

Guidelines for write-ups

Required: 6 write ups in each of the five week blocks of the clerkship

Write-ups should not be more than 5-6 pages.

The write-ups should be in the "Atchley" format and should aspire to comprehensively address the patient's acute hospital presentation as well as their chronic medical problems and health care needs (wellness/prevention). The write ups should include a formulation and a discussion that is focused on clinical reasoning. Each patient's presentation may lend itself to emphasis on different aspects of clinical reasoning: i.e. one of the following: differential diagnosis, pathophysiology, or integration of informative literature on the clinical problem. Never cut and paste (this is plagiarism).

A few specific tips:

After the Chief Complaint, introduce the patient briefly, helping the reader understand the patient and his/her situation: for example, "A.B. is a 65 year old married retired chef and father of two with a history of type 2 diabetes who presents with"

A good **HPI** is hard to write and requires that you have taken your own careful history and integrated the findings so that you know what is important and what is less important. Whenever possible, take your own history **FIRST** and without prejudice from the computer or the notes of others (when you do so, you will not infrequently uncover discrepancies or the fact that disease labels may be poorly supported by data, or simply incorrect). Include pertinent positives and negatives. Remember, if you forgot to ask something, go back and do so.

Make the setting and the symptoms as specific as possible. (for example, "A.B. was in a hot kitchen preparing the appetizers for a VIP party when he noted chest pressure radiating to his left arm") Avoid jargon. Use complete, short declarative sentences.

The **past history** should usually be in the form of a list, but should include pertinent facts about each medical condition or surgical procedure. For example:

"Diabetes: dx 2008, rx metformin, HgbA1C 6-7 range. Last eye exam 6 mos ago was normal. No other complications."

In the **formulation**, avoid a massive run-on sentence that includes uninterpreted phenomenology: instead of: "This 65 year old chef with a history of diabetes but no other cardiac risk factors presents with chest pressure, shortness of breath, a BP of 170/90, heart rate of 90, clear chest, distant heart sounds, cardiogram showing lateral ST depressions and positive troponins", you might say, "This 65 year old diabetic chef presents with chest pain and evidence of cardiac ischemia."

Problem list: there are a number of ways to structure your problem list; make sure you include the long term concerns and needs of your patient including issues of primary and secondary prevention as well as the barriers that may exist to their realization.

Use the opportunity of the discussion to formulate questions and pursue their answers. These could relate to the differential diagnosis of the chief complaint and its work up, or the anticipated acute or chronic complications and long term outcomes of (for example) acute coronary syndrome (i.e. what to look for hour to hour, day to day as well as over the long term), a brief synthesis of the pathophysiology of acute coronary syndrome and how it pertains to the particular patient, or a summary of literature pertaining to current therapy (although for obvious reasons, the rationale for such a discussion has to do with the worthiness of the exercise of a literature review, rather than in the content, which is evanescent).

Look at the examples on Courseworks under "Assignments". List your sources.