other services:

The help of other services or sub-specialties can be mentioned if need be.

Treatment:

Base on the aforementioned information and findings the student is expected to write down his plan of treatment with sound rationalization.
At this stage the student is allowed to look at the patient's file. The student is expected to compare his findings, thoughts, and plans with those in the file and to give his comments.

Follow-up:

On a daily basis the student has to report on the patient's condition as well as any plans after discussion with the team, following the patient. Daily progress notes should be written using the SOAP format.

The SOAP format should be used as follows:

§ **S (Subjective):** *Changes in the patient status, in the patient's or his guardian's words.*
§ **O (Objective):** *Vital signs, examination of concerned system(s), and new investigations results.*
§ **A (Assessment):** *Your interpretations and evaluation of the patient condition*
based on the subjective and objective data.
§ **P (Plan):** *Your decisions based on the assessment (e.g. order a new investigation, add or stop a medication).*

Prognosis and future plan:

The student has to give his/her opinion regarding the prognosis. The student, as well, must write down the future plan for the patient (irrespective of whether the patient has been discharged or not).

General Comments:

The student is required to write down a brief comment on the overall management care and plans for the patient.