

CMS-3122-P-1

Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. Stephen Doms

Date & Time: 03/25/2005

Organization : Dr. Stephen Doms

Category : Physician

Issue Areas/Comments

Issue

Categories of providers permitted to perform a history and physical examination

With regard to the providers permitted to perform a history and physical examination, I would like to inform you that podiatrists (DPMs) have a statutory right in the state of Minnesota to perform such tasks. Our law provides that if a podiatrist has completed an approved hospital residency, he or she may then perform H&Ps for hospital admission. As podiatrists are also defined as "physicians" under federal Medicare rules, it only makes sense to add this category of providers to perform the necessary H&Ps. Oralmaxiofacial surgeons are dentists (DDSs) and dentistry is analogous to podiatry in diagnosis and treatment of a specific anatomical region of the human anatomy. I urge you to support allowing podiatrists to perform the history and physical examinations. Stephen Doms, DPM

CMS-3122-P-2

Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. Charlene Clark

Date & Time: 03/28/2005

Organization : Good Samaritan Regional Medical Center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I would like to encourage the addition of the proposed changes regarding authentication of verbal orders. At this time the verbal orders are authenticated days to weeks after the fact. As a hospitalist who is part of a team who cares for the patient 24/7 in a seamless fashion, the signing of verbal orders of the night team the following morning by the day physician assures all orders have been reviewed, and patient care assured. The current system is not in the patient's best interest.

Issue

Timeframe for authentication of verbal orders

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CMS-3122-P-3

Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. Clifford Hall

Date & Time: 03/28/2005

Organization : Inpatient Care Service/GSRMC

Category : Physician

Issue Areas/Comments

Issue

Authentication of verbal orders

I would like to strongly support the ability of physicians who are actively caring for a patient to co-sign verbal orders. As the Director of an active Hospitalist program at our Regional Medical Center in Corvallis Oregon, I feel patient care will be better served by the new regulations. The current system does not ensure timely review of the orders and requires inordinate expenditure of resources in trying to track down the ordering physician sometimes weeks and months after the order was given. Thank you for adopting the new changes.

CMS-3122-P-4

Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Mr. Michael Beck

Date & Time: 03/30/2005

Organization : Pinnacle Pointe Hospital

Category : Psychiatric Hospital

Issue Areas/Comments**Issue**

Authentication of verbal orders

I agree with the continued need to authenticate orders. I would appreciate clarification on a verbal order being legible, complete, dated and timed. At the time the verbal order is given, the transcribing nurse will date and time the order in a legible and complete fashion. Is it necessary that a physician date and time the order a second time at the time of authentication?

Issue

I agree with the proposal for having a history and physical examination completed no more than 30 days before or 24 hours after admission. I believe the requirement for the H&P to be placed in the record within 24 hours should be removed or modified to "as soon as possible." The majority of the hospitals I'm familiar with, including the one I work with now, have physicians that dictate their H&Ps. Typical expected turn around times for transcription is 24 hours. I believe it will be very difficult for providers to have an H&P placed in the record within 24 hours if their Medical Staff know they have 24 hours to complete one and the Transcription services turn-around-time goal is another 24 hours. Medical staff (482.22)

I agree with the proposal for having a history and physical examination completed no more than 30 days before or 24 hours after admission. I believe the requirement for the H&P to be placed in the record within 24 hours should be removed or modified to "as soon as possible." The majority of the hospitals I'm familiar with, including the one I work with now, have physicians that dictate their H&Ps. Typical expected turn around times for transcription is 24 hours. I believe it will be very difficult for providers to have an H&P placed in the record within 24 hours if their Medical Staff know they have 24 hours to complete one and the Transcription services turn-around-time goal is another 24 hours. Timeframe for completion of the medical history and physical examination

I agree with the proposal for having a history and physical examination completed no more than 30 days before or 24 hours after admission. I believe the requirement for the H&P to be placed in the record within 24 hours should be removed or modified to "as soon as possible." The majority of the hospitals I'm familiar with, including the one I work with now, have physicians that dictate their H&Ps. Typical expected turn around times for transcription is 24 hours. I believe it will be very difficult for providers to have an H&P placed in the record within 24 hours if their Medical Staff know they have 24 hours to complete one and the Transcription services turn-around-time goal is another 24 hours. Timeframe for authentication of verbal orders

I do not agree with the need to enforce a 48 hour timeframe for the authentication of verbal orders. Current regulatory text requires a patient to be seen by their attending physician as required by the condition of the patient. The verbal order timeframe will add additional burden on the physician simply for paperwork duties. Many residential facilities,

including our own residential program, must be compliant with CMS hospital regulations. The Medical Staff are only expected to see their patients once to twice weekly. The requirement to sign verbal orders within 48 hours would negate the once to twice weekly expectation our physicians have scheduled themselves to for many years.

CMS-3122-P-5

Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter :

Date & Time: 03/30/2005

Organization :

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

I have a comment regarding the security of medications on this docket. I would suggest that the word "secure" be more definitive. The text references the practice of medications being left at the patient's bedside however, there is no guidance as to whether this is acceptable. Is this secured? It is unclear.

What is the definition of an unauthorized person? Is this any person who is employed by the health care organization (i.e. nurse, housekeeper, etc) or is this limited only to those that have a license/certification that allows handling of medications? If "authorized" is limited to only those personnel that have a licence or certificate that allows them to have access to medications then it seems that allowing medications to stay at a patient bedside would then make the med unsecured and thus the facility would be out of compliance.

The terms "authorized" and "secured" need to be more defined so as to provide more guidance for the health care industry.

Thank you.

CMS-3122-P-6

Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. Carlos Sepulveda

Date & Time: 04/01/2005

Organization : Dr. Carlos Sepulveda

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

As a podiatrist practicing at The Commonwealth of Puerto Rico, I completely agreed with the Medicare proposal for podiatrist to perform physical examinations and admissions at hospital. We are trained to do such performance, and if we are capable of do foot & ankle surgery; then, why we could not perform physical examinations and patient admissions? Allow the stop to the continuous abusive pattern and disruption of medical privilege that the podiatric profession has obtain for years.

CMS-3122-P-7 Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Ms. Nancy Griffin

Date & Time: 04/05/2005

Organization : St. Mary's Medical Center

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-3122-P-7-Attach-1.DOC

Attachment #7

H & P examination. The proposed requirement would expand the number of permissible practitioners who may perform the H&P and the time frame for its completion to 30 days prior to admission up to 24 hours after admission. H & P (or update to H & P) must be on chart by 24 hours after admission.

My comments are: completion of H & P by "other qualified individual" is appropriate as physicians, Registered Nurses with special training, Nurse Practitioners and Physician Assistants are qualified to perform. These relaxed time frame requirements are appropriate. They will facilitate timely communication and decrease expenditures for unnecessary H & P activities that might be incurred simply to satisfy conditions that add no value.

Authentication of verbal orders. This regulation would require that all orders, including verbal orders, must be dated, timed, and authenticated by a practitioner responsible for the care of the patient. During a five year transition period from publication of the final rule, it would allow all orders, including verbal orders, to be dated, timed and authenticated by the prescribing practitioner or another practitioner responsible for the care of the patient. Additionally, the proposed rule states that in the absence of a State law specifying the timeframe for authentication of verbal orders, verbal orders would need to be authenticated within 48 hours. Finally, this requirement clarifies and reinforces current regulations regarding who may accept verbal orders, authentication of all orders for drugs and biologicals, and authentication of medical record entries.

My comments are: Since physicians share accountability via contractual or ethical arrangements and are not always present 24 hours a day, it is appropriate that Medical Record entries be dated, timed, and authenticated by the prescribing practitioner or another practitioner who is responsible for the care of the patient.

Security of Medications. This regulation requires that all drugs and biologicals be kept in secure areas, or locked when appropriate, to prevent unauthorized persons from obtaining access.

My comments are: "All drugs and biologicals must be kept in a secure area, and locked when appropriate." I suggest you wait and clarify for exceptions. The term "secure" may require exceptions. For instance - in the surgical holding room or other non-public areas with constant presence of authorized hospital personnel - medications may be in a rolling cart that is unlocked but under constant supervision. Or a patient care area medication room where medications are in locked carts, drawers or cabinets however the room itself is not locked, but is behind the nursing desk. Consider medications brought in by patients who refuse to surrender such to nursing staff for "safe keeping" with the intent to prevent double dosing. These and other situations require careful thought.

"Only authorized personnel may have access to locked areas". Accommodations for housekeeping, security patrols and others must be acceptable under this requirement.

Post anesthesia evaluation. This requirement permits the post anesthesia evaluation for inpatients to be completed and documented by any individual qualified to administer anesthesia. The current CoP requires that the individual who administers the anesthesia do this evaluation.

My comments are: This is appropriate since as anesthesiologists and CRNAs are qualified to perform and share accountability via contractual or ethical arrangements and because certain individuals are not always present 24 hours a day.

CMS-3122-P-8

Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. Fred Rotenberg

Date & Time: 04/05/2005

Organization : Dept of Anesthesia, Rhode Island Hospital

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I agree wholeheartedly with the proposed changes to code CMS 3122-P (secure drugs) and post anesthesia evaluation. Thank you for your attention to these matters.

CMS-3122-P-9 Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Ms. Rose Dunn

Date & Time: 04/05/2005

Organization : Ms. Rose Dunn

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment.

CMS-3122-P-9-Attach-1.DOC

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Attachment #9
April 5, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-3122-P
PO Box 8010
Baltimore, MD 21244-8010

Dear Sir or Madam:

I am writing to you regarding the proposed Verbal Order rule §482.24 (c)(1)(iii) and its proposed timeframe of authentication within 48 hours.

I am a health information professional and a past president of the American Health Information Management Association. I have worked with numerous hospitals and medical staffs across the US. I respect your attempt to resolve the timeframe issue, but...it adds no value. If an order is issued and carried out promptly, as it should be, signing the order after the fact does nothing to reverse any misadventure that may have occurred because of an unsigned order.

While not representative of 100% of the physicians practicing in the US, orders, even some written by the physicians themselves, remain unsigned at the time of discharge. Health information management/medical record departments throughout the US spend enormous sums in resources to pursue signatures on orders—verbal or otherwise, for what? It's too late.

Establishing a rule that says verbal orders must be signed within 48 hours, will not change the fact that some will continue to be unsigned at discharge and, again, HIM staff will continue to expend resources to chase physicians, after discharge, to sign an order. Moreover, once signed, getting them timed and dated accurately to reflect when the authentication really occurred—will be a myth.

I understand that you are attempting to pinpoint responsibility. Pinpointing responsibility after the fact does not ensure patient safety. Requiring physicians to issue written orders themselves, regardless of the time of day, pinpoints responsibility. The reality is that there are some facilities where the physician may issue only verbal orders. This is "telemedicine" at its "finest." The practice is not acceptable, but it does allow the hospital to facilitate patient care, sometimes in the total absence of the physician.

If you want teeth in your rules, then allow NO verbal orders. With the technology access we have today in the US, the physician can fax or email an order to the hospital, SNF, or ambulatory surgery center, if he/she doesn't wish to show up in person to write or enter an order.

If the physician is on-site, then he/she should use his/her quill or computer access to order services—not ask the nurse standing next to him to do it. Will this hinder care? I doubt not.

Will it hinder the physician's ease of treating patients remotely—not significantly. Where will he/she be that there will not be a fax machine or computer? The golf course, perhaps. But, you've solved that hurdle with the provision of allowing another clinician covering for the physician the authority to authenticate the order. Then that clinician can write it, too!

Finally, will a physician actually writing the order or typing it into an email or CPOE (computerized physician order entry) system protect the individual carrying out the order and improve patient safety? —Yes.

I hope you will give my comments some consideration. It's a frustrating issue, as is apparent in your comments in the *Federal Register*. Perhaps it's frustrating because there is no real sanction if orders are not signed within *any* reasonable timeframe. Forbidding verbal orders may be the solution. Allowing verbal orders IS a safety issue.

Sincerely,

Rose Dunn

Rose T. Dunn, RHIA, FAHIMA, CPA, CHPS, FACHE
Chief Operating Officer

CMS-3122-P-10

Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter :

Date & Time: 04/06/2005

Organization :

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

CMS proposals for History and Physical Examinations, Authentication of Verbal Orders, Securing Medications, and Post-anesthesia evaluations:

Regarding Condition of Participation: Nursing Services (482.23) "Orders for drugs and biologicals be documented and signed by a practitioner who is responsible for the care of the patient and authorized to write orders by hospital policy in accordance with state law" - the term "practioner" is concerning in this COP. Physicians/LIPs ensure that orders (including medication orders) are appropriate, accurate, complete, etc. Physician/LIP signature maintains the appropriate level of accountability as with verbal orders.

CMS-3122-P-11**Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations****Submitter :** Dr. mark singleton**Date & Time:** 04/06/2005**Organization :** Stanford University School of Medicine**Category :** Physician**Issue Areas/Comments****GENERAL**

GENERAL

As a member of the Stanford Medical School Adjunct Faculty, teaching anesthesiology residents the sub-specialty of Pediatric Anesthesiology, I strongly endorse the proposed changes CMS-3122-P. While a rare occurrence, our patients, the smallest and most fragile of any surgical patient, have developed immediately life threatening respiratory or cardiac arrest IN THE HALLWAY ON THE WAY TO THE RECOVERY ROOM! This required immediate return to the operating room for emergency resuscitative measures to save the patient's life. If, on those occasions, the anesthesia cart containing emergency drugs and equipment had been locked after our initial departure, the seconds or minutes required to unlock the cart would clearly have resulted in organ damage or even the death of our patient. I have never, in more than 20 years as an anesthesiologist in both private and academic practice, heard of a problem or patient safety issue as a result of open access anesthesia carts in operating rooms or other secure anesthetizing locations. We, in my specialty of anesthesiology, are aware of heavy marketing pressure being applied toward hospital administrators and operating room staffs, by the manufactures of sophisticated, expensive and often ill advised anesthesia carts which impose unnecessary barriers to access to needed medications and equipment. It would be a tragedy to allow these economic pursuits to contribute to potential harm to our patients.

I am also in favor of the proposed changes to the policies on H&P timing, and post anesthesia evaluations being done by qualified individuals other than the anesthesiologist who administered the anesthetic, as this person is often not available.

I applaud CMS for its advocacy of the most excellent possible patient care and safety and continued willingness to work with physicians and health professionals to further these goals.

CMS-3122-P-12

Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Mr. Dwayne STONE

Date & Time: 04/07/2005

Organization : Anesthesiology Consultants Exchange PC

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Section 3 "Securing Medications"

I am the Chief Anesthesia Technician in a large surgery area. I am so glad that this issue is being considered. It is extremely difficult to lock medications between cases (other than controlled drugs). With this rule out of the way, It should be easier to gain compliance on more important issues from the Anesthesia providers.

CMS-3122-P-13 Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. John F. Anderson

Date & Time: 04/08/2005

Organization : Catholic Health Initiatives

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-3122-P-13-Attach-1.DOC

CMS-3122-P-13-Attach-2.DOC

Note: CMS did not receive an attachment to this document. This may have been due to improper submission by the commenter or it may have been a result of technical problems such as file format or system problems.

CMS-3122-P-14 Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Mr. James Rathlesberger

Date & Time: 04/08/2005

Organization : California Board of Podiatric Medicine

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-3122-P-14-Attach-1.DOC



MEDICAL BOARD OF CALIFORNIA
BOARD OF PODIATRIC MEDICINE
1420 HOWE AVENUE, SUITE 8, SACRAMENTO, CA 95825-3229
PHONE: (916) 263-2647 FAX: (916) 263-2651
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www.bpm.ca.gov

April 8, 2005

Attachment #14
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-3122-P
P.O. Box 8010
Baltimore, MD 21244-8010

Re: CMS-3122-P, Condition of Participation: Medical Staff (§ 482.22), Section 482.22(c)(5)

Ladies and Gentlemen:

The State of California Board of Podiatric Medicine applauds your moving forward with this revision to regulations to permit Doctors of Podiatric Medicine to perform history and physical examinations.

Our licensees are trained, tested, competent and accustomed to providing this service, which is an essential component to quality care and the licensed scope of practice. Our Department of Consumer Affairs Legal Office has opined since 1992 [<http://bpm.ca.gov/licensing/hp1992.pdf>] that it is malpractice for the DPM not to perform the history and physical examination as indicated. DPMs independently diagnose, prescribe and practice podiatric medicine and surgery and there should be no barrier to their performing complete medical history and physical examinations.

Current application of your existing regulations is disrupting the efficient delivery of quality care to podiatric medical patients in many California facilities. The final promulgation of your proposal is a matter of importance and urgency for patient care and consumer protection.

Thank you very much for taking this long-awaited, necessary step for modern and efficient health care delivery.

Sincerely,

James H. Rathlesberger, M.P.A.
Executive Officer
Board of Podiatric Medicine

CMS-3122-P-15**Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations****Submitter : Dr. Kenneth Y. Pauker****Date & Time: 04/08/2005****Organization : Dr. Kenneth Y. Pauker****Category : Physician****Issue Areas/Comments****GENERAL**

GENERAL

Securing Medications - As a practicing anesthesiologist who cares for critically ill patients during emergency surgeries, I can attest to the fact that adopting the new rule will help to prevent injury to patients from lack of immediate access to medications. The old regulations were unworkable and a general beauracatic mess which created requirements for compliance without having a reral problem they intended to address. Vendors who argue for the necessity for locking all medications despite their being in a secure area are simply looking to have regulations which would force purchase of more of their equipment. I support the new rules.

H&P's - I agree with liberalizing the timne frames to 30 days because the 7 day period does not comport with getting patients ready for surgery in these days of the need for scheduling and arranging for tests and consultations well in advance. A 7 day rule simply creates work without any evidence that it is any safer or promotes any better care.I support the new rules.

Post-Anesthesia evaluations - Allowing partners or associates to write the follow-up notes is another example of addressing the realities of a busy practice wherein it is simply physically impossible given time and space constraints to do reliably what is presently required. I support the new rules.

CMS-3122-P-16**Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations****Submitter :** Dr. Virgil Airola**Date & Time:** 04/11/2005**Organization :** self**Category :** Physician**Issue Areas/Comments****GENERAL**

GENERAL

RE:Section 482.25(b)(2)(i)--Locked Anesthesia Cart Proposed Rule Change: I strongly support removing the requirement in secure areas of hospitals & care facilities. Although the PYXIS Machines are helpful in allowing controlled substances to be present in operating rooms that function can be controlled seperately from drawers containing non-controlled, potentially life-saving medications. When I close my PYXIS anesthesia cart now, I cannot quickly reopen it with either a typed password or a thumbprint especially if my patient suddenly develops an airway obstruction, an arrhythmia, or other life threatening condition. Also the PYXIS carts have no battery back-up and without power they cannot be opened at all. The proposed new rule will allow me to use the PYXIS carts without the concern that my patient is always needlessly at risk for preventable harm because sudden events cannot be managed effectively because the needed drugs are temporarily unavailable. In a critical situation when seconds count, a locked drawer of life-saving medications is unsafe and an open drawer can mean the difference between brain damage and a near-miss for patients. I support the proposed rule change to allow unlocked medication carts in secure areas of medical facilities. Thank you, Dr. Virgil Airola

CMS-3122-P-17**Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations****Submitter :** Dr. T. Reid Ecton**Date & Time:** 04/11/2005**Organization :** Podiatric medicine and surgery**Category :** Other Practitioner**Issue Areas/Comments****GENERAL**

GENERAL

As a practicing surgeon of the foot and ankle I am interested in seeing the planned changes to COP regarding podiatric Histories and physicals. All podiatrists are trained in physical diagnosis as part of educational process, residency programs require a complete and efficient understanding and action in doing history and physicals for not only foot and ankle surgery, but medical issues as well. They are reviewed by MD/DO physicians as part of the educational process. In Kaiser Permanente we have been providing H&Ps for all of our patients in the past. The efficiencies and quality of care that comes from expedition in providing our own physicals is both appropriate and reasonable given the education and demonstrated competencies in the past.

I am happy to see these regulations parallel the rational behavior that has been part of the normal care and management of podiatric patients. Thanks you for your work on this issue.

CMS-3122-P-18

Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. Helen O'Keeffe

Date & Time: 04/11/2005

Organization : Permanente Medical Group

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Re locked carts for anesthesia:

We had a problem recently where a cart, thought to be open, locked itself when the drawer was closed with the key inside the top drawer. . needed work to reopen the cart. . this could be a real problem in an emergency. . luckily the case had not yet started. .

There is an inherent conflict between accessibility and security. As a practicing anesthesiologist, I would like the security-lock location to be the main OR access, and not my immediate access to life-saving equipment. .Reality check: in over 30 years of practice I can think of several situations where lack of immediate access would have been a problem. . I have experienced no incidents of misuse of my anesthesia cart by others. . .

CMS-3122-P-19

Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Ms. Janet Gallaspy

Date & Time: 04/12/2005

Organization : Forrest General Hospital

Category : Hospital

Issue Areas/Comments

Issue

Nursing services (482.23)

CMS asked for comments related to whether there are "recurring problems with prescribing practitioners denying that they gave a verbal order after the verbal order was carried out." This does not happen frequently but is a rare to occasional issue. When this happens, the process is to get the Nurse and Physician together in the same room to arrive at the truth. Most frequently, the physician initially does not remember but does when his/her memory is jogged.

Timeframe for completion of the medical history and physical examination

CMS proposes "that when a medical history and physical examination is completed WITHIN the 30 days before admission, the hospital must ensure that an updated medical record entry documenting an examination for any changes in the patient's current condition is completed." This requirement needs to be more fully defined. At what point between admission and 30 days does it become necessary to update the patient's condition? As stated now, if the physician does an H&P the day before admission, the hospital would have to require an update within 24 hours. I don't think this is your intent. The requirement should be reworded to indicate anything completed greater than an "X" number of days prior to admission must be updated. This would be clear and much easier to administer than a vague "within 30 day" range.

CMS-3122-P-20

Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. Lawrence Gluckstein

Date & Time: 04/13/2005

Organization : Medical Anesthesia Consultants

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

As a practicing anesthesiologist for 20 years, I know from first hand daily experience that immediate access to the medications of my profession is absolutely essential. Seconds count when a patient is not properly breathing. The anesthetic care of a patient does not cease at the end of surgery. Indeed the process of emergence from anesthesia is a high risk period. Locking down the anesthesia cart and removing syringes of medication for this patient during this time is not only a diversion from patient care, but also removes the very tools of the trade from immediate access when they are likely to be needed immediately.

CMS-3122-P-21 Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. Gordon Sinclair

Date & Time: 04/13/2005

Organization : Kaiser Permanente

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir,

The request for Podiatric Surgeons H&P performed and covered by Medicare/Medical is only practical. Durring our training we are equiped to perform accurate H&P in order to admit patients, perform surgery, and treat patients both in hospitals and clinics.

Sincerely, DR.Gordon Sinclair

More importantly this would save time and money, by having only on doctor do the H&P.

CMS-3122-P-22

Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. John Stanec

Date & Time: 04/13/2005

Organization : Medical Anesthesia Consultants

Category : Physician

Issue Areas/Comments**GENERAL**

GENERAL

Regarding the issue of locked carts in the Operating Theater, I would like to comment that actually locking each individual cart, and medications between cases constitutes a serious hazard to our patients. The transition from the OR to the Post Anesthesia Care Unit (PACU) is a dangerous time, and numerous emergencies may present rather suddenly. Having quick access to emergency medications is an absolute necessity for proper care.

There have been numerous times when I personally have had patients experience severe laryngospasm, with subsequent hypoxia due to inadequate ventilation. There are times when it is so severe that rapid administration of succinylcholine is necessary to secure ventilation and blood oxygen levels. When this happens, the last thing that I need to be wasting precious minutes on, would be fumbling with the lock on a cart. The brain does not appreciate a lack of oxygen, nor ill conceived mandates.

CMS-3122-P-23

Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. Gregory Garbin

Date & Time: 04/14/2005

Organization : Medical Anesthesia Consultants, MGI

Category : Physician

Issue Areas/Comments**GENERAL**

GENERAL

I strongly oppose the requirement to locked anesthesia carts in operating rooms when the operating room suite is already a secured facility. I would like to relay an incident which jeopardized a patient's life.

We had recently performed a carotid endarterectomy on an class ASA IV patient with multiple medical conditions including end-stage renal disease, cardiomyopathy, and diabetes. She was recovered in the ICU after an uneventful stay in the PACU. The procedure was performed late in the day, and by the time the patient reached the ICU, it was early evening. The OR was particularly slow that day, so no rooms were going and the crew had cleaned up and secured the facility.

I received a STAT page to the ICU. The patient was experiencing an acute rebleed of the surgical site. We had to rush to the OR emergently. I knew that that patient would be a challenging intubation because of the expanding hematoma in her neck, so I requested that we proceed directly to the OR so that I would have the medications and airway adjuncts necessary to address a difficult intubation.

Upon arrival in the OR, I found the anesthesia cart locked with the padlock which has been used in our facility for the past 3 years. I was understandably nervous and somewhat shaking since I knew the patient was on the verge of a full-blown respiratory arrest. Still, I knew that I needed certain medications and airway adjuncts which were available in my anesthesia cart. I entered the combination and the lock would not open. I tried again, still it would not open. By this time, the nurse had applied the necessary monitors to the patient and I could see that time was of the essence. The O2 sat was now in the upper 80's (it was upper 90's with face mask O2 in the ICU) and I still could not open the pad lock. I tried to settle myself and relax so that any fumbling of my fingers due to nervousness couldn't interfere with my ability to open the lock, but try as I may, the lock wouldn't open. I finally had to run to the OR next door and open the locked cart in there to get what I needed. It opened with the same efforts which had failed in the OR where we had brought the patient. I grabbed what I needed and proceeded to secure the airway before the patient's O2 sats sank any further and I was lucky to have had the nearby OR cart fully stocked and able to be unlocked quickly. I had to think, however, that had this occurred in our OB suite, there is not a nearby OR to run to in the event that the lock on the anesthesia cart malfunctioned. It was later determined that the original lock was misprogramed somehow and that the accepted combination was no longer valid.

This patient could have lost her life due to this "safety measure". Obviously there are occasions where the locks can do more harm than good. I would like to know what the relative statistics are of "close calls" such as mine versus OR staff abuse of medications found in the anesthesia carts. To my knowledge, meds such as Pavulon, Vecuronium, Neostigmine, Dopamine, Glycopyrrolate, Reglan, Ephedrine, Saline, Ancef, Lasix, etc. do not have high abuse potential. I can understand narcotics, which are additionally locked within our locked anesthesia carts. This rule is simply DANGEROUS and UNSAFE. It must be changed immediately before a patient dies.

CMS-3122-P-24 Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. Napoleon knight

Date & Time: 04/14/2005

Organization : carle foundation hospital

Category : Hospital

Issue Areas/Comments

Issue

Authentication of verbal orders

Verbal orders should be used infrequently but it makes total sense, and is a reality of the practice of medicine that there will be times that a verbal or telephone order will need to be signed by another physician who is covering the care of the patient. Emergent situations, vacations, are good examples. With the growing number of hospitalist physicians, there will need to be that flexibility as well.

Categories of providers permitted to perform a history and physical examination

A welcome change, long overdue.

Completion of the medical history and physical examination

Wonderful to allow more flexibility to allow providers other than physicians to do these.

Nursing services (482.23)

securing medications should serve the function well. with advances in technology such as omnicells and pixus, they should be able to be adequately secured without needing to be locked. Technology has moved on, and so should we.

Timeframe for completion of the medical history and physical examination

It would be wonderful to allow more flexibility for h&p's to be done. The change would have to concur with those of the Joint Commission who want them done within 24 hours. A bit of a disconnect. If you have 30 days, and the patient then needs an update h&p, it may lead to dissatisfaction on the part of the patient.

Timeframe for authentication of verbal orders

The 5 year timeframe is reasonable and should allow an adequate period of time to evaluate. Verbal orders should be readback for clarification, and should then be able to be signed in the timeframe for telephone orders.

CMS-3122-P-25

Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. Arne Brock-utne

Date & Time: 04/14/2005

Organization : MAC

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I am an anesthesiologist in Walnut Creek California.

We need IMMEDIATE ACCESS to EMERGENCY medications in the OR. I work at a number of different facilities. If the carts are locked, I may not remember the code to unlock the cart, and may not be able to treat the 2 year old patient with severe laryngospasm with a falling blood oxygen saturation and dropping heart rate, in time before he has a cardiac arrest.

Please - the OR is secure enough already.

Please - for the sake of our patients under anesthesia, do not require locked carts in the OR.

Thank you.

Arne Brock-Utne, MD

CMS-3122-P-26 Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Mrs. Faye Anderson

Date & Time: 04/15/2005

Organization : Southeast AL Medical Center

Category : Other Health Care Professional

Issue Areas/Comments

Issue

Authentication of verbal orders

(1) the 48-hr rule would only load an additional responsibility onto nurses, who are already in short supply and caring for sicker patients; (2) a 48- hrs lapse does not provide any additional reassurance for many orders; (3) Joint Commission readback requirement now verifies verbal orders; (4) many individuals are not comfortable signing another's orders and incurring the responsibility for the validity of the order. These comments are from Medical Executive Committee members Dr. Ted Paulk, Dr. Kami Sester, and Dr. James Jones.

CMS-3122-P-27

Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. Elizabeth Drum

Date & Time: 04/19/2005

Organization : Temple University Children's Medical Center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I am writing to support the revision of the provision 482.25(b)(2) requiring all drugs and biologicals to be kept in a secure area. I support the position statement approved by the ASA. I would like to make sure that it is clear that nonprofessional support personnel work in the operating room (housekeeping, orderlies, etc) as well as other professionals (nurses, technicians, etc.). It should be clear that these personnel meet the definition of "authorized personnel". They are not to remove or interfere with medications.

In addition, I also support the revision to section 482.52(b)(3) which would permit the postanesthesia evaluation for inpatients to be completed and documented by any individual qualified to administer anesthesia. It is impractical and unreasonable to think that the person who administered the anesthesia will always be able to perform the postanesthesia evaluation. As long as an individual is qualified to administer anesthesia, he or she would know how to perform the postanesthesia evaluation.

CMS-3122-P-28

Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. Rodger Barnette

Date & Time: 04/19/2005

Organization : Temple University School of Medicine

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Dear Sir or Madam,

This comment is made in regard to 'Securing Medications' and specifically addresses issues within an operating room suite.

The operating room is a restricted access area, open only to hospital employees whose jobs bring them into this area. The proposal indicates that if 'authorized personnel only' are permitted within the area it meets the CMS definition of 'secure'.

I recommend that the proposal specifically state that non-professional support personnel (housekeeping personnel, orderlies, etc.) are authorized personnel. These individuals are, by policy and conditions of employment, enjoined from removing medications, syringes, or needles from the operating room.

It is my professional judgment that this issue has a bearing on patient safety and good anesthesia practice.

Thank you,

Rodger Barnette, MD

CMS-3122-P-29 Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. Andrew Herlich

Date & Time: 04/19/2005

Organization : Temple University School of Medicine

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

It is imperative that the operating room be considered a sufficiently secure area so that emergency drugs and equipment may be continuously prepared for any emergencies. The current view is that everything must be locked without the ability to have emergency preparations. Patients will die or practitioners will just ignore the rules. Please change the rules to permit emergency preparedness within the operating room setting.

CMS-3122-P-30

Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. Kennon Martin

Date & Time: 04/20/2005

Organization : Paradise Podiatry Group

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

April 14, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-3122-P
P.O. Box 8010
Baltimore, MD 21244-8010

RE: CMS-3122-P, Condition of Participation: Medical Staff (?42.22), Section 482.22 (c) (5)

Ladies and Gentlemen:

Your proposed rule in regards to the current medical history and physical examination requirement is really applauded and appreciated by me and my profession.

As a practicing podiatrist for 30 years, I have had to defend the podiatrist's ability and qualifications to do history and physicals in many, many hospital committees and medical staff meetings. The one barrier always quoted to prevent us from being able to practice within the scope of our practice and license has been the rule (CoP) which states that only a doctor of medicine or osteopathy, or oromaxillofacial surgeon is to perform the history and physical.

California's Department of Health Services through their Licensing and Certification division have always stated that in accordance with state law, podiatrists in California may do complete history and physicals, however, the current Medicare rule only allows an M.D., D.O. or oromaxillofacial surgeon to do the history and physical on a Medicare patient for hospital admissions when they have "been granted such privileges by the medical staff in accordance with state law.

It will be such an improvement for the rule to include all practitioners who may practice ??in accordance with state law?. This is an important aspect for us, as podiatrists, because California's state law allows podiatrists to do complete history and physicals.

The proposed rule will accomplish the objectives of bringing the rule up-to-date with the current healthcare practice, it will reduce the burden on medical staffs and most importantly, will continue to ensure patient safety. The tremendous amount of energy that has been spent on this subject,

over the last 25 years, has been unduly burdensome. The time that has been spent within the state agencies, medical staff committees, corporate hospital committees and medical associations can now be put towards other healthcare issues that can benefit our patients.

This is a rule change that is appropriate and worthwhile for our patients. I thank you for making this change.

Sincerely,
Kennon J. Martin, D.P.M.

CMS-3122-P-31 Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Pamela Schauben

Date & Time: 04/22/2005

Organization : Shands Jacksonville

Category : Pharmacist

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-3122-P-31-Attach-1.DOC

As a patient safety advocate and frequent lecturer on the subject as well as a practicing hospital-based pharmacist, I applaud the intention to return to a more common-sense approach to the issue of medication security. I believe there are three issues that would serve this goal while preserving and **improving** patient safety:

1. Emergency carts such as crash carts and anesthesia carts (for example, in Trauma and Cardiac emergency centers) need to be readily available in order to treat patients whose lives are in imminent danger. The standard should state that these carts should be sealed (e.g., tamper-evident) but must **never** be locked, due to the common problems of misplacing keys, forgetting the passcode, agency employees, etc.
2. Medication carts should remain locked or in line of site of a licensed practitioner, but should not require additional security. Many hospitals have invested in self-locking carts, which should provide adequate control of medications. A nurse called emergently to a bedside should not be required to first secure a medication cart in a locked room down the hall.
3. Sodium chloride solution in the form of saline flush and respiratory saline should be exempt from the standard. These items are completely innocuous, and are truly excipients, rather than medications. Further, these products are required on a frequent basis to provide routine (but important) care to patients, such as flushing lines to prevent medication precipitation, keeping lines open, etc. as well as providing suction (frequently on an emergent basis).

Sincerely,

Pamela Schauben, R.Ph., M.S.
Manager, Inpatient Pharmacy Services
Shands Jacksonville Department of Pharmacy
Clinical Associate Professor
University of Florida College of Pharmacy

CMS-3122-P-32

Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. Neil Brister

Date & Time: 04/22/2005

Organization : Temple University Hospital

Category : Physician

Issue Areas/Comments**GENERAL**

GENERAL

I wish to comment in regards to 'Securing Medications' and specifically addresses issues within an operating room suite. The operating room is a restricted access area, open only to hospital employees whose jobs bring them into this area. "Locking" carts at end of case focuses the physician's attention away from the patient. The proposal indicates that if 'authorized personnel only' are permitted within the area it meets the CMS definition of 'secure'. I recommend that the proposal specifically state that non-professional support personnel (housekeeping personnel, orderlies, etc.) are authorized personnel. These individuals are, by policy and conditions of employment, enjoined from removing medications, syringes, or needles from the operating room. It is my professional judgment that this issue has a significant bearing on patient safety and good anesthesia practice. Thank you, Neil Brister, MD, PhD

CMS-3122-P-33

Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. Scott Schartel

Date & Time: 04/25/2005

Organization : Dept of Anesthesiology, Temple University

Category : Physician

Issue Areas/Comments**GENERAL**

GENERAL

Ladies and Gentlemen:

I write in support of the proposed change made in regard to 'Securing Medications' in the operating room. I believe that the proposed new language is an appropriate recognition that an operating room suite which is restricted to 'authorized personnel' is secure for non-controlled medications. I believe the requirement that anesthesia carts must be locked between cases if professional staff are not present in the individual operating room poses a patient safety issue by distracting anesthesiologists' attention from their patients at a time when the patients are very vulnerable and need undivided attention. I would recommend that the language of the proposed rule be expanded to include within the definition of authorized personnel all staff whose job description brings into the operating room (physicians, nurses, technicians, and non-technical support personnel such as housekeepers.) These individuals are, by policy and conditions of employment, enjoined from removing medications, syringes, or needles from the operating room. It is my professional judgment that this issue has a bearing on patient safety and good anesthesia practice. Thank you. Scott Schartel, DO

CMS-3122-P-34 Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. James Lonergan

Date & Time: 04/25/2005

Organization : CAA,PC

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

1. I believe that delegation of the post-op anesthesia follow-up by any member of the anesthesia team should be allowed.
2. I don't believe it necessary to change the hospital bylaws to allow for this.

CMS-3122-P-35 Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. Richard Boehler

Date & Time: 04/26/2005

Organization : St Joseph Medical Center

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-3122-P-35-Attach-1.TXT

Attachment #35
William D. Rogers, MD
1911 Belle Haven Rd.
Alexandria, VA 22307

Dear Dr. Rogers,

I am writing on behalf of the Medical Staff of St Joseph Medical Center in my capacity as Vice President for Medical Affairs and Chief Medical Officer. The Executive Committee of the Medical Staff feels strongly that there should be a change in one of the current CMS conditions of participation. In particular, we feel that the requirement for a pre-operative history and physical exam to be completed only by a physician credentialed by the medical staff at a particular hospital is onerous and does not bring value to the operative process or the patient.

As a tertiary community hospital with centers of excellence that attract patients from throughout Maryland and bordering states, at least half of our surgical patients are cared for by primary care practitioners who are not members of our medical staff (and who are most unlikely to seek privileges). Under the current condition of participation, we are obligated to provide an additional history and physical exam beyond that of the patient's personal physician. Historically, the surgeon would validate the referring physician's history and physical exam (assuming the appropriate timeframe) on the day of surgery and attest to that with a short statement or co-signature. This worked exceedingly well, but since the adoption of this requirement in December, 2004, we and others have had to change our practice to be in compliance.

As a result, patients have to travel a day or two in advance of surgery, incurring unnecessary expense and inconvenience to complete this process. Alternatively, hospitals are providing a hurried exam by a midlevel provider the morning of surgery to comply with this regulation. Patients are appropriately confused and baffled as to why their personal physician's exam is not sufficient.

It is our position that a physician who is credentialed by a JCAHO-accredited hospital should be capable of performing this function regardless of the site of surgery. While I believe it has been argued that a hospital is knowledgeable about the quality of care for all providers on its staff (in contrast to outsiders), in reality many primary care providers have limited or no involvement with inpatient medicine in our current modes of practice. As a result, having a meaningful appraisal of the quality of care rendered by many credentialed providers of primary care is not realistic.

I am confident that many hospitals in Maryland, and throughout the country, are struggling with compliance to this regulation and meeting the same level of general dissatisfaction as are we. We would appreciate your help in addressing this. I would be happy to discuss this further and to represent our medical staff's position in an ongoing dialogue. I look forward to hearing from you.

Sincerely yours

CMS-3122-P-36 Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. Julie Marfell

Date & Time: 04/26/2005

Organization : Frontier School of Midwifery and Family Nursing

Category : Nurse Practitioner

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-3122-P-36-Attach-1.RTF



The Frontier School of Midwifery and Family Nursing, Inc.

195 School Street, P.O. Box 528, Hyden, KY 41749, (606) 672-2312, Fax (606) 672-3776
www.midwives.org www.frontierfnp.org

Attachment #36

April 26, 2005

To whom it may concern,

I am writing to support the proposed changes to HCFA 3745-P/CMS 3122-P as a family nurse practitioner, and the Chairperson of the Department of Family Nursing at the Frontier School of Midwifery and Family Nursing I would agree that the regulation as it currently stands does not facilitate patient care and does cause a burden to individuals providing care to vulnerable rural populations. I would also like to see this regulation expanded to include critical access hospitals. These hospitals are in rural areas and are providing health care to individuals that would otherwise need to travel distances to receive in-patient care. Many of these hospitals receive referrals and admissions from rural health clinics. Nurse practitioners, and nurse-midwives provide care to individuals in these clinics and often cover their inpatient care as well.

I thank you for the opportunity to comment on these proposed changes. Please feel free to contact me with any questions.

Sincerely,

Julie Marfell, ND, BC, FNP
Chairperson, Department of Family Nursing.

CMS-3122-P-37 Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Mrs. Vivianne Griffiths

Date & Time: 04/28/2005

Organization : Hospice and Palliative Care of Louisville

Category : Nurse Practitioner

Issue Areas/Comments

GENERAL

GENERAL

As a nurse practitioner working in hospice in the in patient setting I am not recognized as a provider under Medicare "A" even though I manage a substantial amount of the patient's care. My orders which would be recognized independent of my collaborative physician in an ambulatory care setting , are not recognized in the hospital setting and have to be co-signed. I practice within my scope of practice and yet the Medicare regulations do not recognize my education and the clinical skills I bring to my practice setting . I urge you to support revisions in the conditions of participation. The first 3 items affect my practice greatly and limit my ability to function independently in other areas of the organization. Thank you.

Vivianne Griffiths, M.S.N., A.R.N.P.

CMS-3122-P-38**Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations****Submitter :** Dr. Patricia Dailey**Date & Time:** 04/29/2005**Organization :** Anesthesia Care Associates Medical Group, Inc**Category :** Physician**Issue Areas/Comments****GENERAL**

GENERAL

I am writing in support of the proposed CMS rules published March 25, 2005 with regard to securing medications. Section 482.25 (b)(2)(i)

The end of a surgical case, like landing an airplane, is a risky time period. It is not the time to lock away medications. It is UNSAFE practice to lock urgently needed medications, such as those to treat rapid heart rate or low blood pressure, in anesthesia carts. Medications need to be immediately accessible.

I have attempted to use locked anesthesia carts. On too many stressful situations I have not been able to get into locked anesthesia carts. I have tried many different brands of carts. I have had situations where I have had the wrong key, the key has jammed in the lock, the doors have jammed, the combination has not worked. The worst time was when I couldn't get into the locked cart to get the needed drugs when a mother came for cesarean delivery for fetal distress; we had to get a cart from another room. We lost valuable time.

The operating room suite, both in surgery and labor and delivery, is a limited-access secure location. It is safe practice for anesthesia professionals to leave non-controlled medications on the top of their anesthesia carts or anesthesia machines for brief periods (e.g., while going to a nearby holding area to bring a patient into the operating room). In addition, in suites kept at the ready for trauma patients or emergency obstetrical cases, non-controlled substances need to be immediately available, in a secure area, but not locked away in an anesthesia cart. I support keeping drugs and biologicals in secure areas, and locking them when appropriate.

CMS-3122-P-39**Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations****Submitter :** Dr. Marcus Corley**Date & Time:** 04/29/2005**Organization :** Mills-Peninsula Hosp**Category :** Physician**Issue Areas/Comments****GENERAL**

GENERAL

I wish to respond to the locking of Anesthesia Carts in the OR. I think this is a bad idea and is unnecessary since this is a secure area to begin with. I have witnessed "near miss" problems because of locked carts that could easily have resulted in patient injury or problems. For instance, around 2 a.m., an emergency craniotomy for intracerebral bleeding was called and the anesthesiologist, perhaps due to the haste and hour, did not bring a cart key. The nurse on call was unfamiliar with how to obtain a backup key. Eventually after some delay a key was obtained. The patient expired before transportation to the OR. This was not thought to be due to the OR problem, but it might have been. a "near miss!" This policy could be an unnecessary barrier to patient care. Narcotic medicines are locked up anyway. Do not require locked carts in the OR in addition.

Marcus Corley, M.D.

CMS-3122-P-40

Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. Vincent Hetherington

Date & Time: 04/29/2005

Organization : Ohio College of Podiatric Medicine

Category : Academic

Issue Areas/Comments

GENERAL

GENERAL

Ohio College of Podiatric Medicine
Office of Academic Affairs
10515 Carnegie Avenue
Cleveland, Ohio 44106-3081

April 25, 2005

Mark B. McClellan, MD, PhD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-3122-P
P.O. Box 8010
Baltimore, MD 21244-8010

RE: CMS-3122-P

Comments on Medicare and Medicaid Programs; Hospital Conditions of Participation: Requirements for History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Postanesthesia Evaluations; Proposed Rule (70 Fed. Reg. 15266, March, 25, 2005)

Please see attached letter and supporting documentation

Vincent J. Hetherington DPM

CMS-3122-P-40-Attach-1.DOC

CMS-3122-P-40-Attach-2.DOC

CMS-3122-P-40-Attach-3.DOC

CMS-3122-P-40-Attach-4.DOC

CMS-3122-P-40-Attach-5.DOC

CMS-3122-P-40-Attach-6.DOC

CMS-3122-P-40-Attach-7.DOC

**Ohio College of Podiatric Medicine
Office of Academic Affairs
10515 Carnegie Avenue
Cleveland, Ohio 44106-3081**

April 25, 2005

Mark B. McClellan, MD, PhD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-3122-P
P.O. Box 8010
Baltimore, MD 21244-8010

RE: CMS-3122-P

Comments on Medicare and Medicaid Programs; Hospital Conditions of Participation: Requirements for History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Postanesthesia Evaluations; Proposed Rule (70 Fed. Reg. 15266, March, 25, 2005)

Via electronic mail

Dear Dr. McClellan:

The Ohio College of Podiatric Medicine is one of eight colleges of podiatric medicine in the United States, and was founded in 1916 in Cleveland, Ohio. On behalf of the college, our students, and alumni, we are pleased to provide comments on the proposed rule that would revise four of the current hospital conditions of participation (CoPs) for approval or continued participation in the Medicare and Medicaid programs. We offer the following comments specific to podiatric medical education and the training received by podiatric medical students.

Specific training in the performance of a medical history and physical examination occurs as a result of several courses, laboratory, and clinical learning experiences in the college curriculum. These courses provide a continuum of experience offered in the second, third, and fourth years of the college curriculum and are listed below. Syllabi describing the key experiences are attached.

The continuum of education begins in year one with a didactic and laboratory introduction to history and physical exam skill and technique. Refinement of history taking in a simulated patient laboratory occurs in year two of the curriculum. The third year refines physical examination skills by the use of simulated patients and closely supervised clinical experience in a hospital and ambulatory clinical setting. Year four provides a hospital based environment to complete the training and demonstrate competence in a clinical setting on medical services at affiliated hospitals.

The history and physical curriculum and supporting course work is outlined below by year:

<u>YEAR ONE</u>	Physical Diagnosis 1 Lecture and Lab Physical Diagnosis 2 Lecture and Lab
<u>YEAR TWO</u>	Standardized Patients (Utilizes live Patient Simulation in simulated patient laboratory)
<u>YEAR THREE</u>	Simulated Patients (Utilizes live Patient Simulation in simulated patient laboratory) Third Year Physical Diagnosis Rotation (Hospital based clinical rotation) New Patient Evaluation Clinical Rotation (Ambulatory based clinic experience) Advanced Cardiac Life Saving Course (certification) Neurology Course Dermatology Course General Medicine Course (Includes all organ systems)
<u>YEAR FOUR</u>	Senior Medicine Rotation (Hospital based clinical rotation) Clerkships Experiences

The ability to perform a complete medical history and physical is a requirement for graduation from the college as well as a skill required to enter residency training. The experiences provided in the college are further enhanced and refined during the postgraduate residency training.

The overall responsibility for the physical diagnosis curriculum is under the supervision of the Chairperson of the Department of General Medicine of the Ohio College of Podiatric Medicine, Dr. Edweana Robinson, an allopathic physician, who has been a member of the college faculty and department chair of general medicine for over 20 years.

Feedback from clerkship and residency directors has shown that students trained at the Ohio College of Podiatric Medicine are as well or better prepared as allopathic and / or osteopathic students and residents in this area.

Additional information about the college is available on our website at <http://www.ocpm.edu>

If you have any questions specific to the information provided, please do not hesitate to contact:

Office of Academic Affairs
Ohio College of Podiatric Medicine
10515 Carnegie Avenue
Cleveland, Ohio 44106-3081
Phone number (216) 707 8012
FAX (216) 707 8005
Or via e mail at vjh@ocpm.edu

Sincerely,



Vincent J. Hetherington, DPM
Vice President and Dean of Academic Affairs



Edweana Robinson MD
Chair, Department of General Medicine

THIRD YEAR
PHYSICAL DIAGNOSIS ROTATION
2004 – 2005 ACADEMIC YEAR

Course Coordinators:
Edweana Robinson, M.D.
Vincent J. Hetherington, D.P.M.

DESCRIPTION OF ROTATION

The Physical diagnosis rotation is a one month experience in area hospitals which is designed to provide experiences in history and physical examinations. Each rotation site will provide the same core experiences (based on the goals and objectives) in patient assessment techniques.

RATIONALE

The podiatric physician serves both as a primary care provider, as well as, consultant to the health care management team. As a primary care provider, the podiatric office serves as an entry point to the health care system, provides care for commonly occurring conditions, sees patients on a regular basis over the life of the patient, and coordinates care when signs and symptoms of systemic diseases outside the scope of practice present themselves.

The podiatric medical student must develop good history and physical examination skills, which enable accurate diagnosis and management of patient problems. Management refers to the process of evaluating signs and symptoms, identifying systemic and podiatric medical conditions and developing treatment strategies including appropriate referral as needed.

As consultant, the podiatrist serves a secondary and tertiary prevention function, screening for disease precursors and arresting and retarding the effects of existing conditions.

As the healthcare system moves from a disease orientation to a health orientation, the role of the podiatrist on the primary care team will become better defined. As physician, the podiatrist, working in tandem on the healthcare team, will contribute to the health maintenance process by primary, secondary and tertiary preventive methods.

Interdisciplinary healthcare teams will deliver comprehensive, longitudinal, patient-centered care to patient populations. Interdisciplinary training not only provides opportunities for healthcare professionals to learn about other disciplines, but also provides a collegial environment, which fosters communication, cooperation and efficient patient care.

At the end of this rotation, the podiatric medical student is expected to be able to complete a history and physical examination and record it accurately, and distinguish normal from abnormal findings.

GOALS AND OBJECTIVES FOR PRIMARY PODIATRIC CARE STUDENTS

Goals:

1. The podiatry student will develop the skills and knowledge required to perform and interpret a medical interview and routine physical examination.
2. The podiatry student will develop the skills and knowledge required to self evaluate and an independent learning program for future learning.

Objectives:

1. Demonstrate effective techniques for communicating and interacting with patients.
2. Obtain and record a complete patient history and review of systems.
3. Perform a basic physical examination utilizing the traditional techniques of inspection, palpation, percussion and auscultation.
4. Interpret findings of the basic physical examination of the patient, distinguish normal from abnormal findings and develop a differential list.
5. Properly record all data in the patient record.
6. Present clear, concise case presentations orally to include relevant history and physical findings.

EVALUATION STRATEGY

1. Students will be evaluated by rotation staff based on the goals and objectives. (See evaluation form.)
2. Students are **required** to keep a log of every patient encounter including date of encounter, patient identification number, primary diagnosis, and level of participation. **Logs must be turned into the Graduate Placement office within one week of the end of the rotation.** (See log form) **A minimum of 2-3 history physicals are required of each student.**
3. Students are **required** to evaluate the program and the faculty involved in the training. (See program and faculty evaluation forms)

LEARNING RESOURCES

REQUIRED READINGS:

1. Bates, Barbara, **A Guide to Physical Examination**, Lippincott, Philadelphia, Pennsylvania, Chapters 1 through 19.

SUGGESTED READINGS:

1. Harrison's **Internal Medicine**.
2. Adam, R.D., and Victor, M., **Principals of Neurology**, McGraw Hill, New York, NY.
3. Barrows, H.S., **Guide to Neurological Assessment**, Lippincott, Philadelphia, PA.
4. DeJong, R. **The Neurological Examination**, Lippincott, Philadelphia, PA
5. Fitzpatrick, T. Polano, M. and Surmond, D., **Color Atlas and Synopsis of Clinical Dermatology**, McGraw Hill, New York, NY, 1983.
6. Juergens, J., et al., **Peripheral Vascular Disease**, W.B. Saunders, Philadelphia, PA.
7. Marriott, H., **Practical Electrocardiography**, Williams and Wilkins, Baltimore, MD., Chapters 1-4, 6, 7, 9, 10, 13-15, 23, 26.
8. Nover, A., **The Ocular Fundus**, Lea and Febiger, Philadelphia, PA 1981 pp. 3-47, 69-86, 93-101, 106-133, 157-160, 180-181.
9. Samitz, M.H., **Cutaneous Disorders of Examination**, Macmillian Publishing Co., New York, NY.
10. DeGowin and DeGowin, **Bedside Diagnostic Examination**, Macmillian Publishing Co., New York, NY

INSTRUCTIONAL STRATEGY

This rotation is scheduled over a 4 week period. Days of attendance are scheduled by the institution.

ATTENDANCE IN CLINIC IS MANDATORY

All excused absences from this rotation must be made up. It is the student's responsibility to fulfill all of his or her clinic obligations.

UNEXCUSED ABSENCES WILL RESULT IN AUTOMATIC FAILURE. Only the Program Director has the authority to excuse a student.

II) GENERAL STRATEGY

A) Guided Patient Care

- 1. All students must have a clean white lab coat with appropriate identification.**
- 2. All students should bring with them the following items:**
 - Stethoscope
 - Sphygmomanometer
 - Tuning fork
 - Neurological hammer
 - Biomechanical measuring device
 - Otoscope/Ophthalmoscope

STUDENT EVALUATION:

Evaluation for this rotation will be based on a composite of several factors culminating in one complete evaluation. At the completion of the rotation, students will receive a Satisfactory, Unsatisfactory or Incomplete evaluation.

Faculty and staff will evaluate student's performance on a daily basis and provide feedback to the student in order that he or she may continually improve their skills.

The Composite Clinical Evaluation addresses the following areas:

- A. CASE PRESENTATIONS**
- B. CLINICAL SKILLS**
- C. CHARTING**
- D. PATIENT LOG**
- E. ATTITUDE AND MOTIVATION**
(See Clinical Evaluation Form Pages)

EXPECTATIONS:

A. PROPER CASE PRESENTATION TO INCLUDE:

Name, Age Sex, Race
Chief Complaint
History of Present Illness
(N.L.D.O.C.A.T)
Significant Past Medical History
Systems Review
Medications
Allergies
Physical Findings
Proper Identification of Patient's Problem
Suggested Treatment(s)

Case Presentation should take no more than five to ten minutes in most cases, and should include only pertinent information and should be done without cards.

IMPROPER PRESENTATIONS:

Incorrect information
Inaccurate information
Incomplete information
Lack of orderly presentation

CLINICAL FACULTY WILL VERBALLY IDENTIFY DEFICIENCIES IN CASE PRESENTATIONS TO THE STUDENT AND SUGGEST RESOLUTION.

GRADING FOR CASE PRESENTATION:

SATISFACTORY: Consistently proper case presentations

UNSATISFACTORY: Consistently improper case presentations

B. CLINICAL SKILLS

Students will be evaluated on their ability to perform basic history and physical examination skills in the clinical setting. Students will turn in a copy of the last two completed histories and physicals to the preceptor and a copy, even if it is not officially placed in chart, is to be turned in to the Graduate Placement Office with logs.

CLINICAL FACULTY WILL VERBALLY IDENTIFY DEFICIENCIES IN CLINICAL SKILLS TO THE STUDENT AND SUGGEST RESOLUTION.

C. PROPER COMPLETION OF MEDICAL CHARTS TO INCLUDE:

Legibly written
Proper spelling and grammar
Vital information (Patient's name, number, date)
Student signature and Clinician's name
Initial History and Physical (accurately record all history and physical findings)
Progress note

S	Subjective Findings
O	Objective Findings
A	Assessment
P	Plans

IMPROPER CHARTING:

Illegibly written
Absent vital information
Data written in wrong section of SOAP note
Improper assessment
Incorrect, inaccurate, incomplete plans

CLINICAL FACULTY WILL VERBALLY IDENTIFY DEFICIENCIES IN CHARTING TO THE STUDENT AND SUGGEST RESOLUTION.

GRADING OF CHARTING:

SATISFACTORY: Consistently proper charting
UNSATISFACTORY: Consistently improper charting

D. PATIENT LOG:

Students are required to keep a log of all the patients that they have treated during this rotation. This log should include date of encounter, patient identification number, primary diagnosis, and level of participation. This log must be turned in to the Office of Graduate Placement at the conclusion of the rotation for proper credit. Failure to turn in a completed log will result in a grade of Incomplete (I) for the rotation.

F. ATTITUDE AND MOTIVATION: (see Clinical Evaluation Form)

OHIO COLLEGE OF PODIATRIC MEDICINE

STUDENT: _____

ROTATION DATES: _____

PROGRAM DIRECTOR: _____

LOCATION: _____

1. The student is able to describe methods of and rationale for: a. patient scheduling
b. patient processing for the initial visit and subsequent visits c. scheduling of surgery and/or other procedures in the office or hospital setting.

1. Unsatisfactory 2. Needs improvement 3. Satisfactory 4. Not observed
Comments: _____

2. The student was able to accurately, clearly and concisely make an oral case presentation.

1. Unsatisfactory 2. Needs improvement 3. Satisfactory 4. Not observed
Comments: _____

3. The student was able to accurately, clearly and concisely chart: a. an initial history and physical examination b. an outpatient or inpatient progress note.

1. Unsatisfactory 2. Needs improvement 3. Satisfactory 4. Not observed
Comments: _____

4. The student was able to accurately, clearly and concisely perform and interpret the findings of the history and physical examination including: a. History of the Present Illness b. Past medical history c. Medications d. Allergies e. Review of Systems f. Physical findings

1. Unsatisfactory 2. Needs improvement 3. Satisfactory 4. Not observed
Comments: _____

5. When given the results of a history and physical examination, the student was able to develop a list of differential diagnoses/working diagnoses.

1. Unsatisfactory 2. Needs improvement 3. Satisfactory 4. Not observed
Comments: _____

6. When given a differential diagnosis, the student was able to identify special tests and

Adheres to professional and/or ethical standards. Is honest. Corrects errors.

Satisfactory

Unsatisfactory

6. Respect for Patients

Maintains patient's confidentiality. Demonstrates empathetic behavior. Is patient with patients and family members. Is sensitive to patient's immediate physical and/or emotional needs. Does not present prejudiced view of patients. Is considerate to patients. Addresses patients appropriately.

Satisfactory

Unsatisfactory

7. Chemical Dependency/Mood Disorder

Change personality, dressing habits or neatness. Excessive irritability, anger beyond control. Apparent mental confusion, drowsiness, inattention to responsibility. Loud when normally quiet, inappropriate euphoria. Depressed. Unsteady gait.

Satisfactory

Unsatisfactory

Which of the following words would you use to describe this student's attitude and motivation? (Please circle choices.)

Empathetic

Apathetic

Enthusiastic

Hesitant

Sympathetic

Impatient

Conscientious

Lazy

Mature

Emotional

Dedicated

Arrogant

Hard Working

Stubborn

Motivated

Bored

Comments: _____

OVERALL EVALUATION:

PASS _____ FAIL _____

Signature of Program Director

Date

SENIOR MEDICINE ROTATION

SYLLABUS

2004 - 2005 ACADEMIC YEAR

CLASS OF 2005

EDWEANA ROBINSON, M.D., CHAIRMAN, DEPARTMENT OF MEDICINE
VINCENT J. HETHERINGTON, D.P.M., VICE PRESIDENT & DEAN OF ACADEMIC AFFAIRS

DESCRIPTION OF ROTATION

The Senior Medicine rotation is a two month experience in one of several hospitals which is designed to provide experiences in history and physical examinations. Each rotation site will provide the same core experiences, (based on the goals and objectives), in patient assessment techniques (i.e., history and physical examination), the understanding of disease processes, and management strategies. In addition to the core experiences, each rotation site may add additional exposures and training.

RATIONALE

The podiatric physician serves both as a primary care provider as well as consultant to the health care management team. As a primary care provider, the podiatric office serves as an entry point to the health care system, provides care for commonly occurring conditions, sees patients on a regular basis over the life of the patient, and coordinates care when signs and symptoms of systemic diseases outside the scope of practice present themselves.

The podiatric medical student must develop good history and physical examination skills, which enable accurate diagnosis and management of patient problems. Management refers to the process of evaluating signs and symptoms, identifying systemic and podiatric medical conditions and developing treatment strategies including appropriate referral as needed.

As consultant, the podiatrist serves a secondary and tertiary prevention function, screening for disease precursors and arresting and retarding the effects of existing conditions.

As the healthcare system moves from a disease orientation to a health orientation, the role of the podiatrist on the primary care team will become better defined. As physician, the podiatrist, working in tandem on the healthcare team, will contribute to the health maintenance process by primary, secondary and tertiary preventive methods.

Interdisciplinary healthcare teams will deliver comprehensive, longitudinal, patient-centered care to patient populations. Interdisciplinary training not only provides opportunities for healthcare professionals to learn about other disciplines, but also provides a collegial environment, which fosters communication, cooperation and efficient patient care.

At the end of this rotation, the podiatric medical student is expected to be able to complete a history and physical examination, record it accurately, order and interpret appropriate special studies and laboratory tests, develop a list of differential diagnosis, be able to discuss basic pathologies and suggest a management strategy.

GOALS AND OBJECTIVES

Goals:

1. The podiatry student will develop the skills and knowledge required to perform and interpret a medical interview and routine physical examination and generate a diagnostic hypothesis.
2. The podiatry student will develop the skills and knowledge required to order appropriate tests and examinations (in a cost-effective manner) to arrive at a provisional diagnosis.

3. The podiatry student will develop the skills and knowledge required to discuss disease processes and propose a management strategy including appropriate referral.
4. The podiatry student will develop the skills and knowledge required to self evaluate and direct an independent learning program for future learning.

Objectives:

1. Demonstrate effective techniques for communicating and interacting with patients.
2. Obtain and record a complete patient history and review of systems.
3. Perform a basic physical examination utilizing the traditional techniques of inspection, palpation, percussion and auscultation.
4. Interpret findings of the basic physical examination of the patient, distinguish normal from abnormal findings and develop a differential list.
5. Order and interpret appropriate tests and examinations (in a cost-effective manner) to arrive at a provisional diagnosis.
6. Propose a management strategy for the patient's problems including appropriate referral.
7. Properly record all data in the patient record.
8. Present clear, concise case presentations orally to include relevant history and physical findings, differential diagnosis, recommendations for follow-up studies, and management strategies for specific conditions.

EVALUATION STRATEGY

1. Students will be evaluated by rotation staff based on the goals and objectives. (See evaluation form.)
2. Students are **required** to keep a log of every patient encounter including date of encounter, patient identification number, primary diagnosis, and level of participation. **NOTE: I would suggest that you make two copies of your logs, one for the Graduate Placement Office and one for the staff at your H&P rotation, if required. ***Logs and Cover Sheet must be turned in within one week of the end of the rotation*** (see example log form and cover sheet).
3. Students are **required** to evaluate the program and the faculty involved in the training (see program and faculty evaluation forms).

LEARNING RESOURCES

REQUIRED READINGS:

1. Bates, Barbara, **A Guide to Physical Examination**, Lippincott, Philadelphia, Pennsylvania, Chapters 1 through 19.

STUDENTS ARE REQUIRED TO HAVE COMPLETED READING ASSIGNMENTS PRIOR TO THE BEGINNING OF THE ROTATION.

SUGGESTED READINGS:

- *1. Harrison's **Internal Medicine**.
 2. Adams, R.D., and Victor, M., **Principals of Neurology**, McGraw Hill, New York, NY
 3. Barrows, H.S., **Guide to Neurological Assessment**, Lippincott, Philadelphia, PA
 4. DeJong, R. **The Neurological Examination**, Lippincott, Philadelphia, PA
 5. Fitzpatrick, T. Polano, M. and Surmond, D., **Color Atlas and Synopsis of Clinical Dermatology**, McGraw Hill, New York, NY, 1983.
 6. Juergens, J., et al., **Peripheral Vascular Disease**, W.B. Saunders, Philadelphia, PA
 7. Marriott, H., **Practical Electrocardiography**, Williams and Wilkins, Baltimore, MD, Chapters 1-4, 6,7,9,10, 13-15, 23, 26.
 8. Nover, A., **The Ocular Fundus**, Lea and Febiger, Philadelphia, PA, 1981; pp. 3-47, 69-86, 93-101, 106-133, 157-160, 180-181.
 9. Samitz, M.H., **Cutaneous Disorders of Examination**, Macmillian Publishing Co., New York, NY.
 10. DeGowin and DeGowin, **Bedside Diagnostic Examination**, Macmillian Publishing Co., New York, NY.
- *Major reference for Brecksville VAMC.

Instructional Strategy

This is an eight week clinical rotation for Fourth Year students which consists of guided patient care.

ATTENDANCE IN CLINIC IS MANDATORY.

All excused absences from this rotation must be made up. It is the student's responsibility to fulfill all of his or her clinic rotation obligations.

UNEXCUSED ABSENCES WILL RESULT IN AUTOMATIC FAILURE. - Only the Program Director has the authority to excuse a student!

II) GENERAL STRATEGY

A) Guided Patient Care

1. All students must have a clean white lab coat with appropriate identification.
2. All students should bring with them the following items:
 - Stethoscope
 - Sphygmomanometer
 - Tuning fork
 - Neurological hammer
 - Biomechanical measuring device
 - Otoscope/Ophthalmoscope

STUDENT EVALUATION:

Evaluation for this rotation will be based on a composite of several factors culminating in one complete evaluation. At the completion of the rotation, students will receive a Honors, Satisfactory, an Unsatisfactory or an Incomplete evaluation.

Faculty and staff will evaluate students' performance on a daily basis and provide feedback to the student in order that he or she may continually improve their skills. If, at the mid-way evaluation, it is felt by the faculty and staff that a student's performance is unsatisfactory, he or she will be notified in writing of the areas of weakness and of ways to improve performance.

The Composite Clinical Evaluation addresses the following areas:

- A. CASE PRESENTATIONS
 - B. CLINICAL SKILLS
 - C. CHARTING
 - D. PATIENT LOG
 - E. ATTITUDE AND MOTIVATION
- (See Clinical Evaluation Form Pages)

EXPECTATIONS:

A. PROPER CASE PRESENTATION TO INCLUDE:

- Name, Age, Sex, Race
- Chief Complaint
- History of Present Illness
(N.L.D.O.C.A.T.)
- Significant Past Medical History
- Systems Review
- Medications
- Allergies
- Physical Findings
- Proper Identification of Patient's Problem
- Suggested Treatment(s)

Case Presentation should take no more than five to ten minutes in most cases, and should include only pertinent information.

IMPROPER PRESENTATIONS:

- Incorrect information
- Inaccurate information
- Incomplete information
- Lack of orderly presentation

CLINICAL FACULTY WILL VERBALLY IDENTIFY DEFICIENCIES IN CASE PRESENTATIONS TO THE STUDENT AND SUGGEST RESOLUTION.

GRADING FOR CASE PRESENTATION:

SATISFACTORY: Consistently proper case presentations

UNSATISFACTORY: Consistently improper case presentations

B. CLINICAL SKILLS

Students will be evaluated on their ability to perform basic history and physical examination skills in the clinical setting.

CLINICAL FACULTY WILL VERBALLY IDENTIFY DEFICIENCIES IN CLINICAL SKILLS TO THE STUDENT AND SUGGEST RESOLUTION.

C. PROPER COMPLETION OF MEDICAL CHARTS TO INCLUDE:

Legibly written

Proper spelling and grammar

Vital information (Patient's name, number, date)

Student signature and Clinician's name

Initial History and Physical (accurately record all history and physical findings)

Progress note

S Subjective Findings

O Objective Findings

A Assessment

P Plans

IMPROPER CHARTING:

Illegibly written

Absent vital information

Data written in wrong section of SOAP note

Improper assessment

Incorrect, inaccurate, incomplete plans

CLINICAL FACULTY WILL VERBALLY IDENTIFY DEFICIENCIES IN CHARTING TO THE STUDENT AND SUGGEST RESOLUTION.

GRADING OF CHARTING:

SATISFACTORY: Consistently proper charting

UNSATISFACTORY: Consistently improper charting

D. PATIENT LOG:

Students are required to keep a log of all the patients that they have treated during this rotation. This log should include date of encounter, patient identification number, primary diagnosis, and level of participation. This log must be turned in to the rotation contact person of the respective facility, at the conclusion of the rotation for proper credit. Failure to turn in a completed log will result in a grade of Incomplete (I) for the rotation.

E. ATTITUDE AND MOTIVATION: *SEE EVALUATION FORMS

OHIO COLLEGE OF PODIATRIC MEDICINE

STUDENT: _____ ROTATION DATES: _____

PROGRAM DIRECTOR: _____ LOCATION: _____

1. The student is able to describe methods of and rationale for: a. patient scheduling
b. patient processing for the initial visit and subsequent visits c. scheduling of surgery and/or other procedures in the office or hospital setting.

1. Unsatisfactory 2. Needs improvement 3. Satisfactory 4. Not observed
Comments: _____

2. The student was able to accurately, clearly and concisely make an oral case presentation.

1. Unsatisfactory 2. Needs improvement 3. Satisfactory 4. Not observed
Comments: _____

3. The student was able to accurately, clearly and concisely chart: a. an initial history
and physical examination b. an outpatient or inpatient progress note.

1. Unsatisfactory 2. Needs improvement 3. Satisfactory 4. Not observed
Comments: _____

4. The student was able to accurately, clearly and concisely perform and interpret the
findings of the history and physical examination including: a. History of the Present
Illness b. Past medical history c. Medications d. Allergies e. Review of Systems
f. Physical findings

1. Unsatisfactory 2. Needs improvement 3. Satisfactory 4. Not observed
Comments: _____

5. When given the results of a history and physical examination, the student was able to
develop a list of differential diagnoses/working diagnoses.

1. Unsatisfactory 2. Needs improvement 3. Satisfactory 4. Not observed
Comments: _____

5. When given the results of a history and physical examination, the student was able to
develop a list of differential diagnoses/working diagnoses.

1. Unsatisfactory 2. Needs improvement 3. Satisfactory 4. Not observed
Comments: _____

6. When given a differential diagnosis, the student was able to identify special tests and examinations to aid in the diagnosis.

1. Unsatisfactory 2. Needs improvement 3. Satisfactory 4. Not observed
Comments: _____

7. When given the results of special tests and examinations, the student was able to arrive at an appropriate provisional diagnosis.

1. Unsatisfactory 2. Needs improvement 3. Satisfactory 4. Not observed
Comments: _____

8. When given a provisional diagnosis, the student was able to formulate appropriate management strategies.

1. Unsatisfactory 2. Needs improvement 3. Satisfactory 4. Not observed
Comments: _____

ATTITUDE AND MOTIVATION (Non-cognitive Traits)

1. Reliability and Responsibility

Can be depended upon to do his/her duty. Follows through on tasks he/she agreed

to perform. Arrives on time for class, clinic and rounds, etc. Is available to treat patients. Brings appropriate instruments to see patients.

Satisfactory

Unsatisfactory

2. Maturity

Behaves respectfully. Accepts blame for failure. Makes inappropriate demands. Is abusive and critical during times of stress.

Satisfactory

Unsatisfactory

3. Critique

Accepts criticism. Looks at self objectively. Takes steps to correct shortcomings. Reacts to criticism.

OVERALL EVALUATION:

PASS _____ FAIL _____

Signature of Program Director

Date

OHIO COLLEGE OF PODIATRIC MEDICINE

DEPARTMENT OF GENERAL MEDICINE

PHYSICAL DIAGNOSIS I

COURSE COORDINATOR: EDWEANA M. ROBINSON, M.D.

COURSE INSTRUCTOR: EDWEANA M. ROBINSON, M.D.

ACADEMIC YEAR-2004-2005

SPRING SEMESTER

FRESHMAN CLASS

SECTION II

MAIN GOALS OF THE COURSE

At the conclusion of this course, the student should...

- develop proper techniques for communicating and interacting with patients.
- know how to conduct and record a good patient history and review of systems.
- become proficient in the ability to perform a basic physical examination of the patient utilizing the traditional techniques of inspection, palpation, percussion and auscultation.
- be able to interpret the findings of the basic physical examination of the patient (distinguish normal from abnormal grossly).
- be able to identify the findings as specific basic pathologies.
- be familiar with the significant findings in specific pathologies (basic).
- demonstrate ability to perform required basic examination techniques/skills in the laboratory.
- be able to interpret aforesaid basic examination finding in the laboratory.

RATIONALE

Physical Diagnosis is the art and science of searching for and discovery of clues in order to generate hypothesis and then ultimately form a “decision on hypothesis”. “Decision on Hypothesis” refers to problem solving methods and subsequent tests, whether based on branching or matching logic or statistical probability.

The patients’ reaction to diseases is mainly a subjective one and is reflected in the answers to the physician’s questions: the history. But disease leaves objective tracks as well, and it is the physician’s task - all physicians - to seek them out. The method employed is physical examination and the tools are those of physical diagnosis.

In pathology, one studies disease. In clinical training, one works with illness. Illness represents the totality of signs and symptoms that together characterize a single patient’s response. Physical diagnosis, therefore, represents the bridge between the study of disease and the management of illness.

The specialist in Podiatric Medicine and Surgery is part of a dynamic process which now foresees the podiatrist routinely, perhaps of necessity, performing a complete history and physical examination for hospital medical and surgical admissions. In order to be a competent medical and surgical specialist in podiatry, a student must have a firm data base in diagnostics as well as meet minimal competency in performance of physical examination skills.

At the end of the course, a student should be able to conduct a medical interview (patient history), perform a routine medical physical examination, and generate diagnoses.

For more detailed goals and objectives for the course, please refer to the Master Syllabus on file in the library.

POLICIES

1. Class will meet on Tuesday from 3 to 5 pm and Thursday from 3 to 6pm. Except for days when lectures are scheduled, you are expected to attend on your assigned lab days. Attendance is not mandatory; however, attendance will be taken for the record. Please consult the schedule for your assigned lab time.
2. The course coordinator is: E.M. Robinson, M.D.
 Office: 201 Administration Building
 Office #: 707-8050

3. Grading Scale: 90 - 100 = A
 80 - 89 = B
 70 - 79 = C
 < 70 = F

The course coordinator reserves the right to lower the grading scale as deemed necessary.

4. Examinations: There will be a mid-term and final examination. Each will be worth 50% of the grade. The midterm will cover history taking, vital signs, head, eyes, ears, nose, throat and neck, cranial nerves(80 points) and funduscopy slides (20 points).

The final examination will cover chest, heart, abdomen and breast, male and female genitalia. There will be 5 bonus points on the final examinations. The points obtained from the bonus will be added to the final average grade.

There will be a practical examination for each student at the end of the course. Consult the schedule for the weeks the practicals will be conducted. Later in the semester, a lottery drawing will be held to determine the order students will be tested. There are no points for passing the practical examination. However, if a student fails the practical, the student will have a second change to perform the physical examination for the instructor. Failure after the second attempt will result in a grade of **F** for the semester, no matter what the numerical grade attained on written examination.

5. A list of the instruments required for the course is found later in the syllabus. Each student must come prepared with instruments to perform the assigned physical examination.
6. The remainder of the policies are in line with those published in the Student Handbook.
7. Information presented in class and in the required text takes precedence over information from outside sources.

INSTRUMENT LIST

OPHTHALMOSCOPE

OTOSCOPE

FLASHLIGHT/PENLIGHT

TONGUE DEPRESSORS

RULER AND FLEXIBLE TAPE MEASURE

THERMOMETER

SPHYGMOMANOMETER

STETHOSCOPE

WATCH WITH A SECOND HAND

DATE	TIME	TOPIC	LAB/LECTURER
T 1/4	3:00-5:00 PM	INTRODUCTION / HISTORY TAKING LECTURE	ROBINSON
TH 1/6	3:00 -4:00 PM 4:00-6:00 PM	HISTORY TAKING LECTURE HISTORY TAKING LAB	ROBINSON ROBINSON/TA
T 1/11	3:00-5:00 PM	HISTORY TAKING LAB	ROBINSON/TA
TH 1/13	3:00-5:00 PM 5:00-6:00 PM	VITAL SIGNS LECTURE VITAL SIGNS LAB	ROBINSON ROBINSON/TA
T 1/18	3:00-5:00 PM	VITAL SIGNS LAB	“
TH 1/20	3:00-4:00 PM 4:00-5:30 PM	VITAL SIGNS LAB FUNDOSCOPY LECTURE	“ ROBINSON
T 1/25	3:00-5:00 PM	HEENT/CN/NECK LECTURE	ROBINSON
TH 1/27	3:00-6:00 PM	FUNDOSCOPY LAB	ROBINSON/TA
T 2/1	3:00-4:00 PM 4:00-5:00 PM	FUNDOSCOPY LAB HEENT/CN/NECK LAB	“ “
TH 2/3	3:00-6:00 PM	HEENT/ CN/ NECK LAB	“
T 2/8	3:00-5:00 PM	CHEST LECTURE/REVIEW	ROBINSON
TH 2/10	3:00-6:00 PM	CHEST LAB	ROBINSON/TA
T 2/15	3:00-4:00 PM 4:00-5:00 PM	CHEST LAB HEART LECTURE I	“ ROBINSON
TH 2/17	3:00-4:00 PM 4:00-6:00 PM	HEART LECTURE II HEART LAB	“ ROBINSON/TA

MIDTERM EXAMINATIONS 2/21/05 - 3/4/05

Physical Diagnosis Midterm 2/21/05

SPRING BREAK 3/07/05 - 3/11/05

T 3/15	3:00-5:00 PM	HEART LAB	“
TH 3/17	3:00-6:00 PM	HEART LAB SIMULATOR	“
T 3/22	3:00-5:00 PM	ABDOMEN LECTURE	ROBINSON
TH 3/24	3:00-6:00 PM	ABDOMEN LAB	ROBINSON/TA
T 3/29	3:00-4:00 PM 4:00-5:00 PM	LOTTERY DRAWING FOR PRACTICALS ABDOMEN LAB	ROBINSON ROBINSON/TA

TH 3/31	3:00-6:00 PM	BREAST/MALE/FEMALE GENITALIA LECTURE	ROBINSON
T 4/5	3:00-5:00 PM	BREAST/TESTICULAR LAB	ROBINSON/TA
TH 4/7	3:00-4:00 PM	REVIEW	
	4:00-6:00 PM	BREAST/TESTICULAR LAB	"
TU 4/12	NO CLASS		
TH 4/14	PRACTICALS BEGIN		

***** PRACTICALS FROM APRIL 14 THROUGH APRIL 26 AS DRAWN IN LOTTERY. *****

TH 4/28 FINAL EXAMINATION

FINAL EXAMINATION FOR PHYSICAL DIAGNOSIS
TUESDAY 4/28/05

FINAL EXAMINATIONS FOR ENTIRE COLLEGE
MAY 2 THROUGH MAY 13, 2005

LEARNING RESOURCES

REQUIRED TEXT:

Bates, Barbara, **A GUIDE TO PHYSICAL EXAMINATION AND HISTORY TAKING**,
Eighth edition, Lippincott, 2002.

READING ASSIGNMENTS

HISTORY TAKING LECTURE AND LAB	PP. 1-59, 59 – top of 75; 83-89 reading only
VITAL SIGNS LECTURE	PP. 75-83; 90, 93, 255, 658-top of 663; 740-741
FUNDOSCOPY LECTURE	PP. 183-191
HEENT/NECK LECTURE	PP. 115-181; 192-196, 198-208; 593
CRANIAL NERVES LECTURE	PP. 176; 196-197; 567-middle of 571; 612-613
CHEST LECTURE	PP. 209 - 243
HEART LECTURE	PP. 245 – 254; 256-295
ABDOMEN LAB	PP. 317 - 366
BREAST LECTURE	PP. 297-315
MALE GENITALIA/	PP. 367-382
FEMALE GENITALIA	PP. 383 - 408

LABORATORY GROUPS

ASSIGNMENTS ARE FOR ALL LAB GROUPS

GROUP A ABOKI - DHALI WAL

GROUP B DiGIUSEPPE - LAKE

GROUP C LEMON - SEIKO

GROUP D SHERMAN - YODER

DAILY LAB ASSIGNMENTS

HISTORY TAKING LAB

1/6/05	4-5PM	GRP A	5-6PM	GRP B
1/11/05	3-4PM	GRP C	4-5PM	GRP D

VITAL SIGNS LAB

1/13/05	5-6PM	GRP A		
1/18/05	3-4PM	GRP B	4-5PM	GRP C
1/20/05	3-4PM	GRP D		

FUNDOSCOPY LAB

1/27/05	3-4PM	GRP A	4-5PM	GRP B	5-6PM	GRP C
2/1/05	3-4PM	GRP D				

HEENT/CN/NECK LAB

2/1/05	4-5PM	GRP A				
2/3/05	3-4PM	GRP B	4-5PM	GRP C	5-6PM	GRP D

CHEST LAB

2/10/05	3-4PM	GRP A	4-5PM	GRP B	5-6PM	GRP C
2/15/05	3-4PM	GRP D				

HEART LAB

2/17/05	4-5PM	GRP A	4-5PM	GRP B
3/15/05	3-4PM	GRP C	4-5PM	GRP D

HEART SIMULATOR LAB

3/17/05	3-4PM	GRP A	4-5PM	GRP B	5-6PM	GRP C
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FOR THIS LAB: Grp A: Aboki – Ellison Grp B: Fiala – Prince Grp C: Regler - Yoder

ABDOMEN LAB

3/24/05	3-4PM	GRP A	4-5PM	GRP B	5-6PM	GRP C
3/29/05	4-5PM	GRP D				

BREAST AND TESTICULAR EXAM LAB

4/5/05	3-4PM	GRP A	4-5PM	GRP B
4/7/05	3-4PM	GRP C	4-5PM	GRP D

PHYSICAL DIAGNOSIS

TOPIC: TAKING A MEDICAL HISTORY

GOAL:

The student should be knowledgeable in the taking of the patient's medical history.

OBJECTIVE:

At the conclusion of this learning module the student should be able to:

- relate the purposes of the medical history.
- list and understand the triple quest of diagnostic history taking.
- recount in detail basics of patient communication during the interview.
- list the basic sequence of the medical history components.
- outline the questioning strategies for the individual medical history components.
- outline and explain in detail the components of the basic medical progress note.

PHYSICAL DIAGNOSIS

TOPIC OUTLINE: TAKING A MEDICAL HISTORY

I. MEDICAL HISTORY - GENERAL

- A. Definition: An organized account of the events in the patient's life that have relevance to his/her mental and physical health.
- B. Purposes
 - 1. Medical
 - a. Assist in diagnosis
 - b. Record for all medical personnel
 - c. Assist in teaching
 - 2. Legal
- C. Environment for conduction of the interview
- D. The doctor as an interviewer
 - 1. Interrogation in history taking
 - 2. Stock of disease lists to which clusters of signs and symptoms come to mind.
- E. The triple quest or diagnostic history taking
 - 1. Searching for symptoms
 - 2. Eliciting accurate quantitative descriptions
 - 3. Securing precise chronologies of events
- F. Communication and the Patient Interview
 - 1. Pre-interview data
 - a. Name
 - b. Address
 - c. Sex
 - d. Age
 - e. Chief complaint
 - 2. Opening Statement

- a. facilitation
- b. open-ended question
- 3. Checking the chief complaint
 - a. "Admission ticket"
 - b. Uncooperative patient
 - c. Patient-doctor contact
- 4. Assisting the patient's narrative
 - a. Reassurance
 - b. Empathy
 - c. Support
 - d. Reflection
 - e. Silence
 - f. Laundry-list questions
 - g. Yes and no answers
 - h. Questioning while suggesting the answer
- 5. Closing the interview
 - a. final statement
 - b. prescription for action
 - c. physical parting

II THE MEDICAL HISTORY - SEQUENCE OF COMPONENTS WITH AN IN DEPTH ANALYSIS OF THE COMPONENT PARTS

- A. Vital Statistics
 - 1. Name
 - 2. Sex
 - 3. Residence
 - 4. Age
 - 5. Place of birth
 - 6. Race
 - 7. Marital Status
 - 8. Occupation
- B. Chief Complaint
- C. Present Illness
 - 1. Onset
 - 2. Duration
 - 3. Location
 - 4. Characterizing the discomfort
 - 5. Exacerbation / Remissions
 - 6. Course
 - 7. Previous treatment
 - 8. Previous episodes
- D. Past Medical History
 - a. Medical history
 - b. Podiatric history
 - c. Surgeries
 - d. Allergies
 - e. Current medications

E. Psychosocial History

F. Family History

G. System Review

1. Skin
2. Head
3. Eyes
4. Ears
5. Nose
6. Mouth
7. Throat
8. Neck
9. Breast
10. Respiratory system
11. Cardiovascular system
12. Gastrointestinal system
13. Genito-urinary system
14. Gynecological
15. Locomotor
16. Musculoskeletal system
17. Endocrine system
18. Neuropsychiatric

PHYSICAL DIAGNOSIS
AN AID TO SYSTEMS REVIEW

GENERAL

Weight change
Fever-Chills
Weakness
Fatigue
Sweating
Night sweats

ALLERGIES

Sensitivities

Drugs
Vaccines
Foods
Pollens
Chemical
Eczema
Asthma
Hay Fever
Hives

NEUROLOGICAL

Syncope
Convulsions
Sensation
Stroke
Spasm
Pain
Concentration
Gait (Ataxia)
Tremor
Coordination
Paralysis / Strength

ENDOCRINE

Goiter
Glycosuria
Exophthalmos
Growth
Hirsutism
Diabetes
Climatic Intolerance

HEAD

Headache
Trauma
Dizziness

EARS

Pain
Discharge
Vertigo
Deafness
Tinnitus
Correction
(Aids)

SKIN

Hair-nail changes
Itching
Rash / Ulcer
Pigment changes
Lumps

EYES

Last exam (date)
Vision/Glasses
Blurring
Photophobia
Diplopia
Scotoma
Itching/Watering
Inflammation

NOSE

Sinusitis
Polyps
Postnasal drip
Epistaxis
Obstruction
Dysosmia

BLOOD LYMPHATICS

Anemia
Bleeding Tendency
Pain
Node enlargement
Soreness

MOUTH

Teeth
Gums
Breath
Taste
Pain
Dentures
Dental exam (date)

NECK

Pain
Swallowing
Soreness
Node enlargement
Hoarseness
Motion limitation

PSYCHOLOGICAL

Memory
Mood
Sleep patterns
Anxiety
Emotional disturbances
General temperament
Drugs
Alcohol problems
Nail biting
Enuresis

RESPIRATORY

Wheezing
Dyspnea
Hemoptysis
Chest pain
Cough
Sputum
X-rays (date, where)

GENITOURINARY

Dysuria
Nocturia
Hematuria
Stones
Pain
Frequency
Urgency
Masses
Incontinence
Infection
Discharge

OBSTETRICAL / GYNECOLOGICAL

Gravida
Para
Abortions
Miscarriages
Complications

Cycle
Menarche
Duration
Amount
Spotting
Stillborn
Current pregnancy
Sterility
Impotence
Contraception
Pain
Late period (date)
Last pelvic exam (pap)
Discharge
Infections
Itching
Irregularity

GASTROINTESTINAL

CARDIOVASCULAR

Palpation
Angina
Dyspnea
Orthopnea
Paroxysmal Nocturnal
dyspnea (PND)
Edema
Claudication
High blood pressure
Heart attack
Exercise tolerance
Cyanosis
Phlebitis

BREASTS

Lumps
Discharge
Pain

MEDICATION

TRAUMA

Appetite
Anal discomfort/hemorrhoids
Hernia
Abdominal girth
Diarrhea
Jaundice
Indigestion / heartburn
Melena
Nausea / vomiting
Hematemesis
Pain / colic
Dysphagia
Constipation
Stool - shape - color

Current
Past

Current
Past

BONES, JOINTS AND MUSCLES

Trauma Pain / arthritis
Swelling
Fractures
Abnormalities
Stiffness
Limited Motion
Malignancies
Atrophy / Hypertrophy

III OUTLINE AND DESCRIPTION OF THE BASIC PROGRESS NOTE

- A. Flow sheets of multiple visits for a problem or multiple problems.
- B. Subjective Data.
 - 1. Symptoms
 - 2. Significance past medical history, including medications.
- C. Objective Data
 - 1. Signs
 - 2. Labs
- D. Assessment
 - 1. Impressions, interpretations, analysis
 - 2. Evaluations and treatments - past and present
 - 3. Prognoses
- E. Plan
 - 1. Diagnostic, therapeutic, patient instructions and treatment
- F. Medico-Legal Ramifications

HISTORY TAKING LABORATORY

OBJECTIVES:

1. Take a basic medical history on your partner.
2. List the basic components, in order, of an adult and pediatric history.
3. Ask open-ended questions of your partner.
4. Given a particular item, be able to tell where, in the history, it belongs.
5. Outline all parts of a progress note.

HISTORY TAKING QUESTIONS

THE FOLLOWING ARE A SERIES OF QUESTIONS DESIGNED TO HELP THE STUDENT ASSESS THE KNOWLEDGE OF HISTORY TAKING AND INTERVIEWING.

1. The chief complaint should be:
 - a. a paragraph describing the patient.
 - b. a brief statement of what brought the patient to the physician.
 - c. a prose-style account of the problem(s), including symptoms related to the involved organ system.
 - d. a list of problems that have been identified at the end of the interview.

2. The past medical history should include:
 - a. past major illnesses.
 - b. surgical procedures.
 - c. hospitalization.
 - d. allergies.
 - e. all of the above.

3. Before writing a medical history, one must:
 - a. interview the patient.
 - b. organize events chronologically.
 - c. obtain exact identifying data.
 - d. all of the above.

4. After asking a patient, "What brings you to the clinic?" and obtaining the answer, "Doctor, I have been having pain in the chest", you should next ask:
 - a. "When did they begin?"
 - b. "What brought them on?"
 - c. "Where is the pain?"
 - d. "how many times has it happened?"
 - e. "Could you tell me more about the pain?"

ANSWER THE FOLLOWING QUESTIONS EITHER TRUE OR FALSE

5. An interview should be opened with a series of direct questions to obtain as much factual information as rapidly as possible.

6. When specific questions are asked, relatively broad questions should be followed by more narrowly focused ones, and giving advice should be avoided before the patient's complete history is elicited.

7. The patient may present his/her chief complaint in a few words or a short sentence. Your response to this may facilitate or hinder communication. Place a plus sign in the space in front of the response that would hinder communication if the patient states, "This

persistent diarrhea just has me baffled.”

1. “uh hum.”
 2. “Yes”
 3. “Can you tell me a little more about that?”
 4. “Have you been traveling abroad?”
8. As you pursue a chronological history of the patient’s chief complaint, you also want to be aware of responses that facilitate communication. Place a plus sign in the space in front of the open-ended questions and a minus sign in the space in front of the closed-ended questions.
1. “how many times have you had this before?”
 2. “Is the pain sharp?”
 3. “What is the pain like?”
 4. “Do you have nausea with the pain?”
 5. “Where is the pain located?”
9. If a “laundry-list” type of question must be used to elicit information, which one of the following questions below would be the best?
- a. Do you have the pain every day, week or month?
 - b. Do you have the pain once a year, once a week, once a month, or continuously?
10. Which one of the questions below is best to ask a patient who has just told you that he has abdominal pain.
- a. Is it a burning pain?
 - b. What foods aggravate your pain?
 - c. Can you describe the pain for me?
 - d. Does the pain go through to your back?

THESE DIRECTIONS APPLY TO QUESTIONS 11-15

CHOOSE THE ALTERNATIVE THAT BEST DESCRIBES THE QUESTION OR STATEMENT BELOW.

11. Can you tell me more about that
12. Now as I understand it, you have had three operations on your foot, the first in 1955, the second in 1971, and the most recent in 1982.
13. You say you have been vomiting after every meal and wake up at night with it also?
14. Your voice is shaking, and you are moving around in your chair as if you were really upset.

15. "And then?"
- confrontation
 - summation
 - facilitation
16. A 39 year-old woman has told you of her headaches, which have been rather severe for three months. The last headache occurred while eating dinner at a famous restaurant. She then asks you, "Have you ever eaten there" Your best response is:
- "Why yes, have you?"
 - "No, but I intend to
 - Why do you ask
 - This has little to do with your problem. Please stick to your medical problem.
17. This 23 year old woman was healthy until 3 a.m. on 10/21/86, when she awoke with a sudden stabbing pain in the right upper abdomen that was so severe that he screamed. The pain gradually worsened, and she became nauseated. She vomited once. The pain continued to worsen, and her husband rushed her to the emergency room. Which important historical item has been omitted from the description given above?
- mode of onset
 - time of onset
 - alleviation or aggravation
 - location
 - severity
18. A 25 year-old woman complains of recurrent headaches. She says, "I've had this headache for so long, an no doctor has ever been able to find the cause. What do you think it could be?" Which of the following is the best response? What is wrong with the others.
- You seem upset. Is there a problem at home that's bothering you?
 - Could you tell me more about the headaches, so that I can understand more about them.
 - Don't worry, I'm sure we can find the cause.
 - You shouldn't expect someone to understand and diagnose your problems immediately. Give me some more information.

PHYSICAL DIAGNOSIS
LECTURE: VITAL SIGNS

GOALS:

At the completion of this module, the student should be knowledgeable in the techniques of eliciting a patient's vital signs and be able to discern abnormal findings and common underlying associations.

OBJECTIVES:

The student will....

- Enumerate the various techniques / locations of taking recording patient's temperature and know how to interpret results.
- be able to recognize the physical signs of fever.
- know how to elicit, interpret, and record the patient's arterial pulse.
- be able to discern the more common abnormalities of pulse as well as key associations.
- know how to elicit, interpret, and record the patient's pulse pressure and blood pressure (including auscultatory gap).
- be able to interpret normal from abnormal BP and pulse pressure and list examples of commonly associated underlying clinical abnormalities.
- know how to record and interpret patient's respirations.
- be able to discern normal from major abnormal breathing patterns.

PHYSICAL DIAGNOSIS
LECTURE OUTLINE: VITAL SIGNS

- I. Temperature
 - A. Normal body temperature (1 degree = 0.55 degrees c)
 - 1. 98.6 F = 37.0 C = oral
 - 2. Abnormal ranges / max. and min. oral / rectal
 - B. Diurnal variation of body temperature
 - 1. Minimum time - daily
 - 2. Maximum time - daily
 - C. Simultaneous temperatures in various regions
 - 1. Axillary = normal variance less than oral
 - 2. Rectal = normal variance more than oral
 - D. Physical signs of fever
 - 1. Skin findings
 - 2. Heart rate - tachycardia
 - a. proportionality to temperature
 - 3. Chills / rigors
 - 4. Sweats / night sweats
- E. Temperature Patterns
 - 1. Continued fever
 - 2. Remittent fever
 - 3. Intermittent fever
- F. Some common causes of fever (Lancet 2: 236-37)
 - 1. Impaired heat loss
 - a. heat stroke
 - b. CHF
 - 2. Increased heat production
 - a. thyrotoxicosis
 - b. infections
 - 1. local
 - 2. systemic
 - c. neoplasm
 - d. gout
 - e. hematologic
 - f. hemolysis
 - g. pernicious anemia (severe)

h. leukemia, lymphoma

3. Tissue injury / trauma / surgery
 - a. atelectasis
 - b. UTI (Urinary tract infection)
 - c. wound infection
 - d. DVT (deep venous thrombosis)
4. DVT vs. Lymphangitis
5. Thrombophlebitis
6. Drugs

F. Techniques of Temperature Measurement

1. Temperatures may be reported Fahrenheit. Obtain an oral thermometer.
 - a. Shake the thermometer down before beginning the reading--should be less than 96 degrees F (36 degrees C).
 - b. Insert the thermometer under one side of the patient's tongue for five minutes. The patient's mouth should be closed during this time and talking should **not be encouraged**. Painful examinations should also be avoided during this time.
 - c. If the patient is unconscious, an infant, or in some way unable to safely accommodate an oral thermometer, an axillary temperature may be taken. If a rectal thermometer is available, a rectal temperature may be obtained.
 - d. Remove the thermometer and read it. If the temperature is elevated, repeat at one hour intervals until stable.

II. Pulse

- A. Sites of palpable arteries
 1. radial / ulnar
 2. brachial
 3. carotid
 4. femoral and lower extremity

B. Technique

1. With the patient's hand prone, grasp the patient's wrist with your fingertips to obtain the radial pulse. Both pulses should be compared to check for differences in rate and amplitude.
2. The rate is determined by counting for one minute. The pulse rate taken for 15 seconds and multiplied by 4, although commonly performed, may be subject to a percentage of error, especially if the pulse is irregular.
3. Note the pulse characteristics:
 - Regular or irregular
 - Bounding or shallow

C. Normal rate and rhythm

D. Normal arterial pulse contour

E. Common abnormal variations of pulse

1. Pulse alternans
 - a. technique
 - b. rhythm and rate
 - c. amplitude changes
 - d. associated: left-sided heart failure
2. Paradoxical pulse
(JAMA 288: 1030-31, 1974)
(LANCET 1: 530-31, 1978)
 - a. Technique: Sphygmomanometer
 1. greater than 10 mm Hg. decrease with inspiration
 - b. Significance:
 1. pericardial effusion
 2. pericardial tamponade
 3. severe obstructive pulmonary disease
 - a. asthma
 - b. emphysema
 4. hypovolemia

3. Bigeminal pulse (coupled rhythm)
 - a. waveform
 - b. normal beat with alternating premature contraction
 - c. rhythm and amplitude
 - d. differentiate from pulses alternans

4. Bounding pulse
 - a. waveform
 - b. etiologies
 1. HTN
 2. atherosclerosis
 3. hyperkinetic states (e.g. fever, hyperthyroid, etc.)
 4. miscellaneous

5. Bruits or arterial murmurs
 - a. auscultation techniques - bell
 - b. clinical occurrence
 - a. ASO
 - b. Aneurysm (true and false)
 - c. AV fistula

(REF: ARCH INT. MED. 97: 726, 1956)

6. Alterations / Inequality of contralateral pulses
 - a. possible significance

F. Recording of Pulses

1. Grading 1-4 not palpable, barely palpable, palpable bounding
2. Rate / Rhythm

III Blood Pressure

A. Techniques

1. Correct cuff size
 - a. Bag = 80% arm circumference
 - b. Width

2. Cuff Errors
 - a. too narrow
 - b. too short

Blood

3. Blood pressure technique

- a. On the initial patient visit, the blood pressure should be taken in each arm. The usual position is with the patient sitting. The position should be noted with the blood pressure obtained.

pressure should also be taken with the patient standing and lying down.
- b. To begin, deflate the blood pressure cuff completely by opening the stopcock attached to the rubber bulb of the sphygmomanometer.
- c. Wrap the cuff firmly around the upper arm leaving at least 3 cm clear above the antecubital fossa.
- d. Palpate the patient's radial pulse, close the stopcock and inflate the cuff until the pulse is no longer palpable. The pressure when the pulse is no longer palpable approximates the systolic blood pressure.
- e. Deflate the cuff and note the pressure level at which pulse reappears again approximately the systolic pressure.
- f. Place the stethoscope bell on the medial aspect of the antecubital fossa at the site of the brachial artery.
- g. Inflate the cuff again to a pressure 20 mm above the approximated systolic pressure. Deflate the cuff slowly until the first sound is heard. This is the SYSTOLIC BLOOD PRESSURE by auscultation.

NOTE: In some patients, the sound may DISAPPEAR completely at a pressure below the systolic blood pressure and then reappear as the cuff pressure continues to drop. This is known as the AUSCULTATORY GAP. Its presence should be noted when recording the blood pressure.
- h. Continue to deflate the cuff and note the point where the sound becomes muffled. RECORD THIS VALUE.
- i. if the sound is muffled, continue to deflate the cuff and note the pressure at which the sound disappears completely. This pressure should be recorded as the probable diastolic blood pressure.
- j. Repeat on the other arm.
- k. BP should have 3 readings plus auscultatory gap.

4. Auscultatory Gap

- a. normal variance in reading
 - b. occurrence and definition
 - c. how to record
5. Review How to Chart BP
6. Non-vanishing sound to zero mm. Hg.
- a. Significance
 - 1. thyrotoxicosis
 - 2. aortic regurgitation
 - 3. miscellaneous
7. Normal arterial blood pressure
- a. diurnal variation
 - b. normal range
8. Systolic Hypertension
- a. definitions
 - b. some associations
9. Diastolic Hypertension
- a. definitions
 - b. some associations
10. Normal Pulse Pressure
- a. definition
11. Abnormal Pulse Pressure
- a. widened
 - clinical occurrences / etiologies
 - b. narrowed
 - clinical occurrence / etiologies
12. Inequality of BP in Both Arms
- a. causes

13. Orthostatic Hypotension

- a. detection methods
- b. associations

IV. Respirations (Should be counted for one minute)

A. Rate

1. Normal rate

- a. adult - 14-20 cycles/minute
- b. newborn - 44 cycles/minute

2. Abnormalities of rate / increased

- a. increased-tachypnea
- b. usually shallower
- c. common associations
 - 1. anemia
 - 2. fever and infections
 - 3. respiratory distress
 - 4. cardiac insufficiency

3. Abnormalities of rate / decreased

- a. bradypnea
- b. usually deeper
- c. common associations
 - 1. uremia
 - 2. drugs
 - ETOH excess
 - Narcotics, etc.

4. General abnormalities / breathing

- a. hypernea
 - 1. definition
- b. Kussmaul breathing
 - 1. rate/variable
 - 2. depth
 - 3. associations
 - DKA, uremia and metabolic acidosis
 - pneumonia
- c. Cheyne-Stokes
 - 1. definitions
 - 2. graphic
 - 3. association / clinical occurrence

- normal - during sleep in children and aged
- various pathologies
- heart failure / left
- brain damage
- increased intracerebral pressure secondary to numerous causes
- drug induced respiratory depression

5. Charting

VITAL SIGNS LABORATORY

OBJECTIVES

1. Obtain blood pressure, pulse, temperature, and respiratory rate on your partner.
2. List normal values
3. List possible causes for any abnormalities.

TEMPERATURE

1. HOW DO YOU TAKE AN ORAL TEMPERATURE?
 - a.
 - b.
 - c.
 - d.
2. WHAT CAN GIVE A FALSELY HIGH OR FALSELY LOW TEMPERATURE/
3. WHAT IS A NORMAL TEMPERATURE.?
4. WHAT IS THE DIURNAL VARIATION IN TEMPERATURE?
5. WHAT TEMPERATURE IS CONSIDERED TO BE A FEVER?
6. WHAT ARE SOME CAUSES FOR FEVER?
7. WHAT IS A SUBNORMAL TEMPERATURE?

PULSE

1. WHAT IS THE NORMAL PULSE RATE?
2. NAME FOUR SITES WHERE YOU CAN OBTAIN A PULSE
3. HOW DO YOU OBTAIN A PULSE?
4. LIST FOUR CAUSES OF TACHYCARDIA
5. DESCRIBE THE FOLLOWING VARIATIONS OF PULSES, CAUSES, AND HOW THEY DIFFER FROM NORMAL
 - a. Bisferiens pulse
 - b. Bigeminal pulse
 - c. Bounding pulse
6. HOW ARE PULSES GRADED?

RESPIRATIONS

1. WHAT IS A NORMAL RESPIRATORY RATE IN AN ADULT? AN INFANT?
2. WHAT ARE TWO CAUSES OF TACHYPNEA?
3. WHAT ARE TWO CAUSES OF BRADYPNEA?

4. DISCUSS THE FOLLOWING BREATHING PATTERNS AND ASSOCIATED CLINICAL SYNDROMES:

- a. Cheyne-Stokes
- b. Kussmaul

BLOOD PRESSURE

1. WHAT IS A NORMAL BLOOD PRESSURE?
2. WHAT IS CONSIDERED HYPERTENSION IN A PERSON LESS THAN 65 YEARS OLD? IN A PERSON 65 YEARS OR OLDER?
3. HOW DO YOU OBTAIN A BLOOD PRESSURE?
4. WHAT IS ORTHOSTATIC HYPOTENSION AND HOW DO YOU DIAGNOSE IT?
5. WHAT IS THE PROPER CUFF SIZE.
6. WHAT IS AN AUSCULTATORY GAP?
7. WHAT IS THE NORMAL PULSE PRESSURE?

PHYSICAL DIAGNOSIS
BASIC EXAMINATION OF HEAD/EYE/EAR/NOSE/THROAT

GOAL:

The student should be knowledgeable in the basic examination of the head, ears, nose, and throat to the extent of recognizing signs of generalized disease and local lesions requiring the care of a specialist.

OBJECTIVES:

The student will....

- be able to outline the routine history and examination in the patient complaining of headache.
- list and describe the technique of routine eye examination i.e., functional testing and non-functional inspection.
- accurately diagnose common pathological finding of eye: lids, conjunctivae, cornea, sclera, and iris.
- recount basic nasal examination methods.
- be able to discuss clinical findings in basic nasal pathologic conditions with focus on external deformity and internal infection.
- explain the possible underlying significance of epistaxis.
- be able to describe basic techniques of ear examination for both adults and child.
- be able to recognize basic pathology of the tympanic membrane from the normal tympanic membrane.
- recognize basic external ear lesions / pathology.
- be able to list and describe major disease entities of the mouth and pharynx.
- be able to compare the primary types of acute pharyngitis.

PHYSICAL DIAGNOSIS

TOPIC OUTLINE: BASIC EXAM OF HEAD/EARS/NOSE/THROAT

I. HEAD

A. Symptoms - headache

1. History
2. Attributes of pain - headache

P-

Q-

R-

S-

T-

B. General - Extracranial vs. Intracranial

1. Pathophysiology

C. Examination - gross

1. Inspect
2. Palpate

- bones of cranium, carotid, and temporal arteries

3. pinched muscles - neck and upper shoulders
4. Examine eyes

- a. pupils
- b. EOM
- c. visual field defects
- d. fundoscopy

5. Auscultate - bruits

6. Ancillary test signs

- a. Brudzinski's
- b. Kernig's
- c. Nuchal rigidity

II. PHYSICAL DIAGNOSIS - EYE - NON-FUNCTIONAL LEXAM AND INSPECTION

A. Review normal anatomy

B. Lids - Examination

1. technique
2. "lid lag" (Von Graeffe's sign)
3. widened fissure (exophthalmos)
 - a. associations
4. Plaques
 - a. xanthelasma
5. Inflammation and pustules
 - a. dacryoadenitis vs. dacryocystitis
 - b. external sty (hordeolum) vs. internal sty chalazion and meibomian cysts
 - c. palpebral edema
 - d. entropion vs ectropion

C. Conjunctivae

1. Circulation, hyperemia and ciliary flush
2. Subconjunctival hemorrhage
3. Calcification in calcium-phosphorus disorders
 - a. hyperemic reddening
 - b. calcified plaques
 - c. pingueculae
4. Conjunctivitis
 - a. associations - Reiter's misc.

D. Cornea

1. Techniques of examination
 - a. lighting
 - b. 2% fluorescein
2. Superficial keratitis
3. Keratoconjunctivitis Sicca
 - a. assoc. Sjogren's syndrome
 - b. Schermer's test
4. Arcus senilis
5. Kayser-Fleischer Ring
 - a. association

E. Sclera

1. Yellow sclera
 - a. jaundice (icterus)
 - b. fat
2. Blue sclera
 - a. osteogenesis imperfecta

F. Iris

1. Iritis
 - a. features vs. acute glaucoma
2. Iridocyclitis and Uveitis
 - a. associations

III NOSE

1. External Deformities / Conditions
 - a. Rhinophima
 - b. Roseacea
 - c. Cleft
2. Septum
 - a. Deviation
 - b. Assess
3. Vestibule

- a. Furunculosis
- 4. Acute Suppurative Sinusitis (A.S.S.)
 - a. Key symptom: facial / dental pain
 - b. Descriptive signs and symptoms
- 5. Life Threatening Complications of Nasal Infections
 - a. Cavernous sinus thrombosis
 - 1. greater than 50% mortality
- 6. Nasal Polyps
 - a. location
 - b. significance with ASA, asthma, and rhinitis

IV EARS

- A. Review - anatomy
 - 1. external ear
 - 2. eardrum
- B. Review Basic Hearing Pathways
- C. Basic External Examination - Gross
- D. Otoscopic Examination - (aural speculum)
 - 1. Preparation and techniques
 - a. adults
 - b. children
 - 2. Light reflex
 - 3. Normal eardrum
 - a. appearance
- E. Common Middle Ear Pathologies
 - 1. Acute suppurative otitis media
 - a. description
 - b. examples
 - 2. Acute serous otitis media
 - a. description
 - b. examples
 - 3. Perforation
 - a. description
 - b. examples

4. Bullous Myringitis
 - a. description
 - b. examples

F. Clinical Hearing Tests:

1. Definition - perceptive (sensory)
vs. conductive hearing loss
2. Air vs. bone conduction
 - a. Weber's test
 - description of techniques
 - interpretation of results
 - b. Rinne's test
 - description of technique
 - interpretation of results

G. Key Symptoms

1. Earache
 - a. acute
 - b. clinical appearance (overview)
2. Tinnitus
 - a. outer ear
 - b. middle ear
 - c. inner ear
 - d. drugs
3. Vertigo
 - a. definitions
 - b. associations - Labrynthitis
 - c. associations - Meniere's Syndrome
 - d. associations - Trauma, 8th nerve, and brainstem damage

V. MOUTH AND THROAT

A. Review normal anatomy

B. Pathology - lips

1. Cheilosis
 - a. appearance
 - b. association
2. Chelitis
 - a. appearance
 - b. association
3. Angioneurotic Edema
 - a. appearance

- b. association
- 4. CA of the lip
 - a. example
- C. Pathology - Buccal Mucosa and Hard Palate
 - 1. Fordyce spots
 - a. appearance
 - 2. Moniliasis (candidiasis; thrush)
 - a. appearance
 - 3. Aphthous ulcer (Canker sores)
 - a. appearance
 - 4. Chancres
 - 5. CA
 - a. appearance
 - 6. Pigmentation
 - a. appearance
 - b. significance
- D. Inspect Gums and Teeth
 - 1. Gingival hyperplasia
 - a. significance - Dilantin
 - b. recession of gums
- E. Pathology - Tongue
 - 1. normal variants
 - 2. leukoplakia
 - a. appearance
 - b. significance
 - 3. Lichen Planus (Wickham's Striae)
 - a. appearance
 - 4. Myxedema and Acromegaly
 - a. appearance
 - b. association
 - 5. 12th Nerve Paralysis
 - a. appearance
 - 6. Mumps - Stenson's Duct

- a. appearance
- b. association

F. Pathology - Pharynx

1. Technique of Exam (say "AH")
2. Gag reflex
3. Paralysis of 10th cranial nerve
4. Viral pharyngitis
 - a. appearance
 - b. description
5. Streptococcal Pharyngitis
 - a. appearance
 - b. distinct features
6. Peritonsillar Abscess (Quinsy)
 - a. vs. retropharyngeal abscess
 - b. significance

PLEASE NOTE: THE LABORATORY OBJECTIVES FOR THIS SECTION
FOLLOWS THE NECK LECTURE.

HEENT LABORATORY

OBJECTIVES:

HEAD

1. Inspect head for general appearance, symmetry, scars, hair distribution and texture.
2. Palpate frontal and maxillary sinuses.
3. Note any abnormalities or tenderness.
4. List possible causes of abnormalities

EARS

1. Inspect external ear and note any abnormalities.
2. Inspect external canal and tympanic membrane with otoscope. Note any abnormalities.
3. List possible causes for otitis media.

EYES

1. Inspect eyes for appearance, symmetry and location.
2. Inspect conjunctivae, sclerae, palpebrae, eyelashes, eyebrows.
3. Test pupils for equality and roundness, reactivity to light and accommodation.
4. Test extra-ocular movements.
5. Test the visual fields.
6. Perform a fundoscopic examination with the ophthalmoscope.
7. Note any abnormalities and list possible causes.

NOSE

1. Inspect mucosa, nares (externally), septum
2. Note any abnormalities or tenderness.
3. List possible causes for abnormalities.

MOUTH AND THROAT

1. Inspect lips, buccal mucosa, tongue and pharynx.
2. Note the presence of tenderness, masses, or lesions.
3. Note the presence or absences of tonsils.
4. List possible causes for any abnormalities.

HEENT STUDY GUIDE

1. Name the major bones of the cranium and the important underlying vessels.
2. Name the parts of the external eye and the important underlying structures.
3. Name the parts of the ear, both external and internal.
4. Identify the following on the ear, and the significance if any:
 1. Lymph nodes
 2. Tophi
 3. Darwin's tubercle
 4. Sebaceous cyst
 5. Keloids
5. Identify the structures of the nose, externally and internally.
6. Name and identify the paranasal sinuses.
7. Identify the following conditions affecting the nose or mucosa of the nose. Identify the significance.
 1. Furnucle
 2. Allergic rhinitis
 3. Septal deviation
 4. Acute rhinitis
 5. Nasal polyps
8. Identify the structures of the mouth and pharynx.
9. Identify and list the significance of the following abnormalities of the lips:
 1. Herpes simplex
 2. Angular stomatitis
 3. Mucous retention cyst
 4. Angioneurotic edema
 5. Chancre
 6. Chelitis
 7. Carcinoma
10. Identify and list the significance of the following abnormalities of the buccal mucosa and hard palate:
 1. Aphthous ulcers
 2. Torus palatinus
 3. Fordyce spots
 4. Moniliasis
11. Identify and list the significance of the following abnormalities of the teeth and gums:
 1. Gingivitis
 2. Trench mouth
 3. Hutchinson's teeth
 4. Melanin pigmentation
 5. Periodontitis
 6. Gingival hyperplasia
 7. Lead line
12. Identify and list the significance of the following abnormalities of the tongue:

- | | | | |
|----|-------------------|----|-----------------|
| 1. | Smooth tongue | 4. | Hairy tongue |
| 2. | Geographic tongue | 5. | Fissured tongue |
| 3. | Carcinoma | 6. | Leukoplakia |
13. Identify and list the significance of the following abnormalities of pharynx:
- | | | | |
|----|-----------------------|----|-----------------------|
| 1. | Viral pharyngitis | 4. | Strep pharyngitis |
| 2. | Diphtheria | 5. | Peritonsillar abscess |
| 3. | Tonsillar hypertrophy | | |
14. Identify the following facies and their associated abnormalities:
- | | | | |
|----|---------------------------|----|---------------------|
| 1. | Acromegaly | 4. | Myxedema |
| 2. | Nephrotic syndrome | 5. | Cushing's syndrome |
| 3. | Parotid gland enlargement | 6. | Parkinson's disease |
15. Identify the following abnormalities of the eyelids and the significance of each:
- | | | | |
|----|----------------------|----|-------------------|
| 1. | Ptosis | 4. | Exophthalmos |
| 2. | Ectropion/Exotropion | 5. | Periorbital edema |
| 3. | Herniated fat | | |
16. Identify the following and significance associated with each:
- | | | | |
|----|----------------|----|---------------------|
| 1. | Pinguecula | 4. | Sty |
| 2. | Chalazion | 5. | Xanthelasma |
| 3. | Dacryocystitis | 6. | Lacrimal duct gland |
17. Compare and contrast the following types of red eyes:
- | | | | |
|----|----------------|----|----------------------------|
| 1. | Conjunctivitis | 4. | Acute iritis |
| 2. | Corneal injury | 5. | Subconjunctival hemorrhage |
18. Identify and list the significance of the following opacities of the cornea and lens:
- | | | | |
|----|---------------|----|------------------|
| 1. | Corneal arcus | 3. | Corneal scar |
| 2. | Pterygium | 4. | Nuclear cataract |
19. Identify and list the significance of the following pupillary abnormalities:
- | | | | |
|----|-------------------------|----|----------------------------|
| 1. | Benign anisocoria | 6. | Blind eye |
| 2. | Horner's syndrome | 7. | Oculomotor nerve paralysis |
| 3. | Argyll-Robertson pupils | 8. | Adie's pupil |
| 4. | Dilated fixed pupils | 9. | Small fixed pupils |
| 5. | Iridectomy | | |
20. Name the lymph nodes in order in which they are palpated.
21. Discuss the significance of the following types of enlargement of the thyroid gland:
- | | | | |
|----|---------------------|----|---------------------|
| 1. | Diffuse enlargement | 3. | Multinodular goiter |
| 2. | Single nodule | | |

22. List the signs and symptoms of hyper and hypothyroidism.

PHYSICAL DIAGNOSIS
LECTURE: OCULAR FUNDUS

GOALS:

The student will know how to clinically evaluate the ocular fundus and its' importance.

OBJECTIVE:

The student will be....

- able to compare and contrast the various presentations of the normal ocular fundus.
- able to describe proper ophthalmoscopic techniques of examination.
- able to list and explain the fundoscopic changes in Diabetes Mellitus and hypertension.

PHYSICAL DIAGNOSIS

TOPIC OUTLINE: OCULAR FUNDUS

I. IMPORTANCE

II. TECHNIQUE OF EXAMINATION

A. Lateral illumination

B. Degree illumination

1. Vitreous

2. Direct ophthalmoscopy

a. red reflex

3. Refractive anomalies

a. hyperopia

b. myopia

III. REVIEW - ANATOMY OF OCULAR FUNDUS

A. Retina

1. Blood supply

B. Choroid

C. Optic nerve

IV. NORMAL FUNDUS - APPEARANCE

A. Color - Pigment Tessellated/Abiototic

B. Optic Nerve head Cup/Disk Ratio

C. Fovea Centralis and Macula

D. Choroid

1. Variations

V. ABNORMALITIES AND PHYSIOLOGIC VARIANTS

A. Congenital malformations

B. Drusen Bodies of Optic Disc

C. Hyloid Vessels

D. Myelinated Nerve Fibers

E. Cilioretinal Vessels

F. Nevus

VI. NORMAL OPTIC DISC - VARIATIONS

A. Physiologic cupping
1. classifications

B. Scleral Ring

C. Pigmented Crescent

D. Medullary Nerve Fibers

VII. PATHOLOGY

A. Optic Atrophy
1. findings and appearance
2. process

B. Papilledema
1. process
2. findings and appearance
3. stagings

VIII. PATHOLOGY - RETINA

A. Vessels - veins
1. central retinal vein thrombosis and occlusion
a. variform "flame" hemorrhage

B. Hemorrhage - examples
1. deep retinal
2. blot
3. flame
4. Roth's spot (associations)
5. microaneurysms
6. underlying systemic condition possible HTN, DM, SLE, Leukemia, Sickle Cell, and SBE

C. Vessels - Arterial
1. Central retinal artery - occlusion
a. appearance

2. Arteriolar Sclerosis
 - Retinal signs
 - a. Central stripe - early disease
 - "Cooper wire arteries"
 - b. Total stripe - last disease
 - "Silver wire arteries"
 - c. Pipestem sheathing
 - d. Arteriovenous crossing signs
 1. venous nicking
 2. venous humping
 3. venous tapering
 4. venous banking

D. MACULA

1. Macular star
2. Cherry red spot and arterial occlusion
3. Senile degeneration

E. RETINAL SPOTS

1. Cotton-wool patches
 - a. "soft exudates"
 - b. "hard exudates"
2. Pigmentations
3. Drussen (Colloid bodies)

IX. PATHOLOGY - SYSTEMIC

A. Hypertension / Hypertensive Retinopathy

1. Correlation of disease to retinal grading
2. Grading of Retina HTN

Grade I - findings
 Grade II - findings
 Grade III - findings
 Grade IV - findings

B. Diabetes Mellitus / Diabetic Retinopathy

1. General
2. Retina findings
 - a. microaneurysms and deep hemorrhages
 - b. exudates - types
3. Staging

FUNDOSCOPY SLIDES

1. Sagittal section of the eye: OS = Left
OD = Right

- Three layers:
1. Outer layer - Fibrous
Posterior - Sclera
Anterior - Cornea
 2. Middle layer - Vascular (black)
Uvea Posterior - Choroid
Anterior - Ciliary Body
Iris
 3. Inner Layer: Retina-own blood supply

Anterior Chamber - Fluid filled
Lens
Posterior Chamber - Fluid filled - floaters here
Optic Nerve

2. Retina - Picture: Internal limiting membrane acellular
Ganglion Cells - no myelin
Inner plexiform layer - synapse between ganglion and inner nuclear layer
Inner nuclear layer
Outer nuclear layer
Pigmented epithelium: Melanocyte
Bruch's membranes
3. Section of posterior portion of eye: 3 layers
4. Optic Nerve: Becomes ganglionic cell layer where enters / leaves eye - no myelin; called lamina cribosa.
5. Blood supply to retina: Veins larger than artery in ganglionic cell layer. (Central artery in slide)

Common Carotid	Internal Carotid	Ophthalmic Artery	Central Retinal Artery
----------------	------------------	-------------------	------------------------

6. Cataract:
- | | | |
|------------------|-------------|-----------|
| Anterior chamber | Black | 20-10 |
| Vitreous Humor | Black | 10-2 |
| Retina | Black (+) 1 | Red 1 (-) |

7. Disc / Cup:
 - Optic Nerve
 - Cup - Center
8. Scleral ring - nl.
(Sclera does not fit tightly)
9. Pigmented Crescent - Clumping of melanocytes
10. Medullated fibers
Myelin where it should not be normal variant.
11. Black pt. - Brownish green hue
12. Blond pt. - Pale zones with red zones
13. Tigroid retina - Pt. older than 60-normal aging process.
14. Macula: I 1/2 disc diameters away from retina
 Appears darker
 Inferior temporal; greatest concentration of rods & cones
 First area where diabetes makes changes
15. Macula
16. Macula
17. Persistent hyloid vessels - 10% of normal patient congenital vessels should have disappeared
18. Cilio retinal artery - not from retinal circulation off choroid circulation.
19. Hyloid vessels and cilio retinal artery
20. Cholesterol plaque - may give field cuts if stays lodged in area
21. HTN - arteriolar narrowing is first change.
22. HTN - prolonged cooper wire
 silver wire
23. A-V nicking (arterio-venous nicking): Artery crosses vein.
24. Pathology slide - shared adventitia
25. DM + HTN - soft exudates (cotton/wool patches) infarcts in nerve fiber layer:
tell by vessels coming in leaving out. In same layers.
26. Pathology slides - infarcts (soft exudates)

27. HTN - +No disc
+ Cotton / wool patches
28. Retinal hemorrhages
29. HTN - resolving cotton / wool patches
30. HTN - resolution of cotton / wool patches
31. Hard exudate / Macular star: Below nerve fiber layer
Can see vessels cross
Etiology - unclear
Causes: DM + HTN (#1 causes)
32. Drusen bodies - spots with aging
Old (non-DM - Drusen bodies)
Young (DM - hard exudate / Drusen)
(not Drusen bodies)
33. Black spot in retina - follow to see if changing (?)
melanoma
34. Pathology picture of Drusen bodies
35. Chorioretinitis - Toxoplasmosis
Fungal
36. Neovascularization
37. Detached retina
38. Hemorrhage with pale center - Roth spot
Sine qua non - Bacterial endocarditis
39. Papilledema - swollen nerve head; vessels hump backed over disk
- disc margins lost
- line on ophthalmoscope - parallax over optic disc

Fundoscopy Study Guide

1. Identify the three layers of the eye.
2. Identify the layers of the retina.
3. Describe the blood supply to the retina. Identify central retinal artery and vein.
4. Identify the optic cup and disc.
5. What is the normal cup to disc ratio?
6. Identify the following findings in retina?
 - A. Scleral ring
 - B. Pigmented crescent
 - C. Blond patient's retina
 - D. Black patient's retina
 - E. Tigroid retina
 - F. Persistent hyloid vessels
 - G. Cilioretinal artery
7. What are the changes seen in hypertension?
8. Identify A-V nicking.
9. What are the changes seen in diabetes?
10. What are the causes of chorioretinitis? Identify chorioretinitis?
11. Identify a cholesterol plaque and the consequences of it.
12. Identify cotton wool patches. What layer does it occur in and how do you tell. List several causes.
13. Identify a hard exudate. What layer does it occur in and how do you tell. List several causes.
14. Identify a Roth spot and the cause of it.
15. Identify a Drussen body and its cause.

16. Identify papilledema and the cause of it.

PHYSICAL DIAGNOSIS

TOPIC: CRANIAL NERVE EXAMINATION

GOAL:

The student should be knowledgeable in the routine examination of the eye and the cranial nerves.

OBJECTIVES:

At the conclusion of this lecture, the student should be able to.....

- describe the visual reflexes and know how to elicit them.
- describe the basic techniques of examination for the cranial nerves I - XII (1-12)
- explain the underlying rationale (with respect to nerve function) of the various cranial nerve diagnostic testing procedures.

NOTE: The test included is to be of aid to students comprehension.

FUNCTIONAL OCULAR EXAMINATION (CRANIAL NERVES II, III, IV, AND VI)

II. OPTIC NERVE (II)

A. DESCRIPTION OF FUNCTION AND ANATOMIC CORRELATES

1. Sensor nerve: vision
2. The receptor for visual impression is in the retina. The receptor cells are the rods and cones. Rods are concentrated in the periphery of the retina and cones are concentrated in a small area temporal to the disc called the macula. This is the locus of visual acuity and color perception. Synapses are made with bipolar cells in the retina which then synapse with ganglion cells whose long axons pass as far as the lateral geniculate body. They are first concentrated in the papilla

(optic disc) then pass through the optic canal as the optic nerve with macular fibers concentrated in the central portion of the nerve. Within the cranium, the two optic nerves are reorganized at the **optic chiasm** in a partial decussation such that fibers serving the temporal retina (**nasal visual field**) remain ipsilateral and those serving the ipsilateral follow in the **optic tract**. The end result is that all stimuli falling on homonymous parts of the two retinae i.e., both right halves will be transmitted to the occipital cortex on the same side. Since the visual fields as we see them are reversed by the time they reach the retina, this means that the left half of what we see is represented in opposite visual pathway behind the chiasm. The optic tract transmits fibers to the thalamus where another synapse occurs in the **lateral geniculate body**.

From here, the fibers spread as a large fan which sweeps around the temporal horn and back as the **optic radiation** or geniculocalcarine tract to terminate in area 17 of the occipital cortex on the medial surface. Vision here is separated by the calcarine fissure such that stimuli from the inferior retina are represented in the lower half of the cortex. The area of the cortex representing macular vision, if disproportionately large, occupying much of the occipital tip. (see diagram)

B. Clinical Examination

1. An extremely important nerve in terms of both function and diagnosis. Formal exam consists of three parts:
 - a. Best corrected visual acuity using Snellen test cards or standardized reading cards. Measure of macular function.
 - b. Visual field testing utilizing confrontation methods, i.e., finger or small test objects. Increased accuracy obtained with standardized perimeter and tangent screens. Because of the pathway as in relation to other structures, highly accurate localization can be achieved and often the nature of the lesion can be predicted with some certainty.

- c. **Ophthalmoscopic visualization of the optic fundus recording observations of the retina, macula, vessels, and optic fundus . (See Lecture - Fundoscopy).**

2. Diagrammatically, the visual fields are often represented as two circles side by side. They are partitioned into circular portions equidistant from the center called dipters. If a patient's defect involves 1/2 of the field, it is called hemianopsia.

If a quarter of the field is defective, it is a quadrantanopsia. A lesion behind the chiasm would involve the medial 1/2 of one field and lateral 1/2 of the other field, and is a homonymous hemianopia. A pituitary lesion impinges on the crossed nasal fibers in such a way that bitemporal hemianopsia is produced. The general term for a defect within a field of vision of "scotoma".

3. Review of selected field defects with visual pathways associations: Examples....
 - a. blind eye
 - b. bitemporal hemianopsia
 - c. left homonymous hemianopsia
(2 location possibilities)
 - d. quadrant lesions

**FUNCTIONAL OCULAR EXAMINATION
CRANIAL NERVES (III, IV, AND VI)
(Oculomotor, Trochlear, and Abducens Nerves)**

- A. Description of function and Anatomic correlates
1. All 3 primarily motor
 2. Oculomotor nerve innervates:
 - a. levator of eyelid
 - b. constrictor of pupil
 - c. ciliary muscle which controls accommodation
 - d. extraocular muscles excluding lateral rectus, and superior oblique
 3. Trochlear Nerve (IV) innervates superior oblique muscle.
 4. Abducens Nerve (VI) innervates lateral rectus muscle.
 5. Pupillary response: The size of the pupils is determined primarily by two factors; the intensity of illumination and the tonic balance between the sympathetic and parasympathetic neural impulses. The constrictor fibers under parasympathetic control and dilator fibers under sympathetic control. The afferent arc of the parasympathetic system is in the retina (D1) and is transmitted into the optic nerve to the chiasm where some fibers reach the lateral geniculate body, they leave the tracts and enter the mid-brain to synapse bilaterally in the Edinger-Westphal nucleus at the level of the third N. nuclei. The afferent arc travels in the third N. to the ciliary ganglion where another synapse takes place anterior to the pupilloconstrictor fibers via short ciliary nerves. The sympathetic innervation begins in the hypothalamus and travels in the lateral brainstem to the lateral spinal cord at D1. The second order neuron travels up the sympathetic chain to the superior cervical ganglion. The third order neuron travels along the carotid artery to gain access to the pupilodilator fibers and a portion also goes to the sweat glands of the face.
 6. Ocular muscles: The VI nerve controls the lateral rectus muscle which abducts eye. The IV nerve controls the superior oblique muscles which depress the globe when in the adducted position. The remainder of the ocular muscles are mediated by the III nerve i.e. medial rectus, superior rectus, inferior rectus, and oblique. The lid is also under major control of the III nerve via levator palpebrae muscle.

Reciprocal muscles of each eye are linked together to move the eyes together and are called yoke muscles e.g. the medial rectus of one eye and lateral rectus of the other eye are yoke muscles and are controlled by a complex system in the brain-stem called the medial longitudinal fasciculus. Additionally, there are centers in the cerebral hemispheres that influence conjugate eye movement.

B. CLINICAL EXAMINATION
(The Oculomotor, Trochlear, and Abducens Nerves)

1. These cranial nerves are examined together because of their closely related functions of ocular mobility and conjugate movement of the eyes. In addition, the III nerve plays a significant role in pupillary size and response. Examination consists of three important observations:

a. The size and equality of the palpebral fissures and presence or absence of ptosis (drooping of the lid).

b. Visual reflexes (III)

1. Direct vs consensual

2. Accommodation:

- The size and equality of the pupils and their reactions to light and near responses. The reaction of the ipsilateral pupil is the direct response (DR) and the response at the same time of the contralateral pupil is the consensual response (CR). The normal response of the pupils to looking near (tip of nose) is myosis (constriction of the pupil) Abnormal dilation of the eye is called mydriasis.

c. Cardinal fields of gaze and extraocular movements.

- Movements of the eyes in the six cardinal directions and noting smoothness of movement, conjugate movements, and presence or absence of nystagmus (oscillations of the eyes). RL 6 SO 4

1. Nystagmus

a. Definition

1. slow vs fast

2. associated vs disassociated

3. fine vs. coarse

b. End position nystagmus

c. Primary position nystagmus

D. Pupillary Disorders

a. Anisocoria

1. causes

b. Argyll-Robertson Pupil

1. descriptive features

2. associations - tabes dorsalis

c. Adie's pupil

d. Horner's Syndrome

IV: CRANIAL NERVE I - OLEFACTORY NERVE

A. Description of Function and Anatomic Correlates:

1. Least important of the cranial nerves in man, subject to many extraneural disorders such as rhinitis and trauma.
2. Receptoepithelium in the nasal cavity transmit impulse via thin hairlike processes through the cribriform plate to the olfactory bulbs. Axon form the olfactory which becomes th olfactory striae and distributes widely to areas in the primitive cortex known as the piriform lobe.

CRANIAL NERVE V - TRIGEMINAL NERVE

A. Description of Function with Anatomic Correlates:

1. Two functions: sensory and motor
2. Sensory portion innervates facial sensation as three parts:
 - a. ophthalmic (V1)
 - b. maxillary (V2)
 - c. mandibular (V3)

- Sensory fibers to all three divisions of V. are given off via unipolar cells of the semilunar (Gasserian) ganglion located in the middle cranial fossa. The proximal limb of the cells in the semilunar ganglion enter the brain at the level of the mid-pons and dichotomize into ascending and descending fibers by three principal nuclei. Many descend in the long nucleus and tract of the spinal portion which descends to the level of the C2 and transmit primarily pain and temperature impulses. Other fibers ascend in the main sensory nucleus as touch fibers and a small number are involved with mesencephalic nucleus which is proprioceptive to the muscles and likely mediates the jaw jerk.

Sensory fibers ultimately synapse and decussate to the opposite side and ascend in the brain stem in VPM nucleus of the thalamus and hence, to the sensory portion of the cortex.
3. Motor portion controls muscles of mastication Mandibular (V3).
 - a. The motor nucleus of V is a small nucleus which sends fibers out of the pons via the mandibular nerve to the muscles of mastication.

B. CLINICALLY:

1. Ophthalmic (1st division)
 - a. passes through superior orbital fissure
 - b. sensory - distribution and dermatomes

- conjunctivae
- cornea
- upper lid
- forehead
- bridge and tip of nose
- scalp as far posteriorly as vertex of the skull

2. Maxillary (2nd division)

a. Foramen Rotundum -- sphenomaxillary fossa -- inferior orbital fissure -- inferior orbital foramen.

b. Sensory

Supplies tactile, pain and temperature sensation from:

- skin of cheek
- lateral sides of nose
- upper teeth and jaw
- mucosal surfaces of uvula, hard palate, nasopharynx, and lower nasal cavity

3. Mandibular (3rd division)

a. Leaves skull through foramen Ovale

b. Sensory:

- skin of lower jaw
- pinna of ear
- ant. ext. auditory meatus
- homolateral side of tongue
- lower teeth, gums, and floor of mouth
- buccal surface of the cheek

c. Motor

- muscles of mastication
- temporal
- pterygoid
- masseter

C. CLINICAL EXAMINATION - Techniques

1. Facial sensation to pain and touch along dermatomes V1, V2, V3
2. Corneal reflex (v)
3. Motor - bulk and strength (jaw "clamping") of 3 muscles of mastication

VI. CRANIAL NERVE VIII - FACIAL NERVE

A. Description of Function with Anatomic Correlates

1. 2 functions - motor and sensory
2. Primarily a somatic motor nerve innervating muscles of facial expression or so called mimetic muscles.
3. Much smaller sensory portion mediates taste of anterior 2/3 of tongue as well as general sensation external ear (just behind pinna) and external ear canal.
4. The motor nucleus and fibers of the facial nerve have a rather complicated intramedullary course. The nucleus is located deep in the tegmentum of the caudal portion of the pons. Fibers ascend medially and dorsally to loop around the abducens nucleus. Then descend ventrally and laterally to leave the brain in the internal auditory canal transversing laterally to the geniculate ganglion; then bending sharply down on the facial canal and exits at the stylomastoid foramen. The nerve pierces the parotid gland then fans out in many branches to the various mimetic muscles, and also posterior digastric, the stylohyoid, buccinator, platysma.
5. Additionally, distal to the geniculate ganglion, the facial nerve gives off the chorda tympani, which carries fibers of taste from the anterior 2/3 of the tongue via the lingual nerve.
6. **IMPORTANT:** The facial nuclei receive influences from higher centers via corticobulbar fibers. It is an important clinical fact that the fibers of the upper portion of the face receive bilateral corticobulbar innervation while those of the lower portion receive primarily unilateral influence. Hence, an upper motor neuron lesion tends to spare the upper face while a lower motor neuron lesion involves all portions.

B. CLINICAL EXAMINATION

1. Observation: Note Symmetry
 - Testing involves observation of the movement of the face during emotional expression and observing for unilateral or bilateral weakness of such requested movements as closing the eyes, wrinkling the forehead, puffing the cheeks, showing teeth, pursing the lips, and whistling, etc.
 - **NOTE: DISTINGUISH UPPER MOTOR NEURON LESION VS. LOWER MOTOR NEURON LESION.**

NOTE: OBSERVE WIDTH OF PALPEBRAL FISSURES.

2. When indicated, e.g. in Bell's Palsy, taste can be tested on anterior 2/3 of tongue using sugar, sodium chloride, quinine, etc.

CRANIAL NERVE VIII ACOUSTIC (STATO-ACOUSTIC)

A. Description of Function with some Anatomic Correlates

1. 2 divisions: cochlear and vestibular
 - a. Cochlear: serves sense of hearing
 - b. Vestibular: serves sense of balance
2. Anatomy - complicated beyond the scope of this class. Interested students referred to standard neuroanatomy texts.

B. Clinical Examination:

1. Bedside testing involves several maneuvers but primarily the auditory portion lends itself to testing. Under special circumstances, the vestibular portion is tested with caloric responses but this is not routine (for nystagmus).
 - a. Otoscopic inspection of the ear and external canal.
 - b. Each ear tested with faint noise such watch tick.
 - c. Rinne and Weber tests are used to evaluate sensory nerve from middle ear hearing loss. Using a tuning fork, comparison is made of intensity of sound when fork is placed on mastoid bone vs. holding the fork in front of the ear (air condition) then over mastoid (bone conduction). This is Rinne test. Weber's test is evaluated by placing the fork over the center of the head and asking the patient if he hears it better on one side or another. In middle ear deafness, the vibration is louder on the affected side. In sensory nerve loss, the sound is louder on the normal side.
 - d. Neurosensory hearing loss

inner ear / nerve

< Weber - lateralizes to the good ear
Rinne AC > BC (Normal)
 - e. Conductive hearing loss
middle ear / external ear

Weber - lateralizes to poor ear

Rinne BC > AC (Abnormal)

CRANIAL NERVES IX (GLOSSOPHARYNGEAL) AND X (VAGUS)

A. Description of Functions with Anatomic Correlates:

1. Cranial nerves IX and X (glossopharyngeal and vagus): These nerves are tested together because the testable functions are closely related. The tenth nerve conveys taste from the posterior 1/3 tongue and contributes to the sensory innervation of the tonsillar pillars, soft palate, and pharyngeal wall. It innervates the larynx but is primarily involved with autonomic control of many organs via parasympathetic system and these functions are not readily testable at the bedside. It is also involved in reflex arcs for salivation (via inferior salivatory nucleus to parotid gland)
2. Motor IX - to stylopharyngeus muscle
3. The vagus (X) nerve has somatic motor fibers to the soft palate, pharynx, and larynx and are, to a certain extent, under voluntary control.
4. The vagus (X) nerve has autonomic efferent fibers which pass to peripheral ganglion cells and then innervate muscles of the trachea, esophagus, heart, stomach, and small intestine, as well as blood vessels.
5. The vagus (X) nerve has sensory fibers concerned with the reception of visceral sensation from pharynx, larynx, bronchi, esophagus, and abdominal viscera.
6. The IX and X nerve enter and leave the CNS via as rootlets located along the dorsolateral portion of the medulla. They both exit the skull along with the fifth nerve in the jugular foramen; hence lesions here affect all three. Because of the fact that both nerves are afferent and efferent for both the somatic and autonomic nervous system, they are related to a number of brain-stem nuclei in the medulla including the nucleus ambiguus, dorsal motor nucleus of the vagus, fasciculus, and nucleus solitarius and salivatory nuclei.

Interested students are referred to standard neuroanatomy texts for further reading.

B. CLINICAL EXAMINATION - TECHNIQUE - CRANIAL IX AND X

1. "Gag" Reflex (X)

The gag reflex is tested by touching the palate, tonsillar pillars, or just posterior wall of the pharynx with wooden tongue depressor. Normal response is prompt contraction of pharyngeal muscle/movements of uvula and palate with or without gagging.

2. Vagus (X) Testing

Testing includes observation of the movement of the uvula palate when the patient says "AAH". The paralyzed side does not move and is pulled to the intact side. Normally, the median raphe (of soft palate) rises in midline.

In unilateral vagal lesions, swallowing is not usually impaired. However, in bilateral lesions there will be dysphagia and regurgitation of fluids through the

nose.

3. The patient is observed while swallowing liquid and looking for nasal re-gurgitation, pharyngeal movement, etc. (= X dysfunction).
4. There is some overlap:

The symptoms of IX and X dysfunction include disorders of speech, dysphonia and dysarthria, hoarseness, and swallowing (dysphagia).

CRANIAL NERVE XI: SPINAL ACCESSORY NERVE

A. Description of Functions with Anatomic Correlates:

1. Motor nerve to sternocleidomastoid and upper portion of trapezius muscles.
2. There are two roots to this nerve, i.e., cranial and spinal. The cranial root arises from neurons in the caudal pole of the nucleus ambiguus and emerge from the lateral surface of the medulla caudal to the lowest filaments of the vagus nerve. The cranial nerve fibers join the vagus and innervate the intrinsic muscles of the larynx. The spinal portion, which we test at the bedside arises from a series of rootlets in the anterior horn extending from the fifth cervical segment to about the middle of the pyramidal decussation. They unite in a common trunk which extends cephalad in the spinal canal to enter the skull through the foramen magnum and then exit again with IX and Xth nerves via the jugular foramen.

B. CLINICAL EXAMINATION

1. This is a motor nerve to the sternocleidomastoid muscle and upper portion of the trapezius. Contraction of one SCM muscle turns the head in the opposite direction. The bulk and strength are easily observed and tested as patient forces his chin against examiner's hand. The trapezius is observed as patient shrugs his shoulders toward his ears.

CRANIAL NERVE XII (HYPOGLOSSAL NERVE)

A. DESCRIPTION OF FUNCTION WITH ANATOMIC CORRELATES:

1. Primary motor - supplies both extrinsic and intrinsic muscles of the tongue.
2. This nerve is formed by large motor nuclei located in the floor of the fourth ventricle in the medulla. They descend in a well-defined fiber tract close to the midline, but lateral to the medial lemniscus and pyramidal tract. They exit the skull through the hypoglossal canal to go to the intrinsic tongue muscles.

B. CLINICAL EXAMINATION

1. This is an easy nerve to test since its sole function is motor to the tongue muscles.

The tongue is observed as it lies quietly in the floor of the mouth. One looks for atrophy and fasciculation. The patient is asked to protrude the tongue to observe for deviation and then for quick side to side movements. If there is unilateral weakness, the tongue will deviate toward the side of the lesion. If rate is slow, suspect bilateral UMN lesion.

CRANIAL NERVES LABORATORY

OBJECTIVES:

1. Examine each of the cranial nerves.
2. List the test and how it is performed for:
 - a. Visual acuity
 - b. Taste
 - c. Smell
3. List exactly the loss of function if a lesion is present in any of the cranial nerves.

CRANIAL NERVE STUDY GUIDE

1. Describe the testing of the First Cranial Nerve.
2. What is the significance of a bilateral loss of smell?
What is the significance of a unilateral loss of smell?
3. Describe the testing of the second cranial nerve.
4. Identify the visual field cuts with the following lesions:
 - A. (L) optic nerve
 - B. Optic chiasm
 - C. ® optic tract
 - D. (L) optic radiation
5. Describe the testing of the third, fourth, and sixth cranial nerve. Note the movements controlled by each cranial nerve.
6. Describe the findings in the following:
 - A. Oculomotor nerve paralysis
 - B. Blind eye
 - C. Horner's syndrome
 - D. Argyll-Robertson pupil
 - E. Anisocoria
 - F. Adie's pupil
 - G. Dilated fixed pupils
 - H. Small fixed pupils
7. Describe the testing of the fifth cranial nerve. Include motor, sensory and corneal reflex.
8. Discuss the significance of unilateral and bilateral lesions of the fifth cranial nerve.
9. Describe the testing of the seventh cranial nerve.
10. Describe the findings of an upper motor neuron lesion and lower motor lesion of the seventh cranial nerve.
11. Describe the testing of the eighth cranial nerve.
12. Discuss the findings of the following:

- A. Conduction hearing loss
 - B. Sensorineural loss
13. Describe testing of the ninth and tenth cranial nerves.
14. Discuss the significance of findings in:
- A. Hoarseness
 - B. Nasal voice
 - C. Absence of gag reflex
 - D. Lesion on one side of soft palate and of both sides of the soft palate.
15. Describe the testing of the eleventh cranial nerve. What does a lower motor neuron lesion look like?
16. Describe the testing of the twelfth cranial nerve.
17. What findings are present with a lesion of the twelfth cranial nerve on the ® side?

PHYSICAL DIAGNOSIS NECK EXAMINATION

GOAL:

The student should be knowledgeable in the examination of the neck:

OBJECTIVES:

The student will....

- be able to describe the basic technique of the neck examination.
- be able to detail the routine lymph node examination.
- be able to detail the examination of the thyroid gland.
- be able to give a differential diagnosis of any abnormal findings.

PHYSICAL DIAGNOSIS
TOPIC OUTLINE: NECK EXAMINATION

I. NECK

A. Review Pertinent Anatomy

1. Landmarks
2. Lymph Nodes

B. Inspection

1. Symmetry
2. Masses, Enlargements
3. Scars

C. Lymph Node Palpation

1. Pre-auricular
2. Posterior Auricular
3. Occipital
4. Tonsillar
5. Submaxillary
6. Submental
7. Superficial Cervical
8. Deep Cervical Chain
9. Posterior Cervical Chain
10. Supraclavicular

D. THYROID GLAND EXAMINATION

1. Technique
2. Abnormalities
 - a. Single nodule
 - b. Multiple nodules

c. Diffuse goiter

NECK LABORATORY

OBJECTIVES:

1. Inspect the neck for symmetry and presence of or absence of hypertrophy / atrophy or masses.
2. Examine for mobility of the neck.
3. Palpate for lymphadenopathy of head and neck.
4. Palpate thyroid.
5. Note any abnormalities.
6. List possible causes.

**PHYSICAL DIAGNOSIS
CHEST AND LUNG EXAMINATION**

GOAL:

The student should be knowledgeable in the basic technique of chest and lung examination and understand common pathological entities.

OBJECTIVES:

The student will be....

- able to specify key anatomic landmarks of the thorax and correlate them to lung fields.
- able to review the major components in the history of the patient with suspected chest disease.
- able to recognize gross deformities of the chest / thorax.
- able to describe the techniques of chest palpation and percussion.
- able to illustratively describe the basic method of auscultation.
- able to describe and explain the normal breath sounds.
- able to list and describe the major abnormal breath sounds and abnormal sounds of transmission.
- able to differentiate between selected abnormalities of lungs and bronchi.

PHYSICAL DIAGNOSIS

TOPIC OUTLINE: CHEST AND LUNG EXAMINATION / PATHOLOGIES

I. CHEST

A. Review anatomy of lungs - gross

B. Review anatomy of chest wall correlating lung markings thoracic landmarks.

1. midsternal line
2. midclavicular line
3. axillary lines
4. scapular line
5. vertebral line

C. History of Patient with Suspected Chest Disease

1. C.C. - S.O.B. and /or cough

D. Family and Social History

1. Allergic disorders
2. Chronic bronchitis
3. T.B. in family
4. Smoking
 - a. recorded in "pack-years"

E. Occupational History

1. Work factors
 - a. coal
 - b. arc welder
 - c. stone mason
 - d. steel worker
 - e. cotton handler
 - f. farm worker
2. Environmental factors

- a. contact with pigeons or other animals, e.g. parakeets.
 - b. dust, pollen
 - c. miscellaneous
- 3. Geographics
 - a. San Joachin Valley
 - b. Midwestern, Mississippi, etc.
- F. History of Previous Illness
 - 1. T.B.
 - 2. Pneumonia
 - 3. Chest injury
- G. History of Previous Illness
 - 1. Pain
 - a. pulmonary pain
 - b. pleural pain
 - c. intercostal neuritis
 - d. costochondral pain (Tietze's syndrome)
 - 2. Cough
 - a. productive vs. non-productive
 - 3. Dyspnea - associations
 - 4. Hemoptysis - associations
 - 5. Hoarseness and wheeze - associations

II PHYSICAL EXAMINATION

A. Inspection

1. skin color
2. neck vein distention
3. extremities - clubbing, etc.

B. Examination of chest wall

1. AP / Lateral ratio
2. Barrel chest vs. Funnel breast
3. Pectus Carinatum ("Pigeon Breast")
4. Kyphosis
5. Scoliosis
6. Kyphoscoliosis

C. Palpation

1. Techniques - hand position
2. Tactile (vocal) fremitus
 - a. Significance - pathology

NOTE

Flatness
Dullness
Resonance
Hyperresonance
Tympany

LOCATION EXAMPLE

Thigh
Liver
Normal lung
Emphysematous lung
Gastric air bubbles or
puffed cheek

3. Costo-vertebral tenderness

D. Percussion

1. Mediate percussion
 - a. Plexor / Pleximeter Technique
2. Locations of percussion - symmetry

3. Resonance / Dullness / Tympany chest map
 - a. 5 basic percussion notes
 1. flatness
 2. dullness
 3. resonance
 4. tympany
 5. hyperresonance
4. Auscultation
 - a. Percussion / auscultation sequences anterior and posterior thorax
 - b. Stethoscope / Environs
 - c. Normal breath sounds
 1. Vesicular - I : E ratio
 2. Bronchial - I : E ratio
 3. Bronchovesicular - I : E ratio
 4. Tracheal
 - d. Abnormal breath sounds

Old = rales and rhonchus

New = crackles and wheezes
5. Crackles
 - a. definition - discontinuous
 - b. etiology
 - c. coarse vs. fine
 - d. early inspiratory
 - chronic bronchitis
 - asthma (airway obstruction)
 - emphysema
 - e. late inspiratory

- pneumonia
 - CHF
 - rheumatoid lung (Restrictive Pulmonary disease)
 - Interstitial Fibrosis
- f. Differentiating crackles in various disease entities
- g. Wheezes (rhoncus)
1. definition
 - musical
 - high or low pitch (sonorous vs. sibilant)
 - short or long
 - inspiratory or expiratory
 - single or multiple
 2. Etiology - organ pipe analogy
 3. Monophonic
 - asthma
 - asbestosis (lower lung)
 - interstitial fibrosis
 4. Polyphonic
 - definition
 - asthma (Expiratory)
 - COPD
 - DDX: Normal patient with “white noise”

- h. Abnormally transmitted Sounds
 - 1. Egophony
 - definition
 - E -- A with lung consolidation
 - Physiologic basis
- i. Whispered Pectoriloquy
 - 1. Definition
 - 2. Normal chest sound with whispering
 - 3. Changes with consolidation
 - 4. Techniques
- j. Bronchoscopy and Bronchial breathing
 - 1. Physiologic basis -- normal loss of higher frequencies
 - 2. Consolidation -- "airless lung" -- clearing of speech and breath sounds.

III. DIFFERENTIAL OF SELECTED ABNORMALITIES OF LUNGS AND BRONCHI

- A. Normal
- B. Left sided heart failure
 - 1. description
 - 2. percussion notes
 - 3. transmitted sounds
 - 4. breath and sound abnormalities
- C. Emphysema
 - 1. description
 - 2. percussion notes
 - 3. transmitted sounds
 - 4. breath and sound abnormalities

D. Pneumonia / Consolidation

1. description
2. percussion note
3. transmitted sound
4. breath and sound abnormalities

E. Atelectasis

1. description
2. percussion note
3. transmitted sounds
4. breath sound abnormalities

F. Pneumothorax

1. description
2. percussion note
3. transmitted sounds
4. breath sound abnormalities

G. Bronchitis

1. description
2. percussion note
3. transmitted sounds
4. breath sound abnormalities

H. Asthma

1. description
2. percussion note
3. transmitted sounds
4. breath sound abnormalities

CHEST / BACK / LUNG LABORATORY

OBJECTIVES:

1. Inspect back for symmetry and presence of scoliosis. Note appearance of chest wall.
2. Palpate back for any tenderness and presence / absence of tactile fremitus. Determine diaphragmatic excursion and level. Note any CVA tenderness.
3. Percuss all lung fields.
4. Auscultate all lung fields.
5. Note any abnormalities.
6. List possible causes of abnormalities.

PULMONARY STUDY GUIDE

1. List the anatomical landmarks associated with each of the following:
 - A. First vertebral prominence
 - B. Lower border of the upper lobe posteriorly
 - C. Lower border of the lower lobe anteriorly
 - D. Trachea and main bronchi anterior and posterior
2. List the steps in the examination of the thorax and significance of abnormalities.
3. List the characteristics of the breath sounds.
4. Discuss the following thoracic abnormalities. List the effects on respiration and /or circulation.
 - A. Barrel chest
 - B. Funnel chest
 - C. Pigeon chest
 - D. Kyphoscoliosis
5. Discuss the causes of the following alterations in breath sounds and their significance:
 - A. Bronchial breath sounds
 - B. Egophony
 - C. Bronchophony
 - D. Whispered pectoriloquy
6. Discuss causes of the following added breath sounds and their significance:
 - A. Crackles
 - B. Wheezes
 - C. Pleural rubs
7. Discuss the physical findings in each of the following:
 - A. Congestive heart failure
 - B. Pleural fluid
 - C. Consolidation
 - D. Bronchitis
 - E. Emphysema
 - F. Pneumothorax

**PHYSICAL DIAGNOSIS
CARDIAC EXAMINATION**

GOAL

The student should know the essential of basic clinical cardiac examination.

OBJECTIVES:

The student will be able to...

- describe the functional anatomy of cardiac examination.
- specify the routine auscultation areas.
- descriptively review the normal cardiac cycle.
- describe and explain the characteristics of the normal heart sounds.
- describe the basic technique of cardiac auscultation.
- list and evaluate basic systolic and diastolic murmurs.
- list and describe basic extra-systolic and diastolic sounds.

PHYSICAL DIAGNOSIS

TOPIC OUTLINE: CLINICAL CARDIAC EXAMINATION

- I. REVIEW BASIC CARDIAC ANATOMY**
- II. REVIEW THE NORMAL CARDIAC CYCLE**
- III. CLINICAL CARDIAC EXAMINATION**

- A. Stethoscope
 - 1. Bell
 - 2. Diaphragm
- B. Physical characteristics of sound
 - 1. pitch - frequency
 - 2. loudness - intensity
 - 3. quality - harmonics
- C. Inspection and palpation
 - 1. orderly examination
 - 2. P.M.I.
- D. Areas of Auscultation
 - 1. Traditional
 - a. mitral
 - b. tricuspid
 - c. aortic
 - d. pulmonic
 - e. 3rd interspace - Erbs point
- E. Order of auscultation

IV. NORMAL HEART SOUNDS

A. First Heart Sound (S1) - Systolic

1. Pathophysiology
2. Components - 3
3. Location (where to listen) - optimum audibility
4. Splitting
5. Loudness

B. Second Heart Sound (S2) - Systolic

1. Pathophysiology
2. Components
3. Normal physiologic splitting
4. Persistent splitting (RBBB)
5. Wide / fixed splitting (ASD)
6. Reversed (paradoxical) splitting - aortic stenosis
7. Intensity variation
8. Intensity variation and significance
 - a. decreased A2 / increased P2
 - b. increased A2 / decreased P2

C. Third Heart Sound (S3) - Diastolic

1. Physiology
2. Normal S3
3. Pathological (Gallop) S3 - significance
4. Where and how to listen

D. Fourth Heart Sound (S4) - significance

1. Physiology
2. Normal S4

3. Pathological S4 - significance

4. Where and how to listen

V. MURMURS - CARDIAC

A. Mechanisms of Heart Murmurs

1. Anatomic basis

B. Basic Classification Points

1. location

2. radiation

3. intensity

a. grades 1-6

4. pitch

5. quality

VI. SYSTOLIC MURMURS

A. Mid-systolic Ejection Murmurs

1. General

a. Crescendo

b. Decrescendo

2. Innocent systolic murmur

3. Aortic Stenosis

a. pathophysiology

b. location / radiation / intensity / pitch / quality

c. associated signs

d. vs. Syphilitic dilatation aortic root

4. Functional Murmurs

a. anemia

- b. hyperthyroidism

B. Parasystolic Regurgitant Murmurs

- 1. General
- 2. Mitral regurgitation
 - a. location / radiation / intensity / pitch / quality
 - b. associated signs
 - c. pathophysiology

VII. DIASTOLIC MURMUR

A. General

- 1. "Rumbling" murmurs - A.V. valve incompetence
 - a. techniques - how to listen
 - b. intensity / pitch / quality
 - c. timing in cardiac cycle
- 2. Semilunar valve incompetence
 - a. decrescendo
 - b. technique - how to listen
 - c. intensity / pitch / quality
 - d. timing in cardiac cycle

B. Mitral Stenosis

- 1. pathophysiology
- 2. location / radiation / intensity / pitch / quality
- 3. associated findings

C. Aortic Regurgitation

- 1. pathophysiology
- 2. location / radiation / intensity / pitch / quality

3. associated findings

IX. PALPATING THRILLS - SUMMARY

DISORDERS

Mitral stenosis
Mitral regurgitation
Aortic stenosis

X. AUGMENTATION MANEUVERS

A. Position changes (Muller)

1. Squatting from standing
2. Sitting or standing from supine position

B. Valsalva Maneuver

1. 4 phases
2. Clinical value

XI. TAPE - HEART SOUNDS

CARDIAC LABORATORY

OBJECTIVES:

1. Inspect chest wall for any pulsations
2. Palpate to note thrills and point of maximum impulse (PMI)
3. Auscultate all areas. Note any murmurs. Describe normal heart sounds and the timing of the heart sounds in the cardiac cycle.
4. List causes of systolic and diastolic murmurs. Describe location in the cardiac cycle. The following murmurs are to be known by the student in detail:
 - A. Aortic Stenosis / Insufficiency
 - B. Mitral Stenosis / Insufficiency

CARDIOVASCULAR STUDY GUIDE

1. Localize the underlying chambers of the heart on the anterior chest wall.
2. Correlate the events in the cardiac cycle with the left ventricular pressure curve.
3. Correlate the events in the cardiac cycle with ECG findings.
4. List the four heart sounds. Correlate them with the cardiac cycle. List whether the sound is normal or abnormal. Note if split is present and whether it is normal or abnormal.
5. Discuss the examination of the heart. Note the locations in which auscultation should be done and what heart sounds are found there.
6. Discuss the examination of the jugular veins and note the value which is normal.
7. List the grading of murmurs.
8. List the significance of the following:
 - A. Accentuated S1
 - B. Diminished S1
 - C. Split S1
 - D. Split S2
 - E. Wide splitting of S2
 - F. Fixed splitting of S2
 - G. Paradoxical splitting of S2
9. Discuss the following murmurs and the physical findings associated with each and the cause of each murmur:
 - A. Aortic stenosis
 - B. Mitral regurgitation
 - C. Aortic regurgitation
 - D. Mitral stenosis

PHYSICAL DIAGNOSIS

TOPIC OUTLINE: FUNDAMENTALS OF ABDOMINAL EXAMINATION

GOAL:

The student should understand the fundamentals of abdominal examination and be knowledgeable in a basic symptomatic approach to acute abdominal pathology.

OBJECTIVES:

The student will be able to....

- explain the anatomic basis of common significant abdominal referred pain locations.
- list and describe the basic techniques of the external abdominal examination (inspection, palpation, auscultation).
- describe routine examination of the liver and spleen.
- list common signs and symptoms of concerns in the gastrointestinal interview.
- differentiate disease entities utilizing a grouping of symptoms approach toward diagnosis of the acute abdomen and list example groupings.

PHYSICAL DIAGNOSIS

TOPIC OUTLINE: FUNDAMENTALS OF ABDOMINAL EXAMINATION

- I. NECESSITY OF EARLY DIAGNOSIS
- II. REVIEW OF ANATOMY - APPLIED
 - A. Relationship of viscera with the diaphragm
 - B. Topographic divisions of the abdomen
 - C. Phrenic nerve irritation and referred shoulder pain
- III. PATIENT EXAMINATION - EXTERNAL ABDOMINAL
 - A. Inspection
 - 1. Room conditions - patient position
 - 2. Contour abdomen
 - 3. Skin
 - a. striae
 - b. scars
 - 4. Engorged veins - reversal of flow
(significance in inferior and superior vena-caval obstruction)
 - 5. Visible peristalsis
 - 6. Visible pulsations of aorta
 - 7. Symmetry
 - 8. Umbilicus
 - a. variations
 - 9. Color - Jaundice
 - B. Auscultations
 - 1. Techniques - diaphragm
 - 2. Locations - arteries
 - a. renal arteries

- b. aorta
- c. iliac and femoral
- 3. Bruits and Murmurs - Arterial
 - a. Location - abdominal aorta
 - b. CAUSES:
 - 1. Aortic Aneurysm (NOTE: The absence of a bruit never excludes the presence of an aortic aneurysm).
 - 2. Renal artery stenosis and secondary to HTN.
 - c. Hepatic artery bruit - significance
- 4. Peristaltic Sounds
 - a. Auscultative locale -- below and right of umbilicus
 - b. Normal
 - click
 - gurgles
 - borborygmi
 - c. decreased bowel sounds - primary etiologies
 - d. increased bowel sounds - primary etiologies
- 5. Friction Rubs
 - a. significance
 - b. location

C. Percussion

- 1. Normal viscera
 - a. Solid: liver
 - spleen
 - kidneys
 - adrenals
 - pancreas

- ovaries
- uterus
- fluid (ascites)

- b. Hollow: stomach
- small intestine
 - colon
 - gall bladder
 - urinary bladder

2. Technique - Liver

- all 4 quadrants
- a. from tympany to -- dullness
- b. midclavicular line --bi-directional
- c. normal liver "heights"
- midsternal vs midclavicular
- d. pathology

3. Technique - spleen

- a. location
- b. tympany -- dullness
- c. pathology

4. Special Technique - Ascites

- a. definition
- b. dependent dullness
- c. positional shifting dullness
- d. fluid wave

5. Light palpation

- a. direct tenderness
- b. rebound tenderness
- peritoneal inflammation
- c. rigidity - voluntary vs. involuntary
 - 1. significance
 - neoplasm
 - peritoneal irritation

- d. cutaneous hyperesthesia
- 6. Deeper Palpation
 - a. general hand positions and techniques
 - masses, pulsations, contours, organs, and tenderness
 - b. liver - RUQ
 - hooking technique with inspiration
 - c. spleen - LUQ
 - location and obliquity
 - palpation technique
 - d. Right and left kidneys (RUQ and LUQ)
 - locations
 - capture technique
 - e. Aorta
 - location
 - lateral expansion / pathological
- 7. Ancillary
 - a. determination of idiopathic rigidity
 - significance
 - technique
 - b. Obturator test (thigh rotation test)
 - significance
 - technique

BASIC ACUTE ABDOMINAL DISEASE DIFFERENTIAL

- A. Common signs of concern in disease
 - 1. hemorrhage
 - 2. vomiting
 - 3. acute diarrhea
 - 4. chronic diarrhea
 - 5. hematochezia vs. melena
 - 6. constipation
- B. Key Symptoms - Acute abdominal pain
 - 1. Classic locations and disease entities
 - a. Appendicitis - R LQ and McBurneys Pt.
 - b. Diverticulitis - LLQ

- c. Pancreatitis-Central-Epigastic-and RLQ
- d. Cholecystitis-RUQ
- e. Acute Pyelonephritis-RUQ
- f. P.I.D.
- g. Perforated Peptic Ulcer-Epigastic

C. Grouping of Symptoms - Method of Diagnosis in the Acute Abdomen

- 1. Abdominal pain only
 - a. character
 - b. appendicitis vs. obstruction of transverse colon
- 2. Central Abdominal Pain
 - a. appendicitis (acute-open umbilical early)
 - b. initial obstruction small intestine
 - c. acute pancreatitis

WARNING: R/O MI, ANGINA, AND MESENTERIC THROMBOSIS

- 3. Severe Central Pain and Shock (Pain + Pallor, low temperature and low blood pressure and no rigidity)
 - a. pancreatitis (acute)
 - b. dissecting aneurysm
 - c. coronary thrombosis
 - d. mesenteric thrombosis
- 4. Pain with repeated vomiting and increasing distention and constipation
 - a. intestinal obstruction (small) and /or spreading peritonitis
- 5. Pain without vomiting but with increased distention and constipation
 - a. large bowel obstruction / especially sigmoid colon

REVIEW FEATURES - ACUTE APPENDICITIS

- A. General - risks
- B. History
 - 1. gastritis / flatulence - days prior to attack
 - 2. unusual bowel irregularities
- C. Symptoms and Local Signs
 - 1. pain: epigastric, then right iliac
 - 2. vomiting, nausea, loss of appetite
 - 3. local deep tenderness (per abdomen or per rectum)
 - 4. local rigidity of muscles
 - a. tests (as previously described)
 - 5. local distention
 - 6. superficial hyperesthesia
 - 7. fever
 - 8. constipation

ABDOMEN LABORATORY

OBJECTIVES:

1. Inspect. Note any abnormalities of the skin, masses, or contour of the abdomen.
2. Auscultate:
 - A. Note the presence or absence of bowel sounds. List the normal range.
 - B. Listen for bruits or friction rubs over the liver, aorta, renal, iliac and femoral arteries
 - C. List pathologies of bruits and rubs
3. Percuss. Note the size of the liver and list its' normal range. Note any enlargement spleen or liver.
4. Palpate the abdomen lightly and deeply. Note any tenderness. List possible causes for any tenderness.
5. List the special test for appendicitis, pancreatitis, cholecystitis and diverticulitis. Perform each on your partner.

ABDOMEN STUDY GUIDE

1. Review the anatomy of the abdominal wall and the location of the abdominal contents.
2. Discuss the general approach and steps in the examination of the abdominal contents.
3. Discuss the maneuvers for ascites. List the specificity of each.
4. Discuss the following:
 - A. Umbilical hernia
 - B. Diastasis of the recti
 - C. Hernia of the linea alba
 - D. Incisional hernia
5. List the findings in each of the following:
 - A. Fat abdomen
 - B. Gaseous abdomen
 - C. Tumor of the abdomen
 - D. Pregnancy
6. Discuss the following: If abnormal, discuss the significance.
 - A. Bowel sounds
 - B. Bruits
 - C. Friction rubs
 - D. Venous hum
7. Distinguish abdominal wall tenderness from visceral tenderness on physical examination.
8. Distinguish disease of the thorax or pelvis from abdominal tenderness.
9. List the areas of tenderness and possible associated signs of the following:
 - A. Acute cholecystitis
 - B. Acute pancreatitis
 - C. Acute diverticulitis
10. List the signs and symptoms associated with appendicitis. Give the classical history. Name each of the special tests and discuss how each is performed.
11. Distinguish real from apparent liver enlargement.
12. List the significance of the following:
 - A. Smooth large non-tender liver
 - B. Smooth larger tender liver
 - C. Large irregular liver

PHYSICAL DIAGNOSIS

TOPIC: EXAMINATION OF BREAST

GOAL:

The student should have a reasonable approach to examination of the breast.

OBJECTIVES:

The student will be able to...

- illustrate basic anatomy of the female breast with particular emphasis on lymph node location.
- list the key components of breast inspection.
- describe the basic technique of breast palpation.
- enumerate important abnormalities of the breast.

PHYSICAL DIAGNOSIS

TOPIC OUTLINE: EXAMINATION OF BREAST

- I. THE BREAST (and axilla)
 - A. Review normal anatomy
 1. external
 2. cross sectional
 - a. suspensory / Cooper's ligament
 - b. ducts
 - c. pectoral muscle and fascia
 3. frontal - quadrants
 - B. Review - lymph system breast and axillae
 1. lymph node locations
 - a. pectoral
 - b. subscapular
 - c. lateral
 - d. central and deep
 - e. supra and infra-clavicular
 2. normal lymphatic flow from breast
 - C. Breast Examination
 1. patient preparation
 2. inspection
 - a. symmetry and size
 - b. contours / flattening / dimpling
 - c. skin color
 - d. venous pattern
 - e. nipples
 - discharge
 - miscellaneous
 - f. retraction
 3. Position
 - a. patients arms overhead
 - breasts rise symmetrically
 - dimpling
 - b. leaning forward

- c. hands against hips
- 4. Palpation - Technique in order:
 - a. nipple - discharge
 - b. work outward into quadrants
 - c. underarms
 - d. sitting and lying down
 - e. raise arms

D. ABNORMALITIES AND DISEASE

- 1. Inflammatory diseases
- 2. Fibrocystic disease
 - a. description and general information
 - b. findings
 - appearance
- 3. Carcinoma
 - a. general information
 - b. epidemiology
 - c. risk factor
 - family history
 - nulliparous
 - late pregnancy
 - d. general exam features
 - location (quadrant - often U.O.)
 - age
 - number
 - consistency
 - mobility, shape, symmetry (nipple deviation)
 - tenderness
 - retraction signs / dimpling
 - delineation
 - additional vascular
 - edema
 - venous prominence

BREAST EXAMINATION STUDY GUIDE

1. Discuss the basic anatomy of the breast and underlying musculature.
2. Discuss the lymphatic drainage of the breast.
3. Discuss the two approaches to breast and axillary examination.
4. List the visible signs of breast cancer and the cause of each.
5. Discuss the following abnormalities of the breast / nipple / areola:
 - A. Nipple inversion / flattening / retraction
 - B. Nipple pointing
 - C. Edema of the nipple
 - D. Paget's disease
 - E. Nipple discharge
 - F. Supernumerary breast
6. Discuss gynecomastia and cancer of the male breast.
Note the clinical findings and associated pathology.

BREAST LABORATORY

1. Inspect breast for any abnormal contours, masses or dermatitis.
2. Palpate to identify all masses in model. Note the consistency and palpate to identify delineation between the mass and underlying tissue.
3. List the visible signs of breast cancer.

PHYSICAL DIAGNOSIS

TOPIC: EXAMINATION OF THE FEMALE GENITALIA

GOAL:

The student should have a reasonable approach to examination of the female genitalia.

OBJECTIVES:

The student will be able to:

illustrate basic anatomy of the female genitalia

list the key components inspection of the female genitalia

describe the basic technique of examination of the female genitalia

enumerate important abnormalities of the female genitalia

PHYSICAL DIAGNOSIS

TOPIC OUTLINE: EXAMINATION OF FEMALE GENITALIA

- I. The Female Genitalia
 - A. Review normal anatomy
 1. External
 2. Internal
 - B. General approach
 1. External examination
 2. Internal examination
 - a. speculum use
 - b. internal organs
vaginal vault
cervix
bimanual
ovaries
 - C. Abnormalities
 1. Lesions of the vulva
 2. Abnormalities of the cervix
 3. Vaginitis
 4. Abnormalities of position of the uterus
 5. Adnexal masses

STUDY GUIDE FOR FEMALE GENITALIA

1. Discuss the basic anatomy of the female genitalia.
2. Discuss the general approach to an internal and external examination. Know the equipment needed to perform the examination.
3. Describe how to perform the PAP smear.
4. Discuss the following:
 - A. Lesions of the vulva
 - B. Bulges and swelling of the vulva, vagina and urethra
 - C. Variations in the cervix
 - D. Abnormalities of the cervix
 - E. Vaginitis
 - F. Adnexal masses

PHYSICAL DIAGNOSIS

TOPIC: MALE GENITALIA

GOAL:

The student should have a reasonable approach to examination of the male genitalia.

OBJECTIVES:

The student will be able to:

- illustrate basic anatomy of male genitalia
- list the key components to inspection of male genitalia
- describe the basic technique of palpating male genitalia
- enumerate important abnormalities of male genitalia

PHYSICAL DIAGNOSIS

TOPIC OUTLINE: EXAMINATION OF THE MALE GENITALIA

I. MALE GENITALIA

- A. Review normal anatomy
- B. Examination
 - 1. Inspection
 - The penis
 - The scrotum and its contents
 - 2. Palpation
 - The penis
 - The scrotum and its contents
 - Hernias
- C. Abnormalities
 - 1. Penis
 - 2. Hernias
 - 3. Scrotum

STUDY GUIDE FOR MALE GENITALIA

1. Discuss the basic anatomy of the male genitalia.
2. Discuss the general approach to the physical examination of the male genitalia.
3. Discuss the examination for hernias.
4. Discuss the following:
 - A. Abnormalities of the penis
 - B. Abnormalities of the scrotum
 - C. Course and presentation of hernias in the groin
 - D. Differentiation of hernias in the groin

MALE GENITALIA LABORATORY

OBJECTIVES:

1. Inspect the scrotum for any visible signs of abnormalities or masses.
2. Palpate the scrotum and testes of the model for any abnormalities.
3. List the signs of testicular carcinoma.

PHYSICAL DIAGNOSIS II

LOWER EXTREMITY

**Summer Semester
2004**

**Ohio College of Podiatric Medicine
Department of Podiatric Medicine**

COURSE COORDINATOR: Bryan Caldwell, DPM, MS

RATIONALE

A disease is a statement of medical understanding of a biologic or psychological abnormality. The patient's reaction to disease is mainly a subjective one and is reflected in the answers to the physician's questions, the history. Disease leaves objective signs as well, and it is the physician's task to search for them. The method employed is **physical examination** and the tools are those of **physical diagnosis**.

In pathology one studies disease. In clinical training one works with illness. Illness represents the totality of signs and symptoms that together characterize a single patient's response. Physical diagnosis, therefore, represents the bridge between the study of disease and the management of illness.

The focus of this course will be on evaluation of the **lower extremities**. In order to be a competent medical and surgical specialist in podiatry a student must have a firm data base in diagnostics as well as competency in performance of physical examination skills. In keeping with the philosophy that we are training physicians, the entire body is included in the scope of this course. All information from the first semester will be redefined and skills sharpened. The culmination of this course will be a full history and physical examination.

THE GOAL OF THE COURSE

At the end of the course the student will be able to conduct a medical interview (patient history), perform a lower extremity physical examination, and generate a differential diagnosis.

COURSE OBJECTIVES

At the conclusion of this course, the student will:

1. Know how to obtain a patient history including :
 - a. The chief complaint
 - b. The history of the present illness
 - c. The past medical history
 - d. Family history
 - e. Social History
 - f. The review of systems
2. Be able to perform a lower extremity physical examination including:
 - a. Vital signs
 - b. Vascular examination
 - c. Neurological examination
 - d. Dematological examination
 - e. Musculoskeletal examination
3. Demonstrate the components of a lower extremity physical examination.
4. Be able to write a history and physical examination and a progress note utilizing the format of the "Problem Oriented Medical Record".
5. Appreciate the importance of a complete and accurate medical record.

For detailed goals and objectives for lectures, please refer to the " Master Syllabus " in the library.

Time of class

This course will meet on weekdays from 1:30 to 3:30 p.m.

The course coordinator for this course is Bryan Caldwell, DPM. Office hours are by appointment.

Learning Resources

Assigned:

Textbook of Physical Diagnosis History and Examination, MH Swartz
Fourth Edition, Saunders 2002

The Orthopaedic Physical Examination, B Reider
Saunders 1999

Additional Reading:

Mosby's Physical Examination Handbook, HM Seidel et al.
Third Edition, Mosby 2003

INSTRUCTIONAL STRATEGY

This course meets every day from 1:30- 3:30 pm. Attendance at lectures is mandatory. Attendance at all lab sessions is mandatory. **Unexcused absence from any lab session will result in failure of the course.** Changing lab sections is not permitted without prior authorization by the course coordinator.

The course consists of a series of lectures and laboratory sessions. All laboratory sessions are designed to help ensure that the students can adequately perform patient examinations.

A selection of assigned tapes and/or reading materials will be kept on reserve in the library. Students are responsible for assigned reading or viewing.

STUDENT EVALUATION

- A. The course will consist of four (4) lecture sessions and two (2) lab sessions. The course coordinator is Dr. Bryan Caldwell.
- B. The course will meet every day for 2 hours per session during the Summer Semester.
- C. Attendance Is Expected of All Students.
- D. There will be one lecture examination worth 60 points. There will also be a practical examination worth 40 points.

Each question will be of equal value in determining the final grade.

The final grade will be based on the TOTAL of all points earned in the course as well as attendance in all laboratory sessions and satisfactory demonstration of all clinical skills.

- E. The final grade will be determined utilizing the following grade scale:

A	-	90-100%
B	-	80-89%
C	-	70-79%
F	-	0-69% FAILURE

The course coordinator has the prerogative of scaling scores for an individual course.

- F. **Make-up examinations** will be given in accordance with the policies and procedures outlined in the most current Student Handbook. The format for make-up exams will be essay and oral/practical exam.
- G. Any student who misses an examination without an excused absence will receive a "0" for that exam.

- H. **Re-Examination** will be given in accordance with the policies and procedures outlined in the most current Student Handbook.
- I. **It is the responsibility of the individual student to be thoroughly knowledgeable of all policies and procedures outlined in the Student Handbook.**
- J. Occasionally, there may be discrepancies between material presented in class and outside readings (assigned and not assigned). *In this event, classroom presentation will **ALWAYS** take precedence.*
- Additionally, instructors will not be responsible for:
- a) errors in omission or commission in student note services
 - b) any confusion over lecture material, even when confusing or equivocal in nature, **if it is not brought to the attention of either the instructor or course coordinator prior to the examination.**
- K. Any time a student is experiencing academic difficulty, he/she should seek appropriate guidance from the course coordinator. **PLEASE ASK FOR HELP WHEN YOU NEED IT!**

Required Instruments

Each student is responsible for having:

- 1) Stethoscope
- 2) Watch with second hand
- 3) Tape Measure
- 4) 5.07 Semmes Weinstein monofilament
- 5) Tuning fork
- 6) Neuro-Reflex Hammer
- 7) Sphygmomanometer

PREREQUISITES

It is expected that the student have a firm understanding of the anatomy of the lower extremity. This is essential in the formulation of the differential diagnosis of disease states of the lower extremity. Therefore, the names and attachment points of all muscles governing the function of the thighs, legs and feet; the arterial supply to the lower limbs; the nerve distribution to the lower limbs and their associated dermatomes; and the skeletal components of the lower limbs are all fair game for test questions. It is highly recommended, therefore, that the student review their lower extremity anatomy notes **prior to each section of this class and especially prior to each examination.**

Course Schedule

PHYSICAL DIAGNOSIS 1ST YEAR 2004 SUMMER CLASS

June 7	CALDWELL	NEURO LECTURE
June 9	CALDWELL	VASCULAR LECTURE
June 21	CALDWELL	NEUROVASCULAR LAB GROUP A
June 23	CALDWELL	NEUROVASCULAR LAB GROUP B
June 28	CALDWELL	DERM LECTURE
June 30	SPENCER	MUSCULOSKELETAL LECTURE
July 7	SPENCER	MUSCULOSKELETAL LAB GROUP A AND B
July 12	CALDWELL/SPENCER	PRACTICAL EXAM GROUP A
July 14	CALDWELL/SPENCER	PRACTICAL EXAM GROUP B
July 19		FINAL EXAM

Vascular Exam

Goal of Major Topic:

1. The student should comprehend the basic elements of the routine vascular examination.
2. The student should have the ability to diagnose vascular disease by clinical exam, laboratory tests, and/or diagnostic procedures.

Assigned Reading: CHAPTER 14, Textbook of Physical Diagnosis History and Examination, MH Swartz

Objectives:

1. List and understand the components of a lower extremity vascular evaluation.
 - a. Vascular History
 - b. Vascular Exam
 - i. Inspection
 - ii. Palpation of pulses
 - iii. CFT, Elevation - Dependency/Venous fill-time
 - iv. Evaluation of edema
 - v. Identification of bruits and aneurysms
2. Ability to interpret non-invasive and invasive vascular tests
3. List signs and symptoms of arterial insufficiency
4. List signs and symptoms of venous insufficiency, DVT, and lymphatic disease

Topic Outline:

I. Comprehensive Vascular Evaluation

A. General History - Symptoms and Signs:

1. Arteries: Claudication
2. Veins: Prominent veins; swelling; clots
3. Capillaries: Petechiae, Telangectasias
4. Lymphatics: Morning edema; no large veins
5. Nerves: Pain at rest; paresthesias
6. Muscles: Nocturnal cramps
7. Spasms: Color changes/temperature related

B. History of Vascular Illness

C. Past Medical History - Check for:

1. Diseases

- a. Diabetes
- b. Angina
- c. Hypertension
- d. CAD
- e. Toxic States/Sepsis
- f. Connective Tissue Diseases
- g. Hypercholesterolemia
- h. Vasculitis
- i. Sickle cell disease

D. Infections

E. Injuries

F. Healing Rate

G . Drugs and Chemicals

1. Tobacco

H. Family History

1. Diabetes
2. Stroke
3. Angina
4. Xanthomatosis and Hypercholesterolemia
5. Arthritis
6. CAD
7. Sickle cell disease

I. Claudication

1. Leg
2. Foot
3. Differentiation: Vascular vs. Neurogenic

K. Routine Vascular Examination of Lower Extremities

1. Inspection and Palpation: Observe the lower extremity noting:

- a. Size and symmetry
- b. Color. Note the presence of:
 - * Rubor
 - * Cyanosis
- c. Texture of Skin
 - a. onion skin
 - b. induration
- d. Hair Distribution
- e. Nails
- f. Lesions, ulcerations or scars
- g. Skin temperature

2. Pulses

- a. Dorsalis Pedis Pulse
 - b. Posterior tibial pulse
 - c. Lateral tarsal pulse
 - d. Popliteal pulse
 - e. Femoral pulse
- Grading scales for arterial pulsation vary.

- 0/4 absent
- +1/4 barely palpable
- +2/4 normal
- +3/4 strong
- +4/4 bounding

f. Any bruits or thrills - definitions

3. Lymph nodes

4. Skin Turgor

5. Elevation - Dependency Test / Venous Filling Time

6. Capillary Filling Time/Subcapillary Venous Plexus Filling Time

7. Veins

8. Edema

- a. Presence, location and distribution
- b. Character, pitting or non-pitting

c. Grading scale for pitting edema

9. Homan's Sign

L. Non-invasive and invasive vascular testing of lower extremities

1. Ankle-brachial index
2. Segmental Blood pressures
3. Photoplethysmography
4. Duplex doppler scan
5. MRA
6. Pulse volume recordings
7. Arteriograms/venograms/lymphoscintigraphy

Neurological Exam

Goal of Major Topic:

The student will be knowledgeable of the components of the lower extremity neurological examination.

Assigned Reading: Chapter 20 Textbook of Physical Diagnosis History and Examination, MH Swartz

Objectives:

1. The student will be able to:

- a. list and describe the key components of neurological gait analysis.
- b. list and describe two (2) ancillary gait exams
- c. enumerate the distinctive features of the common pathological gaits
- d. explain the clinical significance of proximal vs. distal muscle weakness
- e. list and describe the basic techniques of the lower extremity motor examination including muscle tone.
- f. list and describe the ancillary methods of eliciting a plantar response.
- g. compare and contrast upper motor neuron lesions with lower motor neuron lesions.
- h. diagram the lower extremity sensory dermatomes and cutaneous nerves.
- i. list and describe as well as apply the techniques of the basic lower extremity sensory examination
- j. know how to perform and interpret the tests of cerebellar function.
- k. develop the ability to diagnose neurological disease when given case studies.
- l. understand basic neuroanatomy and how it relates to diagnosis of neurological disease.
- m. explain the importance of the peripheral autonomic nervous system and its component parts.

Physical Examination of the Nervous System - Lower Extremity

I. Anatomy and Physiology

The reflex arc

To elicit a muscle stretch reflex one briskly taps the tendon of a *partially stretched* muscle. By stretching the muscle further, such a tap stimulates special sensory endings in the muscle and generates an impulse that travels up each of many afferent nerve fibers to the spinal cord.

Motor pathways

The spinomuscular Level

The anterior horn cell is the "final common pathway" through which all nervous impulses from higher centers must pass to reach the myoneural junction & influence striated muscle.

The Corticospinal (pyramidal) level

Motor Cortex → Brainstem (fibers cross over in the medulla) → Spinal Cord → Anterior Horn Cells → Muscles

Both corticospinal and corticobulbar neurons are called "Upper Motor Neurons".

The Extrapyramidal Level

The Cerebellum

coordinates muscular activity (voluntary movement is normal or slightly impaired)

Sensory pathways

- 1) lateral spinothalamic tract
- 2) posterior column
- 3) anterior spinothalamic tract

Dermatomes (a dermatome is a band of skin innervated by the sensory nerve root of a single spinal segment)

Cutaneous Nerves
Changes with age

II. Techniques of examination

- 1) mental status and speech
- 2) cranial nerves
- 3) motor system
- 4) sensory system
- 5) reflexes

Motor System

Muscle Tone

Muscle Strength

Muscle strength grading

- 0 No muscular contraction detected
- 1 A barely detectable flicker or trace of contraction
- 2 Active movement of the body part with gravity eliminated
- 3 Active movement against gravity
- 4 Active movement against gravity & some resistance
- 5 Active movement against full resistance without evident fatigue

Coordination - examination of cerebellar function (remember that all components of the motor system play into the performance of smooth & accurate muscular activity)

Gait assessment

Tandem walking assessment

Romberg's test (actually a test of proprioception & therefore posterior column disease)

Hop in place or shallow knee bend

Lower extremity dystaxia : a) heel to shin b) rapid rhythmic alternating movements

Point -to-point Testing

Sensory System

1) **Pain** (analgesia, hypalgesia, & hyperalgesia) & **Temperature**

2) **Light Touch** (Anesthesia, hypesthesia, & hyperesthesia)

3) **Vibration**- often the first sensation to be lost in a peripheral neuropathy

4) **Position**

5) **Discriminative Sensations** - several additional maneuvers test the ability of the **sensory cortex**

1) stereognosis

2) 2 point discrimination

3) point localization

4) extinction

Abates sign

Semmes-Weinstein monofilaments: 4.17 5.07(protective) 6.10

Reflexes: patellar & Achilles

Graded reflex response

- 4+ very brisk, hyperactive with clonus, indicative of UMN disease such as CVA
- 3+ brisker than average, may indicate UMN disease
- 2+ average, normal
- 1+ diminished , low normal, may indicate LMN disease
- 0 no response, LMN disease such as **spinal cord injury**

Plantar response

Abnormal response: Dorsiflexion of hallux & fanning of all toes (+ Babinski)

Normal response: plantarflexion of all toes & sometimes the whole foot

Ancillary Extensor Toe Sign Methods - Chaddock, Oppenheim, Gordon, Stransky

Clonus - rhythmic alternation of contractions of a set of muscles (sustained clonus indicates **UMN disease**)

III. Abnormalities of Gait and Posture

spastic hemiparesis

Steppage (foot drop)

Scissors

Parkinsonian

Cerebellar ataxia

Waddling

IV. Differentiation of Motor Dysfunctions (see Bates *A Guide to Physical Examination*)

1) **Sensory Neuron**

2) **Lower Motor Neuron**

3) **Corticospinal Tract**

4) **Extrapyramidal System**

5) **Cerebellar System**

V. Patterns of Sensory Loss (see Bates *A Guide to Physical Examination*)

1) **Peripheral Nerve**

2) **Multiple Peripheral Nerve**

3) **Sensory Root**

4) **Central Cord Lesion**

5) **Posterior Column**

6) **Half of Cord Transection - *Brown-Sequard***

7) **Entire Cord Transection**

8) **Thalamic Lesion**

9) **Lesion of Sensory Cortex**

Musculoskeletal Exam

Goal of Major Topic

At the completion of this module the student will be knowledgeable of the components of the lower extremity musculoskeletal exam.

Assigned Reading: CHAPTER 19 Textbook of Physical Diagnosis History and Examination, MH Swartz
CHAPTER 7 The Orthopaedic Physical Examination, B Reider

Objectives:

1. The student will be able to:
 - a. Describe the components of the general lower extremity musculoskeletal examination.
 - b. List the grading scale for muscle strength testing of the lower extremity.
 - c. List the major muscle of muscle groups that are tested during the lower extremity examination.
 - d. Gross comparison of the range of motion of joints tested during the lower extremity examination.
 - e. Describe the procedure and clinical significance of the special examination techniques for the ankle.
 - f. Describe the procedure and clinical significance of the special examination techniques for the knee.
 - g. Describe the technique for evaluation of leg length.

Topic Outline

I. General Observations

- A. Observe symmetry, shape and function as the patient ambulates, stands, or sits.
- B. Record the presence of edema.
- C. Record local tenderness.
- D. Record local erythema.
- E. Record joint crepitus
- F. Note deformities of bone, muscle, or joints.
- G. Observe muscle mass and compare upper and lower extremities:
 1. Note atrophy
 2. Note hypertrophy
- H. Note any masses - soft tissue, muscular, and bone as well as location, size, and mobility.
- I. Measure the leg length as determined by the distance from the ASIS to the medial malleolus, or the greater trochanter to the medial malleolus.

II. Muscle Exam

A. Grading Scale - strength 0/5 - +5/+5

B. Hip

1. Flexion: Iliopsoas M.
2. Extension: Gluteus Maximus M.
3. Abduction: Gluteus Medius M.
4. Adduction: Adductor Longus, Adductor Brevis
5. External Rotation - lateral rotators and Gluteus Maximus.
6. Internal Rotation - Gluteus Minimus

C. Knee

1. Flexion
 - a. Semimembranosus
 - b. Semitendinosus
 - c. Biceps femoris
2. Extension
 - a. Quadriceps femoris

D. Ankle

1. Dorsiflexion
2. Plantar Flexion

E. Foot - STJ and MTJ

1. Inversion: Tibialis Posterior, Tibialis Anterior
2. Eversion: Peroneus Longus, Peroneus Brevis

F. Digits

1. IPJ Flexion: Flexor Digitorum Longus, Flexor Digitorum Brevis
2. MPJ Flexion: Lumbricales, Flexor Hallucis Brevis
3. MPJ and IPJ Extension: Extensor Digitorum Longus, Extensor Digitorum Brevis, Extensor Hallucis Longus.

III. Range of Motion

A. Hip

1. 90-degree Flexion leg straight
2. 15 degree Extension leg straight
3. 120 degree Flexion with Knee Flexed
4. 45 degree abduction
5. 30 degree adduction
6. 40-45 degree Internal rotation
7. 40-45 degree External rotation
8. Decreased external rotation (usually) with hip extended.

B. Knee

1. 130 degree Flexion
2. 0 degree Extension
3. 15 degree Hyperextension

C. Ankle Joint

1. 20-25 degree Dorsiflexion
2. 45 degree Plantarflexion

D. Subtalar Joint

1. 30 degree Inversion
2. 20 degree Eversion

IV. Special Exam techniques involving the knee:

- A. Medial and lateral collateral ligament stability
- B. McMurray's Test for menisci
- C. Drawers sign for anterior and posterior cruciate ligaments.
- D. Patella Femoral Grinding Test for Chondromalacia
- E. Floating patella or Apprehension Test
- F. Apley's Compression and Distraction Test

Physical Examination of the Musculoskeletal System

Categories:

1) **Systemic Disease**

2) **Local Disease**

Correlate clinical findings with lab tests (ESR, CRP, ANA, Etc.) or medical imaging (i.e. plain film radiographs, CT scan, or MRI) when appropriate.

Parts of the Musculoskeletal System

Bone

Skeletal muscle

Ligaments

Tendons

Cartilage

Basic functional unit of the musculoskeletal system: The Joint

Capsule surrounds the joint by attaching to bones on either side of the joint within the capsule (turf toe)

Synovial fluid plays a role in joint lubrication and nourishment of the articular cartilage

Bursa can form at any area of repeated irritation when inflamed, this is known as bursitis.

common areas for acute bursitis: HAV, adductovarus 5th, tailor's bunion

Review of specific symptoms: pain, weakness, deformity, limitation of motion, stiffness,& joint clicking

Musculoskeletal Examination of the Ankle and Foot

Inspection:

- 1) look for abnormal or asymmetrical wear patterns on shoes
- 2) assess gait
- 3) inspect in sequential fashion : toes, forefoot, midfoot, hindfoot
- 4) inspect for callosities

Palpation:

- 1) Bony Landmarks
- 2) Soft Tissues

Range of Motion:

Active and Passive

Special Tests:

Lateral Instability:

Anterior Drawer Sign - evaluation for complete tear of **anterior talofibular ligament**

Talar Tilt Test - talus tilts in mortise due to tear of **anterior talofibular and calcaneofibular ligaments**

Medial Instability:

Achilles Tendon Rupture:

Thompson's test.

Gastroc - Soleus Contracture (equinus):
Silfverskiold Test

Flexible Pes Planus:
Heubscher's test
Jack's test

Muscle Testing of the Lower Extremity

1. Stabilization
2. Optimal Test Position
3. Differentiation

Flexor Hallucis Longus

Flexor Hallucis Brevis

Flexor Digitorum Longus

Flexor Digitorum Brevis

Lumbricales

Extensors

Extensor Hallucis Longus

Peroneus Tertius

Peroneus Brevis & Longus

Tibialis Posterior

Tibialis Anterior

Gastrocnemius

Soleus

Biceps Femoris

Semimembranosis/Semitendinosis

Gluteus Maximus

Sartorius

Quadriceps

External Rotators

Internal Rotators

Dermatological Exam

Goal of Major Topic

At the completion of this session, the student will be familiar with the components of the basic dermatologic examination emphasizing morphological identification.

Assigned Reading: CHAPTER 7, Textbook of Physical Diagnosis History and Examination, MH Swartz
Figures are very important.

Objectives

1. The student will be able to:
 - a. list the distinguishing features of the general dermatologic history
 - b. ask key questions relating to the history of a particular skin lesion
 - c. list and describe methods of the general integumentary examination
 - d. recognize specific types of skin lesions by their anatomic distribution and group configuration
 - e. compare and contrast distinguishing features of the various primary and consecutive lesions
 - f. describe the normal nail unit and list common nail pathologies
 - g. describe and list indications for the diagnostic aids and manipulations

Topic Outline

- I. History Taking in the Dermatological Exam
 - A. Age, race, ethnic background, and sex
 - B. Occupational history, both present and past
 - C. Geographic factors
 - D. Leisure activities
 - E. Social Factors
 - F. Present and past medical illness
 - G. Family history
- II. Specific History of a Dermatological Lesion
 - A. Time of onset of skin lesions
 - B. Site of onset
 - C. Character of lesions
 - D. Extension of lesion
 - E. Symptoms, subjective
 - F. Topical Therapy
- III. Examination of the Skin
 - A. Inspection is the chief process - good natural light - observe all skin
 - B. Three categories of observations should be made:
 1. Anatomic Distribution of lesions
 2. Configuration of Groups of lesions
 3. Morphology of individual lesions - primary and secondary (consecutive) lesions
 - C. Palpation to detect nodularity or infiltration: Mobility, Depth, Demarcation and Tenderness.
 - D. Skin Turgor
 1. The turgor or fullness of the skin due to normal tissue fluid accumulation is reduced in:
 - A. General dehydration
 - B. Senile cutaneous atrophy
 - C. Rapid weight loss
 2. The skin over the sternum is pinched with the thumb and under finger, then released. Normally, turgid skin rapidly resumes its customary shape. Loss of turgor is dictated by persistence of the fold for a time after pinching.

IV. Diagnostic Tools To Aid in Dermatological Examination

- a. Wood's light
- b. KOH potassium hydroxide wet mount
- c. DTM - dermatophyte test media
- d. Hand lens

V. Diagnostic Manipulations

- a. Nikolsky's sign
- b. Auspitz Sign
- c. Koebner or isomorphic phenomenon
- d. Tzanck Test
- e. Diascopy

VI. Groups of Lesions by Configurations

- a. Annular arciform and polycyclic grouping
- b. Serpiginous grouping
- c. Iris grouping
- d. Zosteriform grouping
- e. Linear grouping
- f. Retiform grouping

VII. Primary and Secondary Lesions

- a. Macules
- b. Papules
- c. Plaques
- d. Modules
- e. Wheals
- f. Vesicles
- g. Pustules
- h. Cysts
- i. Hyperkeratosis
- j. Scales
- k. Lichenification
- l. Crusts
- m. Atrophy
- n. Sclerosis
- o. Erosions
- p. Fissures
- q. Ulcers
- r. Gangrene
- s. Hypertrichosis or hirsutism
- t. Hypotrichosis
- u. Graying of hair (canities)

VIII. Description of the Normal Nail Unit

- a. nail plate character and angulation
- b. Nail fold
- c. Hyponychium
- d. Eponychium
- e. Matrix

IX. Common Nail pathology

- a. Nail Dystrophy (Trauma, A.S.O.)
- b. Onychomycosis
- c. Psoriasis
- d. Infection
- e. Miscellaneous



Part of the
Ohio College
of Podiatric Medicine



2004-2005

**E.M. Robinson, M.D.
Coordinator**

RATIONALE

The Simulated Patient Lab has been created to offer third year students experiences and feedback not available in other rotations. The use of simulated patients in medical education began about 10-15 years ago and has gained acceptance at many medical schools in the United States and abroad. Simulated patients have been used to train and evaluate medical students, residents and practicing physicians. Simulated patients are actors who are coached to simulate an actual patient so accurately that the simulation cannot be detected by a skilled clinician. In addition student will be provided experience in computerized patient stimulation and simulated models.

MISSION

To provide a quality clinical experience so that students will acquire the knowledge, skills, attitudes and values necessary to the successful practice of podiatry.

GOALS

As a result of working in a learning team, students in the simulated patient rotation will be able to develop:

- critical thinking skills used in the practice of medicine
- physical examination skills other than the lower extremities
- independent self directed learning skills

OBJECTIVES

At the conclusion of the simulated patient rotation, students will be able to:

- Develop relevant and specific questions regarding the history and physical
- Evaluate non-podiatric physical findings
- Recommend the appropriate laboratory work-up
- State an acceptable working diagnosis
- Develop an appropriate treatment plan
- Develop relevant clinical questions which can be answered
- Search and present the best evidence to answer clinical questions
- Develop independent self-directed learning skills during professional lifetime
- Critically assess evaluation and therapeutic decisions of podiatric colleagues

OUTLINE FOR PHYSICAL EXAM

The student should be able to perform the examination techniques, as taught or demonstrated in the Physical Diagnosis course, in an orderly fashion. The student should be able to discuss any abnormalities that might be found. The following is a specific list of physical examination skills. This is not intended to be comprehensive and additional skills not listed may be required, as per instructor.

I. HEAD AND NECK - CRANIUM

- A. General appearance
- B. Inspect head
- C. Symmetry of the skull
- D. Scars
- E. Distribution and texture of hair
- F. Palpate Frontal/Maxillary Sinuses

****NOTE ANY TENDERNESS**

II. EARS

- A. Inspect the external ear, note any abnormalities.
- B. Inspect the external canal and tympanic membrane with the otoscope; note any abnormalities. Student should know different types of hearing loss.

III. EYES

- A. Note the appearance of eyes, location and symmetry.
- B. Inspect the conjunctivae, sclerae, palpebrae, eyelashes, and eyebrows.
- C. Check pupils for equality, reaction to light, direct and consensual and accommodation.
- D. Check the optic disc and fundus with the ophthalmoscope, note any abnormalities. Student should know the different types of fundoscopic changes, especially in hypertension, diabetes, and aging.
- E. Check the extra-ocular movements. Student should know the muscles which control eye movements, note any abnormalities.
- F. Check visual fields, note any abnormalities. If abnormal, student should know where the lesion is located.

NOSE

- A. Inspect. Note any septal perforations, polyps and other abnormalities.\
- B. Check for tenderness.

IV. MOUTH/THROAT

- A. Inspect teeth, gums, tongue and pharynx, note any abnormalities.
- B. Check for tenderness, masses and note the presence or absence of tonsils.

V. NECK

- A. Check for mobility.
- B. Note symmetry of musculature; note any masses.
- C. Palpate lymph nodes of head and neck. Student should know order and possible causes of adenopathy.
- D. Check thyroid. Student should know different types of thyromegaly or nodules and associated diseases.

VII. BACK

- A. Inspect. Check for symmetry and curvatures.
- B. Palpate. Check for costo-vertebral angle tenderness (CVAT), tenderness over the musculature and bony prominences, check mobility.

VIII. LUNGS

- A. Inspect. Check the respiratory rate and the pattern of breathing. Student Should know normal rate and abnormal patterns of breathing. Student should be able to identify landmarks.
- B. Palpate. Check symmetry of excursion and tactile fremitus and whispered voice, note any masses or abnormalities.
- C. Percuss. Check for resonance or dullness, student should know the order to percuss and the abnormalities of percussion. Student should be able to make a differential diagnosis combined with the other findings.
- D. Auscultate. Note the breath sounds, and for spoken voice ("99" and "EE" to "AY" changes.)

X. BREAST

- A. Inspection
- B. Palpation
- C. Student should be able to discuss signs associated with benign cystic disease and malignancy in both sexes.

X. HEART

- A. Inspect. Check for any visible motion of the chest.
- B. Palpate. Check the point of maximum impulse (PMI). Student should know normal location and any abnormalities.
- C. Percussion is not necessary.
- D. Auscultate. Student should know the locations of areas to be auscultated and what is heard there. Students should know normal and abnormal heart sounds.

STUDENTS SHOULD BE ABLE TO DISCUSS THE FOLLOWING MURMURS AND LOCATION IN THE CARDIAC CYCLE:

- Aortic Stenosis
- Aortic Insufficiency
- Mitral Stenosis
- Mitral Insufficiency

XI. ABDOMEN

- A. Inspect. Note any abnormalities of the skin and venous pattern, any mass and shape of the abdomen.
- B. Auscultate. Check the bowel sounds. Student should know normal rate, check bruits. Student should know where to listen, the location of arteries and pathology associated with bruits.
- C. Percuss. Student should know normal sounds, normal size of liver and spleen. Student should know abnormalities associated with changes in sound.
- D. Palpate. Student should know the location of the organs. Note any abnormalities in size, consistency, tenderness or masses. Student should be able to discuss any abnormalities in relation to other findings. Student should be able to arrive at a differential diagnosis and should know the following signs:
 - Voluntary/Involuntary Guarding
 - Rebound Tenderness
 - Rectal Tenderness in Relation to Appendicitis
 - Psoas Sign
 - Obturator Sign

NEUROLOGICAL

1. Orientation
Time-Check date?
Place-Where are you?
Person-Who am I? Who are you?
2. Cranial Nerves: Student should know how to test the cranial nerves, abnormalities and location of the lesion giving rise to the abnormalities.

VITAL SIGNS

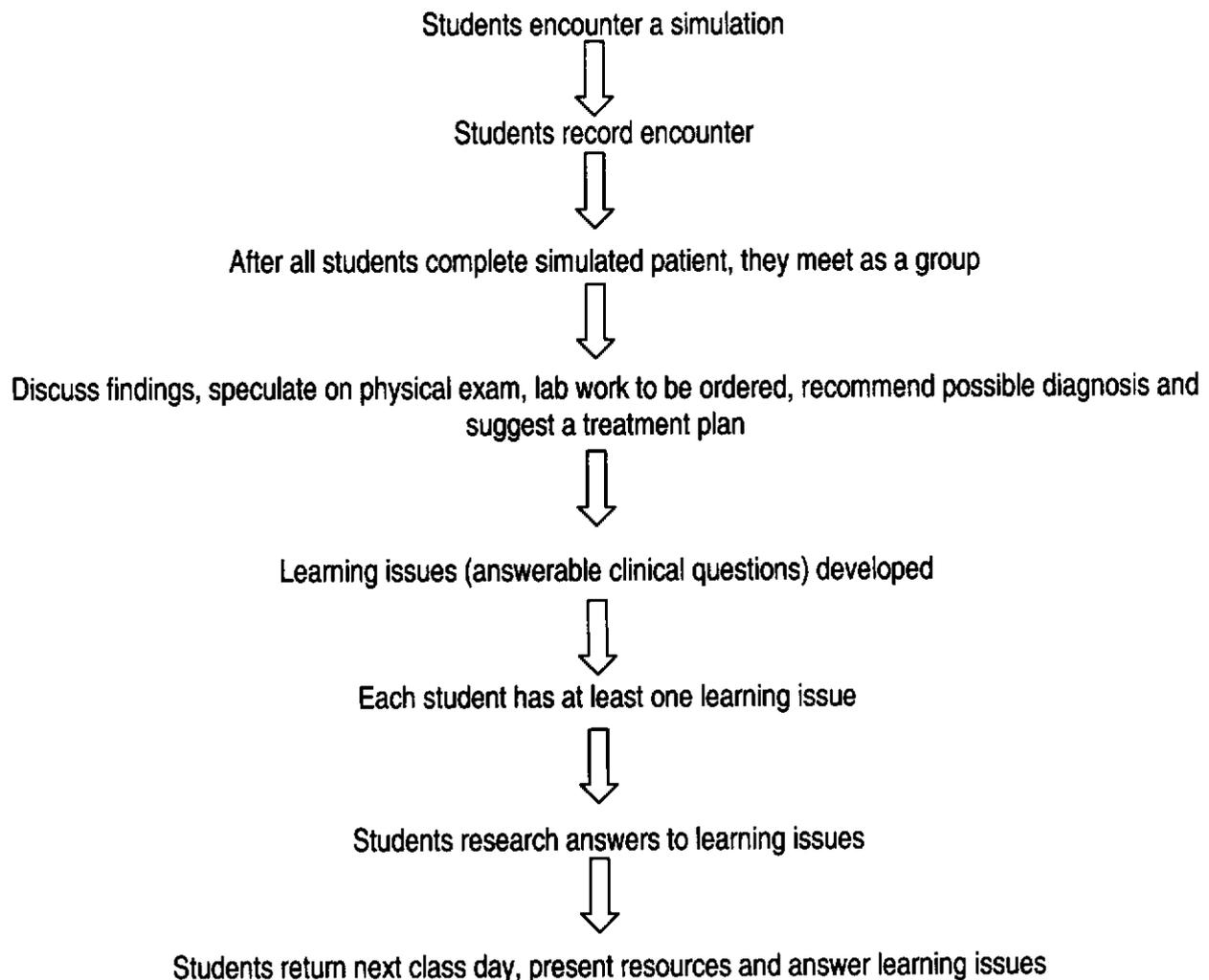
1. Obtain blood pressure.
2. Obtain oral temperature.
3. Obtain pulse.
4. Obtain respiratory rate.

KNOW NORMAL VALUES AND SIGNIFICANT ABNORMALITIES.

INSTRUCTIONAL STRATEGY

The simulated patient rotation is a one-month learning experience for junior students. The rotation meets, Monday through Friday. Sessions with the simulated patients will be audio and videotaped for further instruction at a later date. Some sessions may be observed in real time by faculty tutors and students via one-way glass. In addition, students will review computerized patients in the computer center in the library and receive instructions on a simulated mannequin, as well as live patients.

SUMMARY OF SIMULATED PATIENT ENCOUNTER



EVALUATION

Formative Evaluation

During the course of the rotation, students will receive feedback regarding their & other student's performances. This feedback should be considered when preparing for the exam.

Summative Evaluation

Beginning in October, the summative exam will be offered. The exam dates will be posted by the elevators and third floor classroom. The General Medicine Administrative Assistant will contact all eligible students to notify them of the date. Beginning in October, the exam will be offered at the end of each month. The exam will consist of a timed computerized patient encounter after which students will answer learning issues developed during the encounter and submit their reports within 48 hours to the Administrative Assistant. In addition, after reflection, students may submit a revised working diagnosis and management plan if different than the initial hypotheses.

To receive a passing grade, a student must receive satisfactory marks on ALL subsections of the Summative Simulated Patient Examination form.

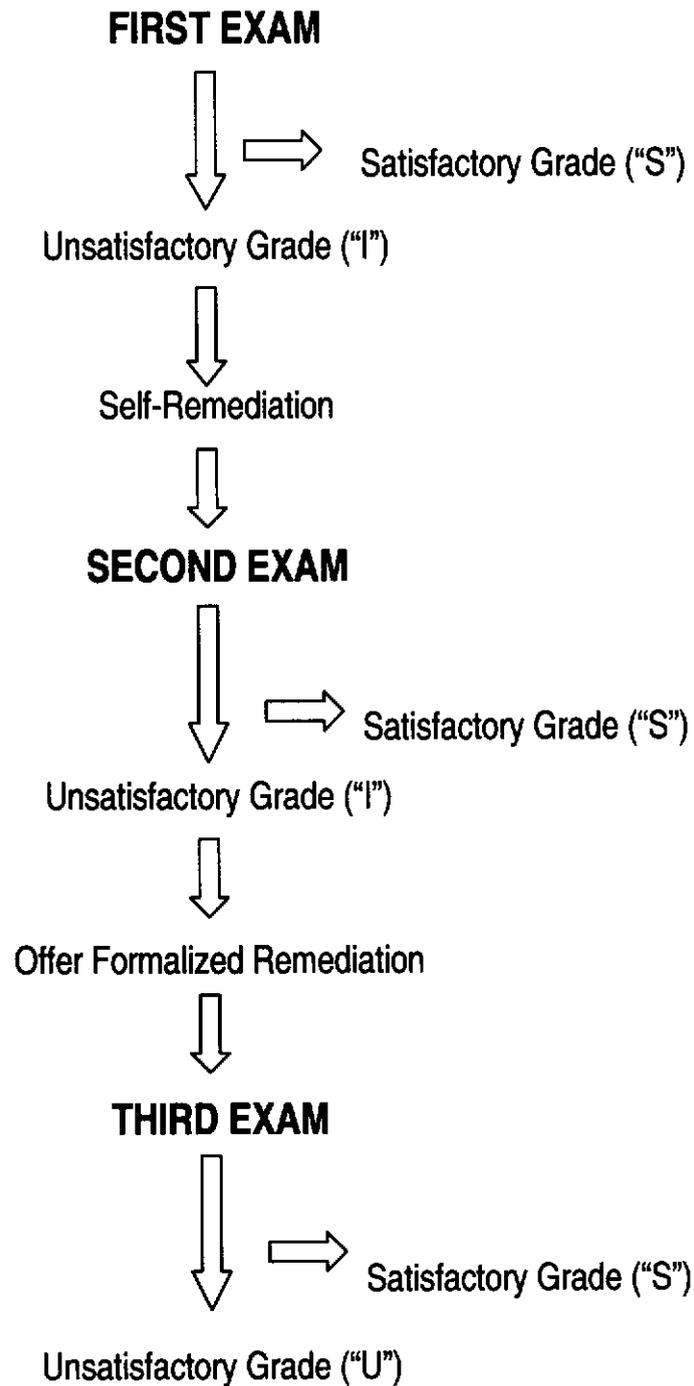
The past medical history: questions should be relevant to the chief complaint and specific in nature. Are you taking any medications? Do you have any allergies to medications? These are examples of nonspecific relevant questions and therefore unsatisfactory. Have you ever injured the (body part) which you are complaining about today. This is an example of a history of present illness question used unsatisfactorily as a past medical history question. The questions should also be unique. Have you ever had thyroid disease? Are you taking any medications for thyroid disease? This is an example of a single question; not two unique questions. Only the number of questions requested should be recorded by the student. Additional questions will not be considered.

Pedal physical examination: questions should be relevant to the chief complaint and specific in nature. What are the results of the neurological examination, vascular examination or musculoskeletal examination? These are examples of unsatisfactory questions regarding the pedal physical examination because they are not specific. What is the range of motion of the first M. P. J. and the second M. P. J.? This is an example of a single question; not two unique questions.

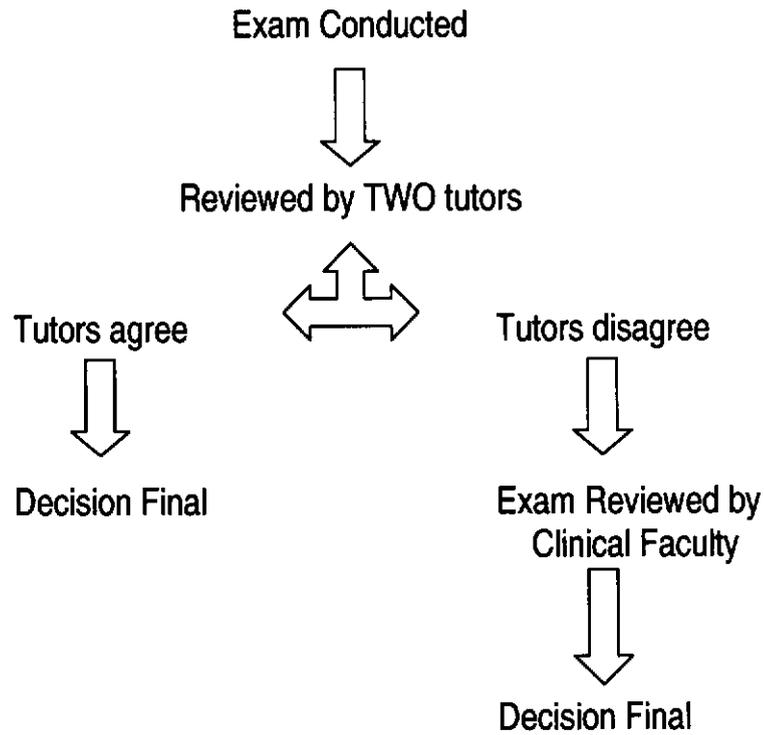
Diagnostic studies: studies which, if ordered will help in diagnosing the problem and defining the treatment plan. Expensive invasive tests, which do not change the management of the patient, should not be ordered, as they will be marked unsatisfactory.

Management plan: the plan for the patient's care needs to be specific and related to the diagnosis in order to receive credit. The plan should be based upon the best evidence available at the time. I would discuss surgery with the patient. I would recommend NSAID's to the patient. These are examples of nonspecific unsatisfactory answers. I would recommend plastazote inserts for the treatment of a rigid flatfoot deformity. This is an example of an unsatisfactory answer because it is not based upon the best available evidence.

SUMMATIVE PROCESS



EVALUATION PROCESS



Any confusion over rotational discussions, explanations, or printed materials, even when confusing or equivocal in nature, must be brought to the attention of the rotational coordinator prior to any examination.

SUMMATIVE SIMULATED PATIENT EXAM RESULTS

STUDENT _____	DATE _____
---------------	------------

SATISFACTORY	UNSATISFACTORY
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1. *Relevant, unique and specific* questions regarding:

A) History of present illness (2)

B) Past medical history (2)

C) Podiatric patient exam (2)

2. Ability to evaluate non-podiatric physical findings

3. Recommend APPROPRIATE diagnostic study

4. Acceptable working diagnosis

5. Developed appropriate management plan

6. Developed acceptable clinical questions (2)

7. Satisfactory clinical report (search strategy)

8. Revised working diagnosis

9. Revised management plan (specific)

OHIO COLLEGE OF PODIATRIC MEDICINE

DEPARTMENT OF GENERAL MEDICINE

**COURSE SYLLABUS FOR
STANDARDIZED PATIENT CLASS
2004-2005**

CLASS: SECOND YEAR

COORDINATOR

GENE SHIMANDLE

2nd YEAR STANDARDIZED PATIENT CLASS

SYLLABUS

RATIONALE:

The standardized patient class has been created to offer second year students experience and feedback on their patient interviewing and history recording skills which will prepare them to function competently in a doctor/patient encounter. The use of standardized patient in medical education began about 20 years ago and has gained acceptance at many medical schools in the United States and abroad. Standardized patient have been used to train and evaluate medical students, residents, and practicing physicians. Standardized patient are actors who are coached to simulate an actual patient so accurately that the simulation cannot be detected by a skilled clinician. In performing the simulation, the standardized patient presents the "gestalt" of the patient being simulated: not just the history, but the body language and personality characteristics as well. Properly trained standardized patients will not vary in the picture they present from student to student.

MISSION:

To provide a quality learning experience so that students will acquire the knowledge, skill, attitudes and values necessary to the successful practice of podiatry.

GOALS:

Students in the standardized patient rotation will be able to develop:

- Patient interviewing skills used in obtaining a medical history.
- Written communication skills used in recording the patient's history.

OBJECTIVES:

At the conclusion of the standardized patient rotation, students will be able to:

- Obtain an accurate history of a standardized patient in a logical order.
- Demonstrate an understanding of the basic principles of accurate history writing
- Use both the patient interviewing and chart writing to generate learning issues which will increase the student's knowledge of interpersonal skills and legal issues involved in patient records.

POLICIES

- 1.) Class will meet on Monday, Wednesday and Friday from 8:30 am to 12:00 pm. Please consult the schedule for your section's assigned time. Attendance is mandatory.
- 2.) The course coordinator

Gene Shimandle
Offices: General Medicine #2
& Simulated Patient Lab, 2nd floor annex
Ext: 7386 or 330 995-0279

- 3.) Grading scale: Pass/Fail
- 4.) The remainder of the policies are in line with those published in the student handbook.

INSTRUCTIONAL STRATEGY

1. At the beginning of each week, each student will interview a "patient". The Interview will be videotaped and the student will have 15 minutes to attempt to complete a thorough history. There will be no physical exam of the patient during this interview. The student will then write up the patient history on the provided history form. During one interview, the student will have 10 minutes to do a thorough H.P.I. only. The student will then write up the patient's in-depth H.P.I. on the provided history form. Appropriate clinical attire is to be worn on patient interview days.
2. During the next two sessions, the student will review their videotapes and write-ups and receive feedback from coordinator. The students will also, with the help of the coordinator, develop learning issues based on this feedback.
3. On the last session of week 3, students will present their learning issue reports to the coordinator and the class. Students will be expected to furnish typed copies of the report for the coordinator and their classmates.
4. During weeks when there are only two days available for standardized patient class, the aforementioned schedule will be adjusted: however, students should still expect to do a patient interview during these weeks.
5. A passing grade requires:
 - A.) Attendance at all class sessions, except for excused illness and/or Absences pre-approved by the coordinator. Students who have an unexpected absence or who are going to be late are expected to leave a message for (the coordinator) at ext. 7386 before the start of class.
 - B.) If a student cannot be present for the FIRST DAY OF THE ROTATION, He/She is responsible for trading with a student in a later rotation. (The coordinator) MUST be notified of this change prior to the start of the rotation.
 - C.) If a student misses the patient interview, He/She must make up the ENTIRE WEEK at a later date.
 - D.) An understanding of the basic interviewing skills as demonstrated in the videotapes and "patient" comments.
 - E.) An understanding of the basic charting principles as demonstrated in the history write-ups.
 - F.) Turning in learning issue reports at the assigned time.

Adult Illnesses: DM HTN Heart Dz Asthma Polio COPD Cancer Sickle Cell

STD: y/n what? _____

HIV: y/n/not tested

INJURIES:

SURGERIES (complications)

HOSPITALIZATIONS:

Social Hx:

Occupation: _____

Marital Status: S/M/D Monogamous: y/n Sexual Pref: Het/homo/bi

Children: y/n how many _____

Smoking: y/n pack per day _____ **Alcohol:** y/n per day _____

Recreational Drugs: y/n what _____

Exercise/Hobbies: _____

Sports/activity level change: yes no _____

Family Hx:

Mother: living/deceased, DM, HTN, TB, arthritis, cancer age _____

Father: living/deceased, DM, HTN, TB, arthritis, cancer age _____

Brother: # _____, living/deceased, DM, HTN, TB, arthritis, cancer age _____

Sister: # _____, living/deceased, DM, HTN, TB, arthritis, cancer age _____

Family Foot Problems: y/n _____

ROS:

General health: poor good excellent fair

Weight Changes: Y/N How much do you think? Appetite: up down

Endocrine: sensitivity to hot and cold _____ goiter _____

lethargy _____ hormoneTx _____ alopecia _____

Skin: rashes _____ psoriasis _____ bruising/bleeding _____ eczema _____ pruritus _____ urticaria _____

Head: heakaches(type/freq.): dizziness _____ fever _____

Eyes: glasses/contacts(near/far/astig) _____ cataracts _____ glaucoma(R/L/both) _____

diplopia _____ vision loss _____ dry eyes _____

Ears: tinnitus _____ deafness _____ infections _____

Nose: rhinitis _____ sinusitis _____ nose bleeds _____

ROS continued:

Mouth/throat: sore throats____dysphagia____sores____swollen tongue____
dentures____bleeding gums____gingivitis____

Neck: pain____stiffness____lumps____edema____

Resp: dyspnea____asthma/wheezing____bronchitis____congestion____emphysema____
pneumonia____

CV: HTN____heart murmur____MI(when)____intermittent claudication____
phlebitis____peripheral edema____

GI: ulcer(gastric,peptic)____thirst____diarrhea____constipation____melena____
hematochezia____jaundice____cholelithiasis____hepatitis____vomiting____
pancreatitis____abdominal pain____

GU: polyuria____dysuria____nocturia____hematuria____incontinence____
nephrolithiasis____

Gyn: last menstrual cycle____regular/any problems(i.e. excessive bleeding, painful)
Replacement therapy?

Skeletal/Muscular: arthritis (DJD, RA, gout)____osteoporosis____back pain____
ROM____digits & nails____

Neuro: depression____mood swings____illusions____hallucinations____
drug habituation____eating disorder____sleeping disorder____
nervousness____insomnia____

IS THERE ANYTHING YOU WISH TO TELL ME ABOUT YOUR HEALTH?

Any questions for me?

Summary:

Exit line:

OUTLINE FOR HISTORY WRITING

I. Chief Complaint (CC:) The reason for visit in patient's own words

II. History of the Present Illness (HPI): NLDOCAT
Pertinent negatives and positives

III. Allergies: List common allergies and any revealed by the patient
List reactions to any allergen

IV. Medications: List all prescript medications, including strength
Dose and frequency as it is taken by the patient

List all over-the-counter medications, vitamins
And homeopathic remedies taken by the patient

V. Past Medical History (PMH): List all the following

- a. Childhood illnesses**
- b. Adult chronic illnesses/**
Complications
- c. Vaccinations**
- d. Sexually transmitted**
diseases

VI. INJURIES requiring medical attention.

VII. SURGERIES: include procedure/hospital/ complications

VIII. HOSPITALIZATIONS: (in addition to surgeries) include
reason/date/hospital/complications

IX. SOCIAL HISTORY:

List all of the following:

- A. Occupation/employment status**
- B. Marital status/children/support systems**
- C. Hobbies**
- D. Caffeine use**
- E. Alcohol use/abuse**
- F. Tobacco use**
- G. Drug use/ abuse**
- H. Sexual preference**
- I. HIV status**

X. FAMILY HISTORY: List all diseases affecting patient's parents, siblings, grandparents, and children (if applicable)

XI. Obtain ages of above, alive/deceased, chronic illnesses (if deceased, obtain cause of death)

XII. Review of Systems: A comprehensive systems approach To symptoms not related to HPI. Each system needs a heading at the margin with a comment for each heading.

STANDARDIZED PATIENT EVALUATION FORM

STUDENT _____ DATE _____

STANDARDIZED PATIENT _____

	SATISFACTORY	NEEDS IMPROVEMENT	NOT OBSERVED
1. The doctor introduced self Appropriately.	_____	_____	_____
2. Made eye contact.	_____	_____	_____
3. Was perceived as devoting full attention to the encounter.	_____	_____	_____
4. Made me feel at ease.	_____	_____	_____
5. The doctor appeared confident.	_____	_____	_____
6. Treated me like I was on the same level: never "talked down " to me or treated me like a child.	_____	_____	_____
7. Allowed me to tell my story; listened carefully; asked thoughtful questions; did not interrupt while I was talking.	_____	_____	_____
8. Showed interest in me as person; not acting bored or ignoring what I had to say.	_____	_____	_____
9. Encouraged me to ask questions; answered them clearly: never avoid my questions or lectured me.	_____	_____	_____

CLINICAL INTERVIEW RATING SCALE CRITERIA

- 1. Introduces self and explains nature and purpose of visit.**
- 2. Does not interrupt patient early during chief complaint, which would result in premature termination of opportunities.**
- 3. Fully characterizes chief complaint (NLDOCAT)**
- 4. Ask additional in-depth questions based on patient's response to NLDOCAT**
- 5. Employs facilitating remarks.**
- 6. Elicits patient's perspectives.**
- 7. Uses transitional statements between sub-sections.**
- 8. Appropriate use of open-ended questions.**
- 9. Avoids use of biomedical terms.**
- 10. Appropriate physical appearance (i.e., professional dress, accessories, make-up, and hairstyle.)**
- 11. Maintains acceptable eye contact.**
- 12. Appropriate kinesics (i.e., body movement, gestures, posture, and distance.)**
- 13. Appropriate paralanguage (i.e., pauses, and corrections to slips of the tongue.)**
- 14. Specificity and verification when appropriate.**
- 15. Avoids interrupting patient and provides explanation/apology if interruptions occurs.**
- 16. Interview progresses logical order.**
- 17. Avoids repeating questions**
- 18. Avoids complex questions**
- 19. Avoids leading questions**
- 20. Summarizes, not merely repeating questions**
- 21. Interview completed with time allotted**



CMS-3122-P-41 Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Mrs. Nancy Post

Date & Time: 04/29/2005

Organization : Orlando Regional Healthcare

Category : Hospital

Issue Areas/Comments

Issue

Completion of the medical history and physical examination

Will there be any changes to either the Surgical or Anesthesia sections of the CoPs related to these proposed changes?

CMS-3122-P-42

Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. Michael Plunkett

Date & Time: 05/02/2005

Organization : Swedish covenant Hospital

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

De. McClelland states that patient safety is compromised is a physician order is not authenticated. If he could give us an example? I have been in practice for 30 years and am yet to find such an occurrence. Physicians are not by the chart 24/7 and orders are relayed by telephone. How is patient safety enhanced by signing these the next day or the next week?

Legally I am responsible whether the order is signed or unsigned. Why not make the requirement for one signature stating, "I am responsible for all orders entered in my name." This would mean one authentication instead of tens of signatures. Surely patients would benefit more from the physician seeing them rather than spending hours in medical records departments.

CMS-3122-P-43

Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. Danial Daley, Jr.

Date & Time: 05/04/2005

Organization : American Association Oral &Maxillofacial Surgeons

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Note: CMS did not receive an attachment to this document. This may have been due to improper submission by the commenter or it may have been a result of technical problems such as file format or system problems.

CMS-3122-P-44

Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. John Graff

Date & Time: 05/06/2005

Organization : John D. Graff, DPM, MPH

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

I am a Podiatric Physician: Just as an Oral Surgeon is licensed by specialty the training and education is not; it is general and complete. It is equal or superior to the DO. I have done all my own H & P's, admit orders, pre and post anesthesia evaluation, floor management and discharges on all my own surgery patients. In the major metro area hospitals, either all specialists or none should CO-ADMIT. DPMs need not have their responsibilities duplicated.

John Graff, DPM, MPH

I have owned and run my own surgery centers with employed MD's, DO's and they never took over for laboratory testing procedures and standardization, H&P's or any other aspect of medicine in these surgical centers.

CMS-3122-P-45 Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Ms. Moraith North

Date & Time: 05/06/2005

Organization : American Assoc of Colleges of Podiatric Medicine

Category : Other Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-3122-P-45-Attach-1.DOC

Attachment #45
May 6, 2005

Mark B. McClellan, MD, PhD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-3122-P
P.O. Box 8010
Baltimore, MD 21244-8010

RE: CMS-3122-P

Comments on Medicare and Medicaid Programs; Hospital Conditions of Participation: Requirements for History and Physical Examinations; Proposed Rule (70 Fed. Reg. 15266, March, 25, 2005)

Dear Dr. McClellan:

On behalf of the Board of Directors of the American Association of Colleges of Podiatric Medicine (AACPM), the national educational organization that represents the seven U.S. colleges of podiatric medicine as well as over 200 hospitals and organizations that conduct graduate training in podiatric medicine, we are pleased to provide comments on the proposed rule that would revise four of the current hospital conditions of participation (CoPs) for approval or continued participation in the Medicare and Medicaid programs. We offer the following comments:

The AACPM supports the proposed revision to the medical staff requirement at § 482.22(c)(5) to specify that a medical history and physical examination must be completed for each patient by a physician (as defined in section 1861(r) of the Act) or other qualified individual who has been granted these privileges by the medical staff in accordance with State law.

Our colleges provide considerable opportunities to predoctoral students so that each graduate is competent to perform comprehensive histories and physicals at the conclusion of his/her four years of podiatric medical school education. Of the seven standards and requirements for accreditation of colleges of podiatric medicine, Standard 3, Educational Program, states, in part "*The Institution offers an educational program that ensures graduation of competent and ethical doctors of podiatric medicine*" Further, Standard 3C – Clinical Sciences, states "*Clinical science instruction shall consist of didactic and laboratory courses and supervised patient care to ... ensure the attainment of knowledge, skills and attitudes for the diagnosis, and evaluation of the overall health status of children and adults, leading to a determination about the relationship of the patient's health to pathology in the lower extremity.*" (CPME:120, October 2002) A brief curriculum review at our institutions indicates both specific didactic and clinical exposures, with ever increasing independence in integrating knowledge learned into acquired skills.

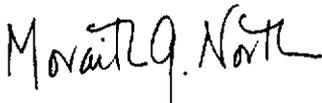
Dr. Mark McClellan
May 6, 2005
Page Two

Additionally, the profession has recently completed a significant revision and paradigm shift for postgraduate podiatric medical education. These residency programs are resource-based, competency-driven and assessment-validated. Of the seven institutional and program standards and requirements for podiatric residencies, program Standard 6.0 states, in part "*The residency program in either Podiatric Medicine and Surgery-24 (PM&S-24) or Podiatric Medicine and Surgery-36 (PM&S-36) ... provides training resources that facilitate the resident's sequential and progressive achievement of specific competencies.*" (CPME:320, July 2003) There are half dozen specific references to the capability of competent performance of comprehensive histories and physicals in both the inpatient and outpatient health care settings. Appropriate assessments of these capabilities are further outlined in other residency standards.

Podiatric physicians are, by education and training, capable of performing a comprehensive history and physical for any of their patients. The AACPM is pleased with the proposed revisions to the hospital CoPs involving H&Ps and we look forward to them being finalized immediately.

If you have questions concerning our comments, please do not hesitate to contact my office at the location listed above.

Sincerely,



Moraith G. North

cc: AACPM Board of Directors

CMS-3122-P-46 Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Ms. Emilie Lucinario

Date & Time: 05/07/2005

Organization : UIC

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-3122-P-46-Attach-1.WPD

CMS-3122-P-46-Attach-2.WPD

Attachment #46
Mark B. McClellan MD, PhD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
File Code: CMS-3818-P
"Personnel Qualification"
<http://www.cms.hhs.gov/regulations/ecomments>

Dear Dr. McClellan:

I am writing your good office to pass a proposal regarding continuous quality improvement for caring for a dialysis patient for a safe and healthy healthcare delivery system.

Proposal # 494.140(e)(3) ("Personnel Qualifications")

To require that each renal technician will be under the direct supervision of a registered nurse in terms of:

- A. Training-Technician should complete at least 3 months experience under direct supervision of RN for the following reasons...
 1. Most of ESRD patients are under the direct care of technician (especially in the acute setting). Many technicians come to dialysis unit with lack of any experience and are being trained primarily by their fellow technician who may have a credentials via a competency test or many years of experience as a technician, but most of them lack a certificate or a license to practice as a technician (No Licensure for Renal Technician). They are responsible for training yet their currently exists a lack of credentialing in that capacity.
 2. Most of technicians display a lack of responsibility. They practice their job to complete a days work not as a professional. They lack the rationale behind what they are doing (they don't have a license to lose) yet they are dealing with life here! An example: a technician cannulating patient 3x a week on the same site, they don't know that they are damaging the access; they don't care, what they know is, its easier for them to do it, but when the access is damaged (excessive bleeding, tearing of access, hematoma), of course its not their problem. It's an additional cost.
(Patient is sent for suturing or worst, replacement of access). Another example, incorrect dialysate concentrate, most of the technicians do not pay particular attention to the correct concentrate. What is available and within their reach is what they use, they don't have the knowledge of hemodynamics and the physiologic reaction on a patient. Regarding a patient with subclavian catheter, the practice of aseptic technique and education of patient regarding risk of infection, failure to note this causes higher cost to medical budget in terms of use of antibiotic use and an increased number of hospitalization days.

3. Technicians, who have practiced for a long time, do not need to worry about a license expiring, maintaining a certificate, or completing continuing education. Therefore there exists no means to measure their knowledge regarding care of renal patients.

These are a few reasons that demonstrate the need for RNs who possess the professional training and expertise to coordinate care. Nurses should be responsible for direct supervision to impart training to new renal technicians.

CMS-3122-P-47

Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. Prasad Gadiraju

Date & Time: 05/08/2005

Organization : Greater Houston Anesthesiology

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-3122-P-47-Attach-1.DOC

Attachment #47

I wish to applaud the CMS on the following proposals.

Section 482.25(b)(2)(i)

This proposed provision would specify that all drugs and biologicals be kept in secure areas, and locked when appropriate.

Section 482.25(b)(2)(ii)

This proposed provision would require that scheduled drugs (II, III, IV, and V), as outlined in the Comprehensive Drug Abuse Prevention and Control Act of 1970, must be locked within a secure area.

Section 482.25(b)(2)(iii)

This proposed requirement states that only authorized personnel would have access to locked areas.

Section 482.52(b)(3)

This proposed requirement would permit the postanesthesia evaluation for inpatients to be completed and documented by any individual qualified to administer anesthesia. Implementation of this standard would give hospitals greater flexibility in meeting the needs of patients and decrease hospital and practitioner burden.

I am an anesthesiologist who vehemently believes in securing medications. However, on many occasions, especially extubating a sick patient, I have to give my undivided attention to the patient. The last thing that I wish to do is waste valuable time in attempting to lock these medications in the OR at that juncture. Moreover, many of these drugs may be needed until the patient is stable and transported. The patient comes first.

I also wish to thank you on revising the proposal to have post up visits completed by any anesthesiologist other than the one who administered anesthesia. Given the working schedule of the anesthesiologists, it is many times impossible to be physically present for the post op visit when my qualified colleague can adequately perform the same duty. I would be always available my some means of communication.

CMS-3122-P-48

Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. Raziuddin Ahmed

Date & Time: 05/10/2005

Organization : Dr. Raziuddin Ahmed

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I am in full agreement that a podiatrist should be able to perform a history and physical on a patient that needs to be admitted to a hospital. Podiatrist have been trained to do this in school and in residency programs. I fail to see what is holding this proposal from becoming law.

Sincerely

CMS-3122-P-49 Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. John Keene

Date & Time: 05/10/2005

Organization : Dr. John Keene

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I am an oral and maxillofacial surgeon, and have reviewed the proposed change to the CMS Conditions of Participation (CoP) related to H&Ps that would allow this service to be performed by a physician as defined by the Social Security Act. The Social Security Act defines physicians as doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors. Although I support the use of this definition in most contexts, I am concerned that applying this definition to the H&P will cause hospital medical staffs to limit this privilege exclusively to MD/DOs and, as a result, negatively impact patient care. Some medical staffs are already attempting to change their bylaws to limit this privilege to MD/DOs, often because of their unfamiliarity with the education and training standards of non- MD/DO practitioners. Limitations or withdrawal of oral and maxillofacial surgeons' H&P privileges would limit access for my patients, as well as maxillofacial trauma patients who would need my services, and would threaten the accreditation status of the 100 accredited oral and maxillofacial surgery residency training programs.

I understand the motivation for using the Social Security Act's definition in the CoP is a result of concerns brought to your attention by podiatrists. Podiatrists with advanced training may be qualified to perform an H&P. I oppose this proposed change and suggest that the CoP should be revised to include a doctor of medicine or osteopathy, an oral and maxillofacial surgeon for patients admitted for oral and maxillofacial surgery, and if they are trained to perform a complete H&P, a doctor of podiatric medicine who has completed an accredited podiatric residency program for patients admitted for podiatric surgery.

Thank you for consideration of these comments.

Sincerely,

Dr. John R. Keene

CMS-3122-P-50

Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. John Gillis

Date & Time: 05/10/2005

Organization : Dr. John Gillis

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

I am an oral and maxillofacial surgeon, and have reviewed the proposed change to the CMS Conditions of Participation (CoP) related to H&Ps that would allow this service to be performed by a physician as defined by the Social Security Act. The Social Security Act defines physicians as doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors. Although I support the use of this definition in most contexts, I am concerned that applying this definition to the H&P will cause hospital medical staffs to limit this privilege exclusively to MD/DOs and, as a result, negatively impact patient care. Some medical staffs are already attempting to change their bylaws to limit this privilege to MD/DOs, often because of their unfamiliarity with the education and training standards of non- MD/DO practitioners. Limitations or withdrawal of oral and maxillofacial surgeons' H&P privileges would limit access for my patients, as well as maxillofacial trauma patients who would need my services, and would threaten the accreditation status of the 100 accredited oral and maxillofacial surgery residency training programs.

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Thank you for consideration of these comments.

Sincerely,

John M. Gillis

CMS-3122-P-51 Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. Steven Sullivan

Date & Time: 05/10/2005

Organization : University of Oklahoma College of Dentistry

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS-3122-P, Completion of the Medical History and Physical Examination

I am an oral and maxillofacial surgeon, and have reviewed the proposed change to the CMS Conditions of Participation (CoP) related to H&Ps that would allow this service to be performed by a physician as defined by the Social Security Act. The Social Security Act defines physicians as doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors. Although I support the use of this definition in most contexts, I am concerned that applying this definition to the H&P will cause hospital medical staffs to limit this privilege exclusively to MD/DOs and, as a result, negatively impact patient care. Some medical staffs are already attempting to change their bylaws to limit this privilege to MD/DOs, often because of their unfamiliarity with the education and training standards of non- MD/DO practitioners. Limitations or withdrawal of oral and maxillofacial surgeons' H&P privileges would limit access for my patients, as well as maxillofacial trauma patients who would need my services, and would threaten the accreditation status of the 100 accredited oral and maxillofacial surgery residency training programs.

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Thank you for consideration of these comments.

Sincerely,

CMS-3122-P-52

Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. Thomas Ocheltree

Date & Time: 05/10/2005

Organization : Christiana Care

Category : Other Practitioner

Issue Areas/Comments

GENERAL

GENERAL

I am an oral and maxillofacial surgeon, and have reviewed the proposed change to the CMS Conditions of Participation (CoP) related to H&Ps that would allow this service to be performed by a physician as defined by the Social Security Act. The Social Security Act defines physicians as doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors. Although I support the use of this definition in most contexts, I am concerned that applying this definition to the H&P will cause hospital medical staffs to limit this privilege exclusively to MD/DOs and, as a result, negatively impact patient care. Some medical staffs are already attempting to change their bylaws to limit this privilege to MD/DOs, often because of their unfamiliarity with the education and training standards of non- MD/DO practitioners. Limitations or withdrawal of oral and maxillofacial surgeons' H&P privileges would limit access for my patients, as well as maxillofacial trauma patients who would need my services, and would threaten the accreditation status of the 100 accredited oral and maxillofacial surgery residency training programs.

I understand the motivation for using the Social Security Act's definition in the CoP is a result of concerns brought to your attention by podiatrists. Podiatrists with advanced training may be qualified to perform an H&P. I oppose this proposed change and suggest that the CoP should be revised to include a doctor of medicine or osteopathy, an oral and maxillofacial surgeon for patients admitted for oral and maxillofacial surgery, and if they are trained to perform a complete H&P, a doctor of podiatric medicine who has completed an accredited podiatric residency program for patients admitted for podiatric surgery.

Thank you for consideration of these comments.

Sincerely,

Thomas C. Ocheltree, DMD

CMS-3122-P-53 Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. Joseph Helman

Date & Time: 05/10/2005

Organization : Dr. Joseph Helman

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS-3122-P, Completion of the Medical History and Physical Examination

I am an oral and maxillofacial surgeon, and have reviewed the proposed change to the CMS Conditions of Participation (CoP) related to H&Ps that would allow this service to be performed by a physician as defined by the Social Security Act. The Social Security Act defines physicians as doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors. Although I support the use of this definition in most contexts, I am concerned that applying this definition to the H&P will cause hospital medical staffs to limit this privilege exclusively to MD/DOs and, as a result, negatively impact patient care. Some medical staffs are already attempting to change their bylaws to limit this privilege to MD/DOs, often because of their unfamiliarity with the education and training standards of non-MD/DO practitioners. Limitations or withdrawal of oral and maxillofacial surgeons' H&P privileges would limit access for my patients, as well as maxillofacial trauma patients who would need my services, and would threaten the accreditation status of the 100 accredited oral and maxillofacial surgery residency training programs.

I understand the motivation for using the Social Security Act's definition in the CoP is a result of concerns brought to your attention by podiatrists. Podiatrists with advanced training may be qualified to perform an H&P. I oppose this proposed change and suggest that the CoP should be revised to include a doctor of medicine or osteopathy, an oral and maxillofacial surgeon for

patients admitted for oral and maxillofacial surgery, and if they are trained to perform a complete H&P, a doctor of

podiatric medicine who has completed an accredited podiatric residency program for patients admitted for podiatric surgery.

Thank you for consideration of these comments.

Sincerely,

CMS-3122-P-54 Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. Kim E. Goldman

Date & Time: 05/10/2005

Organization : Associates in Oral & Maxillofacial Surgery

Category : Other Practitioner

Issue Areas/Comments

GENERAL

GENERAL

I am an oral and maxillofacial surgeon, and have reviewed the proposed change to the CMS Conditions of Participation (CoP) related to H&Ps that would allow this service to be performed by a physician as defined by the Social Security Act. The Social Security Act defines physicians as doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors. Although I support the use of this definition in most contexts, I am concerned that applying this definition to the H&P will cause hospital medical staffs to limit this privilege exclusively to MD/DOs and, as a result, negatively impact patient care. Some medical staffs are already attempting to change their bylaws to limit this privilege to MD/DOs, often because of their unfamiliarity with the education and training standards of non- MD/DO practitioners. Limitations or withdrawal of oral and maxillofacial surgeons' H&P privileges would limit access for my patients, as well as maxillofacial trauma patients who would need my services, and would threaten the accreditation status of the 100 accredited oral and maxillofacial surgery residency training programs.

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Thank you for consideration of these comments.

Sincerely,
Kim E. Goldman, D.M.D.
Associates in Oral & Maxillofacial Surgery, PLC

CMS-3122-P-55 Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. Babak Emami

Date & Time: 05/10/2005

Organization : Oral and Maxillofacial Surgery

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS-3122-P, Completion of the Medical History and Physical Examination

I am an oral and maxillofacial surgeon, and have reviewed the proposed change to the CMS Conditions of Participation (CoP) related to H&Ps that would allow this service to be performed by a physician as defined by the Social Security Act. The Social Security Act defines physicians as doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors. Although I support the use of this definition in most contexts, I am concerned that applying this definition to the H&P will cause hospital medical staffs to limit this privilege exclusively to MD/DOs and, as a result, negatively impact patient care. Some medical staffs are already attempting to change their bylaws to limit this privilege to MD/DOs, often because of their unfamiliarity with the education and training standards of non- MD/DO practitioners. Limitations or withdrawal of oral and maxillofacial surgeons' H&P privileges would limit access for my patients, as well as maxillofacial trauma patients who would need my services, and would threaten the accreditation status of the 100 accredited oral and maxillofacial surgery residency training programs.

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Thank you for consideration of these comments.

Sincerely,

Babak Emami, DMD

CMS-3122-P-56 Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. Peter Kim

Date & Time: 05/10/2005

Organization : Dr. Peter Kim

Category : Individual

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-3122-P-56-Attach-1.DOC

Attachment #56

May 10, 2005

Re: CMS-3122-P, Completion of the Medical History and Physical Examination

I am an oral and maxillofacial surgeon, and have reviewed the proposed change to the CMS Conditions of Participation (CoP) related to H&Ps that would allow this service to be performed by a physician as defined by the Social Security Act. The Social Security Act defines physicians as doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors. Although I support the use of this definition in most contexts, I am concerned that applying this definition to the H&P will cause hospital medical staffs to limit this privilege exclusively to MD/DOs and, as a result, negatively impact patient care. Some medical staffs are already attempting to change their bylaws to limit this privilege to MD/DOs, often because of their unfamiliarity with the education and training standards of non-MD/DO practitioners. Limitations or withdrawal of oral and maxillofacial surgeons' H&P privileges would limit access for my patients, as well as maxillofacial trauma patients who would need my services, and would threaten the accreditation status of the 100 accredited oral and maxillofacial surgery residency training programs.

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Thank you for consideration of these comments.

Sincerely,

Peter H. Kim DDS
Oral & Maxillofacial Surgeon

CMS-3122-P-57

Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. mark grecco

Date & Time: 05/10/2005

Organization : Dr. mark grecco

Category : Physician

Issue Areas/Comments**GENERAL**

GENERAL

Re: CMS-3122-P, Completion of the Medical History and Physical Examination

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Thank you for consideration of these comments.

Mark Grecco, DMD
Oral & Maxillofacial Surgeon

CMS-3122-P-58

Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. Paul Tiwana

Date & Time: 05/10/2005

Organization : University of Louisville

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS-3122-P, Completion of the Medical History and Physical Examination

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patients admitted for oral and maxillofacial surgery, and if they are trained to perform a complete H&P, a doctor of

podiatric medicine who has completed an accredited podiatric residency program for patients admitted for podiatric surgery.

Thank you for consideration of these comments.

Sincerely,

Paul S. Tiwana DDS, MD, MS
Assistant Professor - The University of Louisville, Louisville KY

Chief - Pediatric Oral & Maxillofacial Surgery
Kosair Children's Hospital, Louisville KY

CMS-3122-P-59 Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. wayne witt

Date & Time: 05/10/2005

Organization : American Assoc Oral and Maxillofacial Surgeons

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS-3122-P, Completion of the Medical History and Physical Examination

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Thank you for consideration of these comments.

Sincerely,

Wayne R. Witt DDS

CMS-3122-P-60

Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. Ross Wlodawsky

Date & Time: 05/10/2005

Organization : Dr. Ross Wlodawsky

Category : Physician

Issue Areas/Comments**Issue**

Completion of the medical history and physical examination

I am an oral and maxillofacial surgeon, and have reviewed the proposed change to the CMS Conditions of Participation (CoP) related to H&Ps that would allow this service to be performed by a physician as defined by the Social Security Act. The Social Security Act defines physicians as doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors. Although I support the use of this definition in most contexts, I am concerned that applying this definition to the H&P will cause hospital medical staffs to limit this privilege exclusively to MD/DOs and, as a result, negatively impact patient care. Some medical staffs are already attempting to change their bylaws to limit this privilege to MD/DOs, often because of their unfamiliarity with the education and training standards of non- MD/DO practitioners. Limitations or withdrawal of oral and maxillofacial surgeons' H&P privileges would limit access for my patients, as well as maxillofacial trauma patients who would need my services, and would threaten the accreditation status of the 100 accredited oral and maxillofacial surgery residency training programs.

I understand the motivation for using the Social Security Act's definition in the CoP is a result of concerns brought to your attention by podiatrists. Podiatrists with advanced training may be qualified to perform an H&P. I oppose this proposed change and suggest that the CoP should be revised to include a doctor of medicine or osteopathy, an oral and maxillofacial surgeon for patients admitted for oral and maxillofacial surgery, and if they are trained to perform a complete H&P, a doctor of podiatric medicine who has completed an accredited podiatric residency program for patients admitted for podiatric surgery.

Thank you for consideration of these comments.

Sincerely,

Ross Wlodawsky, D.D.S.

CMS-3122-P-61**Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations****Submitter :** Dr. Scott Podlesh**Date & Time:** 05/10/2005**Organization :** Dr. Scott Podlesh**Category :** Other Health Care Professional**Issue Areas/Comments****GENERAL**

GENERAL

I am an oral and maxillofacial surgeon, and have reviewed the proposed change to the CMS Conditions of Participation (CoP) related to H&Ps that would allow this service to be performed by a physician as defined by the Social Security Act. The Social Security Act defines physicians as doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors. Although I support the use of this definition in most contexts, I am concerned that applying this definition to the H&P will cause hospital medical staffs to limit this privilege exclusively to MD/DOs and, as a result, negatively impact patient care. Some medical staffs are already attempting to change their bylaws to limit this privilege to MD/DOs, often because of their unfamiliarity with the education and training standards of non- MD/DO practitioners. Limitations or withdrawal of oral and maxillofacial surgeons' H&P privileges would limit access for my patients, as well as maxillofacial trauma patients who would need my services, and would threaten the accreditation status of the 100 accredited oral and maxillofacial surgery residency training programs.

I understand the motivation for using the Social Security Act's definition in the CoP is a result of concerns brought to your attention by podiatrists. Podiatrists with advanced training may be qualified to perform an H&P. I oppose this proposed change and suggest that the CoP should be revised to include a doctor of medicine or osteopathy, an oral and maxillofacial surgeon for patients admitted for oral and maxillofacial surgery, and if they are trained to perform a complete H&P, a doctor of podiatric medicine who has completed an accredited podiatric residency program for patients admitted for podiatric surgery.

I would also like to comment that you do not even recognize dentistry and oral and maxillofacial surgery under the grouping of health care providers on your web site.

Thank you for consideration of these comments.

Sincerely,

Scott W. Podlesh, DDS

Diplomate, American Board of Oral and Maxillofacial Surgery

CMS-3122-P-62 Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. Todd Eggleston

Date & Time: 05/10/2005

Organization : Eggleston Oral & Facial Surgery, P.A.

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS-3122-P. Completion of the Medical History and Physical Examination

I am an oral and maxillofacial surgeon, and have reviewed the proposed change to the CMS Conditions of Participation (CoP) related to H&Ps that would allow this service to be performed by a physician as defined by the Social Security Act. The Social Security Act defines physicians as doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors. Although I support the use of this definition in most contexts, I am concerned that applying this definition to the H&P will cause hospital medical staffs to limit this privilege exclusively to MD/DOs and, as a result, negatively impact patient care. Some medical staffs are already attempting to change their bylaws to limit this privilege to MD/DOs, often because of their unfamiliarity with the education and training standards of non- MD/DO practitioners. Limitations or withdrawal of oral and maxillofacial surgeons' H&P privileges would limit access for my patients, as well as maxillofacial trauma patients who would need my services, and would threaten the accreditation status of the 100 accredited oral and maxillofacial surgery residency training programs.

I understand the motivation for using the Social Security Act's definition in the CoP is a result of concerns brought to your attention by podiatrists. Podiatrists with advanced training may be qualified to perform an H&P. I oppose this proposed change and suggest that the CoP should be revised to include a doctor of medicine or osteopathy, an oral and maxillofacial surgeon for patients admitted for oral and maxillofacial surgery, and if they are trained to perform a complete H&P, a doctor of podiatric medicine who has completed an accredited podiatric residency program for patients admitted for podiatric surgery.

Thank you for consideration of these comments.

Sincerely,

Todd Eggleston, DDS
Eggleston Oral & Facial Surgery, P.A.

CMS-3122-P-63

Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. Daniel Quon

Date & Time: 05/10/2005

Organization : Dr. Daniel Quon

Category : Other Practitioner

Issue Areas/Comments**GENERAL**

GENERAL

Re: CMS-3122-P, Completion of the Medical History and Physical Examination

I am an oral and maxillofacial surgeon, and have reviewed the proposed change to the CMS Conditions of Participation (CoP) related to H&Ps that would allow this service to be performed by a physician as defined by the Social Security Act. The Social Security Act defines physicians as doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors. Although I support the use of this definition in most contexts, I am concerned that applying this definition to the H&P will cause hospital medical staffs to limit this privilege exclusively to MD/DOs and, as a result, negatively impact patient care. Some medical staffs are already attempting to change their bylaws to limit this privilege to MD/DOs, often because of their unfamiliarity with the education and training standards of non- MD/DO practitioners. Limitations or withdrawal of oral and maxillofacial surgeons' H&P privileges would limit access for my patients, as well as maxillofacial trauma patients who would need my services, and would threaten the accreditation status of the 100 accredited oral and maxillofacial surgery residency training programs.

I understand the motivation for using the Social Security Act's definition in the CoP is a result of concerns brought to your attention by podiatrists. Podiatrists with advanced training may be qualified to perform an H&P. I oppose this proposed change and suggest that the CoP should be revised to include a doctor of medicine or osteopathy, an oral and maxillofacial surgeon for patients admitted for oral and maxillofacial surgery, and if they are trained to perform a complete H&P, a doctor of podiatric medicine who has completed an accredited podiatric residency program for patients admitted for podiatric surgery.

Thank you for consideration of these comments.

Sincerely,

Daniel Quon, D.M.D.

CMS-3122-P-64**Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations****Submitter :** Dr. James Hargan**Date & Time:** 05/10/2005**Organization :** The Oral and Facial Surgery Center of Kentucky**Category :** Physician**Issue Areas/Comments****GENERAL**

GENERAL

RE: CMS-3122-P, COMPLETION OF THE MEDICAL HISTORY AND PHYSICAL EXAMINATION

I am an oral and maxillofacial surgeon, and have reviewed the proposed change to the CMS Conditions of Participation (CoP) related to H&Ps that would allow this service to be performed by a physician as defined by the Social Security Act. The Social Security Act defines physicians as doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry and chiropractors. Although I support the use of this definition in most contexts, I am concerned that applying this definition to the H&P will cause hospital medical staffs to limit this privilege exclusively to MD/DOs and, as a result, negatively impact patient care. Some medical staffs are already attempting to change their bylaws to limit this privilege MD/DOs, often because of their unfamiliarity with the education and training standards of non-MD/DO practitioners. Limitations or withdrawal of oral and maxillofacial surgeons' H&P privileges would limit access for my patients, as well as maxillofacial trauma patients who would need my services, and would threaten the accreditation status of the 100 accredited oral and maxillofacial surgery residency training programs.

I understand the motivation for using the Social Security Act's definition in the CoP is a result of concerns brought to your attention by podiatrists. Podiatrists with advanced training may be qualified to perform an H&P. I oppose this proposed change and suggest that the CoP should be revised to include a doctor of medicine or osteopathy, an oral and maxillofacial surgeon for patients admitted for oral and maxillofacial surgery, and if they are trained to perform a complete H&P, a doctor of podiatric medicine who has completed an accredited podiatric residency program for patients admitted for podiatric surgery

Thank you for consideration of these comments.

Sincerely,

J.K. Hargan, DMD, MD

CMS-3122-P-65 Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. Arlet Dunsworth

Date & Time: 05/10/2005

Organization : Dr. Arlet Dunsworth

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

I practice Oral and Maxillofacial surgery, and have reviewed the proposed change to the CMS Conditions of Participation (CoP) related to H&Ps that would allow this service to be performed by a physician as defined by the Social Security Act. The Social Security Act defines physicians as doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors. I support the use of this definition in most applications, but I am concerned that applying this definition to the H&P will cause hospital medical staffs to limit this privilege exclusively to MD/DOs and, as a result, negatively impact Oral & Maxillofacial patient care. Some medical staffs are already attempting to change their bylaws to limit this privilege to MD/DOs, often because of their unfamiliarity with the education and training standards of non-MD/DO practitioners. Limitations or withdrawal of oral and maxillofacial surgeons' H&P privileges would limit access for my patients, as well as maxillofacial trauma patients who would need my services, and would threaten the accreditation status of the 100 accredited oral and maxillofacial surgery residency training programs.

I understand the motivation for using the Social Security Act's definition in the CoP is a result of concerns brought to your attention by podiatrists. Podiatrists with advanced training may be qualified to perform an H&P, and I would support their opportunity to do this. I oppose this proposed change and suggest that the CoP should be revised to include a doctor of medicine or osteopathy, an oral and maxillofacial surgeon for patients admitted for oral and maxillofacial surgery, and if they are trained to perform a complete H&P, a doctor of podiatric medicine who has completed an accredited podiatric residency program for patients admitted for podiatric surgery.

Thank you for consideration of these comments

Arlet R. Dunsworth, D.D.S, M.S.D.

CMS-3122-P-66

Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter :

Date & Time: 05/10/2005

Organization :

Category : Other Practitioner

Issue Areas/Comments**GENERAL**

GENERAL

Re: CMS-3122-P, Completion of the Medical History and Physical Examination

I am an oral and maxillofacial surgeon, and have reviewed the proposed change to the CMS Conditions of Participation (CoP) related to H&Ps that would allow this service to be performed by a physician as defined by the Social Security Act. The Social Security Act defines physicians as doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors. Although I support the use of this definition in most contexts, I am concerned that applying this definition to the H&P will cause hospital medical staffs to limit this privilege exclusively to MD/DOs and, as a result, negatively impact patient care. Some medical staffs are already attempting to change their bylaws to limit this privilege to MD/DOs, often because of their unfamiliarity with the education and training standards of non- MD/DO practitioners. Limitations or withdrawal of oral and maxillofacial surgeons' H&P privileges would limit access for my patients, as well as maxillofacial trauma patients who would need my services, and would threaten the accreditation status of the 100 accredited oral and maxillofacial surgery residency training programs.

I understand the motivation for using the Social Security Act's definition in the CoP is a result of concerns brought to your attention by podiatrists. Podiatrists with advanced training may be qualified to perform an H&P. I oppose this proposed change and suggest that the CoP should be revised to include a doctor of medicine or osteopathy, an oral and maxillofacial surgeon for patients admitted for oral and maxillofacial surgery, and if they are trained to perform a complete H&P, a doctor of podiatric medicine who has completed an accredited podiatric residency program for patients admitted for podiatric surgery.

Thank you for consideration of these comments.

Sincerely,

CMS-3122-P-67**Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations****Submitter : Dr. William Clark****Date & Time: 05/10/2005****Organization : Dr. William Clark****Category : Physician****Issue Areas/Comments****GENERAL**

GENERAL

Re: CMS-3122-P, Completion of the Medical History and Physical Examination

I am an oral and maxillofacial surgeon, and I have reviewed the proposed change to the CMS Conditions of Participation (CoP) related to H&Ps that would allow this service to be performed by a physician as defined by the Social Security Act. The Social Security Act defines physicians as doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors. Although I support the use of this definition in most contexts, I am concerned that applying this definition to the H&P will cause hospital medical staffs to limit this privilege exclusively to MD/DOs and, as a result, negatively impact patient care. Some medical staffs are already attempting to change their bylaws to limit this privilege to MD/DOs, often because of their unfamiliarity with the education and training standards of non- MD/DO practitioners. Limitations or withdrawal of oral and maxillofacial surgeons' H&P privileges would limit access for my patients, as well as maxillofacial trauma patients who would need my services, and would threaten the accreditation status of the 100 accredited oral and maxillofacial surgery residency training programs.

I understand the motivation for using the Social Security Act's definition in the CoP is a result of concerns brought to your attention by podiatrists. Podiatrists with advanced training may be qualified to perform an H&P. I oppose this proposed change and suggest that the CoP should be revised to include a doctor of medicine or osteopathy, an oral and maxillofacial surgeon for patients admitted for oral and maxillofacial surgery, and if they are trained to perform a complete H&P, a doctor of podiatric medicine who has completed an accredited podiatric residency program for patients admitted for podiatric surgery.

Thank you for consideration of these comments.

CMS-3122-P-68

Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. Harry Sacks

Date & Time: 05/10/2005

Organization : Dr. Harry Sacks

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Eliminating OMFSs privileges to perform H&P's will only serve to delay treatment, increase lengths of hospital stay, decrease competition and generally increase the cost of treatment. Anything not explicitly stated often implies exclusion. We strongly oppose any changes excluding OMFSs from providing services they are trained for and have provided in the past.

CMS-3122-P-68

Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. Harry Sacks

Date & Time: 05/10/2005

Organization : Dr. Harry Sacks

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Eliminating OMFSs privileges to perform H&P's will only serve to delay treatment, increase lengths of hospital stay, decrease competition and generally increase the cost of treatment. Anything not explicitly stated often implies exclusion. We strongly oppose any changes excluding OMFSs from providing services they are trained for and have provided in the past.

CMS-3122-P-69**Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations****Submitter : Dr. Edward Ellis****Date & Time: 05/10/2005****Organization : University of Texas Southwestern Medical Center****Category : Physician****Issue Areas/Comments****GENERAL**

GENERAL

May 10, 2005

Dear Sir or Madam:

I am an oral and maxillofacial surgeon and direct an OMS training program. I've reviewed the proposed change to the CMS Conditions of Participation (CoP) related to H&Ps that would allow this service to be performed by a physician as defined by the Social Security Act. The Social Security Act defines physicians as doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors. Although I support the use of this definition in most contexts, I am concerned that applying this definition to the H&P will cause hospital medical staffs to limit this privilege exclusively to MD/DOs and, as a result, negatively impact patient care. Some medical staffs are already attempting to change their bylaws to limit this privilege to MD/DOs, often because of their unfamiliarity with the education and training standards of non-MD/DO practitioners. Limitations or withdrawal of oral and maxillofacial surgeons' H&P privileges would limit access for my patients, as well as maxillofacial trauma patients who would need my services, and would threaten the accreditation status of the 100 accredited oral and maxillofacial surgery residency training programs.

I understand the motivation for using the Social Security Act's definition in the CoP is a result of concerns brought to your attention by podiatrists. Podiatrists with advanced training may be qualified to perform an H&P. I oppose this proposed change and suggest that the CoP should be revised to include a doctor of medicine or osteopathy, an oral and maxillofacial surgeon for patients admitted for oral and maxillofacial surgery, and if they are trained to perform a complete H&P, a doctor of podiatric medicine who has completed an accredited podiatric residency program for patients admitted for podiatric surgery.

Thank you for consideration of these comments.

Sincerely,

Edward Ellis III, DDS, MS

Professor of Oral and Maxillofacial Surgery

Director of Resident Education

University of Texas Southwestern Medical Center

Dallas, TX 75390-9109

CMS-3122-P-70

Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. David Obenchain

Date & Time: 05/10/2005

Organization : Oral Maxillofacial Surgeon

Category : Other Practitioner

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS-3122-P, Completion of the Medical History and Physical Examination

I am an oral and maxillofacial surgeon, and have reviewed the proposed change to the CMS Conditions of Participation (CoP) related to H&Ps that would allow this service to be performed by a physician as defined by the Social Security Act. The Social Security Act defines physicians as doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors. Although I support the use of this definition in most contexts, I am concerned that applying this definition to the H&P will cause hospital medical staffs to limit this privilege exclusively to MD/DOs and, as a result, negatively impact patient care. Some medical staffs are already attempting to change their bylaws to limit this privilege to MD/DOs, often because of their unfamiliarity with the education and training standards of non- MD/DO practitioners. Limitations or withdrawal of oral and maxillofacial surgeons' H&P privileges would limit access for my patients, as well as maxillofacial trauma patients who would need my services, and would threaten the accreditation status of the 100 accredited oral and maxillofacial surgery residency training programs.

I understand the motivation for using the Social Security Act's definition in the CoP is a result of concerns brought to your attention by podiatrists. Podiatrists with advanced training may be qualified to perform an H&P. I oppose this proposed change and suggest that the CoP should be revised to include a doctor of medicine or osteopathy, an oral and maxillofacial surgeon for patients admitted for oral and maxillofacial surgery, and if they are trained to perform a complete H&P, a doctor of podiatric medicine who has completed an accredited podiatric residency program for patients admitted for podiatric surgery.

Thank you for consideration of these comments.

Sincerely,

David C Obenchain

CMS-3122-P-72

Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. James Reed

Date & Time: 05/10/2005

Organization : Washington State Society of Oral and Maxillofacial

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

RE: CMS-3122-P

As a medical doctor, dentist and oral and maxillofacial surgeon, I support specific wording to include OMS (oral and maxillofacial surgeons) in the list of providers able to perform history and physical examinations on patients being treated for medicare and medicaid government supported procedures. This wording is needed in our specialized and blended health-care arena to preserve patient care which is provided by oral and maxillofacial surgeons with dental degrees. To exclude this group of providers would exclude the specialized expertise and knowledge base which has been the foundation of head and neck traumatology, oncology, bioengineering and innovation. I support specific wording to include OMS's in providers who with appropriate training are granted history and physical examination priviledges.

James E. Reed, DDS, MD
Seattle, WA

CMS-3122-P-73**Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations****Submitter : Dr.****Date & Time: 05/10/2005****Organization : AAOMS****Category : Other Health Care Professional****Issue Areas/Comments****GENERAL**

GENERAL

I am an oral and maxillofacial surgeon, and have reviewed the proposed change to the CMS Conditions of Participation (CoP) related to H&Ps that would allow this service to be performed by a physician as defined by the Social Security Act. The Social Security Act defines physicians as doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors. Although I support the use of this definition in most contexts, I am concerned that applying this definition to the H&P will cause hospital medical staffs to limit this privilege exclusively to MD/DOs and, as a result, negatively impact patient care. Some medical staffs are already attempting to change their bylaws to limit this privilege to MD/DOs, often because of their unfamiliarity with the education and training standards of non- MD/DO practitioners. Limitations or withdrawal of oral and maxillofacial surgeons' H&P privileges would limit access for my patients, as well as maxillofacial trauma patients who would need my services, and would threaten the accreditation status of the 100 accredited oral and maxillofacial surgery residency training programs.

I understand the motivation for using the Social Security Act's definition in the CoP is a result of concerns brought to your attention by podiatrists. Podiatrists with advanced training may be qualified to perform an H&P. I oppose this proposed change and suggest that the CoP should be revised to include a doctor of medicine or osteopathy, an oral and maxillofacial surgeon for patients admitted for oral and maxillofacial surgery, and if they are trained to perform a complete H&P, a doctor of podiatric medicine who has completed an accredited podiatric residency program for patients admitted for podiatric surgery.

Thank you for consideration of these comments.

CMS-3122-P-74 Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. Scott Goodove

Date & Time: 05/10/2005

Organization : Association of Oral & Maxillofacial Surgery

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS-3122-P, Completion of the Medical History and Physical Examination

I am an oral and maxillofacial surgeon, and have reviewed the proposed change to the CMS Conditions of Participation (CoP) related to H&Ps that would allow this service to be performed by a physician as defined by the Social Security Act. The Social Security Act defines physicians as doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors. Although I support the use of this definition in most contexts, I am concerned that applying this definition to the H&P will cause hospital medical staffs to limit this privilege exclusively to MD/DOs and, as a result, negatively impact patient care. Some medical staffs are already attempting to change their bylaws to limit this privilege to MD/DOs, often because of their unfamiliarity with the education and training standards of non- MD/DO practitioners. Limitations or withdrawal of oral and maxillofacial surgeons' H&P privileges would limit access for my patients, as well as maxillofacial trauma patients who would need my services, and would threaten the accreditation status of the 100 accredited oral and maxillofacial surgery residency training programs.

I understand the motivation for using the Social Security Act's definition in the CoP is a result of concerns brought to your attention by podiatrists. Podiatrists with advanced training may be qualified to perform an H&P. I oppose this proposed change and suggest that the CoP should be revised to include a doctor of medicine or osteopathy, an oral and maxillofacial surgeon for patients admitted for oral and maxillofacial surgery, and if they are trained to perform a complete H&P, a doctor of podiatric medicine who has completed an accredited podiatric residency program for patients admitted for podiatric surgery.

Thank you for consideration of these comments.

Sincerely,

Scott R. Goodove, DDS

CMS-3122-P-75**Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations****Submitter : Dr. Luis Cardenas****Date & Time: 05/10/2005****Organization : Dr. Luis Cardenas****Category : Physician****Issue Areas/Comments****GENERAL**

GENERAL

Re: CMS-3122-P, Completion of the Medical History and Physical Examination

I am an oral and maxillofacial surgeon, and have reviewed the proposed change to the CMS Conditions of Participation (CoP) related to H&Ps that would allow this service to be performed by a physician as defined by the Social Security Act. The Social Security Act defines physicians as doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors. Although I support the use of this definition in most contexts, I am concerned that applying this definition to the H&P will cause hospital medical staffs to limit this privilege exclusively to MD/DOs and, as a result, negatively impact patient care. Some medical staffs are already attempting to change their bylaws to limit this privilege to MD/DOs, often because of their unfamiliarity with the education and training standards of non- MD/DO practitioners. Limitations or withdrawal of oral and maxillofacial surgeons' H&P privileges would limit access for my patients, as well as maxillofacial trauma patients who would need my services, and would threaten the accreditation status of the 100 accredited oral and maxillofacial surgery residency training programs.

I understand the motivation for using the Social Security Act's definition in the CoP is a result of concerns brought to your attention by podiatrists. Podiatrists with advanced training may be qualified to perform an H&P. I oppose this proposed change and suggest that the CoP should be revised to include a doctor of medicine or osteopathy, an oral and maxillofacial surgeon for patients admitted for oral and maxillofacial surgery, and if they are trained to perform a complete H&P, a doctor of podiatric medicine who has completed an accredited podiatric residency program for patients admitted for podiatric surgery.

Thank you for consideration of these comments.

Sincerely,

Luis Cardenas, DMD
Oral and Maxillofacial Surgeon

CMS-3122-P-76

Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. moris aynechi

Date & Time: 05/10/2005

Organization : oral and maxillofacial surgery

Category : Health Care Professional or Association

Issue Areas/Comments**GENERAL**

GENERAL

I am an oral and maxillofacial surgeon, and have reviewed the proposed change to the CMS Conditions of Participation (CoP) related to H&Ps that would allow this service to be performed by a physician as defined by the Social Security Act. The Social Security Act defines physicians as doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors. Although I support the use of this definition in most contexts, I am concerned that applying this definition to the H&P will cause hospital medical staffs to limit this privilege exclusively to MD/DOs and, as a result, negatively impact patient care. Some medical staffs are already attempting to change their bylaws to limit this privilege to MD/DOs, often because of their unfamiliarity with the education and training standards of non- MD/DO practitioners. Limitations or withdrawal of oral and maxillofacial surgeons' H&P privileges would limit access for my patients, as well as maxillofacial trauma patients who would need my services, and would threaten the accreditation status of the 100 accredited oral and maxillofacial surgery residency training programs.

I understand the motivation for using the Social Security Act's definition in the CoP is a result of concerns brought to your attention by podiatrists. Podiatrists with advanced training may be qualified to perform an H&P. I oppose this proposed change and suggest that the CoP should be revised to include a doctor of medicine or osteopathy, an oral and maxillofacial surgeon for patients admitted for oral and maxillofacial surgery, and if they are trained to perform a complete H&P, a doctor of podiatric medicine who has completed an accredited podiatric residency program for patients admitted for podiatric surgery.

Thank you for consideration of these comments.

Sincerely,

moris aynechi

CMS-3122-P-77

Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. Mark Egbert

Date & Time: 05/11/2005

Organization : Pediatric Oral and Maxillofacial Surgeon

Category : Physician

Issue Areas/Comments**Issue**

Categories of providers permitted to perform a history and physical examination

I am a pediatric oral and maxillofacial surgeon practicing full time in a children's hospital and I take call in a busy regional level I trauma center for adult and pediatric facial trauma. I have reviewed the proposed change to the CMS Conditions of Participation (CoP) related to H&Ps that would allow this service to be performed by a physician as defined by the Social Security Act. The Social Security Act defines physicians as doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors. Although I support the use of this definition in most contexts, I am concerned that applying this definition to the H&P will cause hospital medical staffs to limit this privilege exclusively to MD/DOs and, as a result, negatively impact patient care. Some medical staffs are already attempting to change their bylaws to limit this privilege to MD/DOs, often because of their unfamiliarity with the education and training standards of non- MD/DO practitioners. Limitations or withdrawal of oral and maxillofacial surgeons' H&P privileges would limit access for my patients, as well as maxillofacial trauma patients who would need my services, and would threaten the accreditation status of the 100 accredited oral and maxillofacial surgery residency training programs. I am a site reviewer for accreditation of OMS training programs. As such I know well the importance of these programs being able to show that their residents and attending oral and maxillofacial surgeons have H&P privileges codified within the hospital bylaws.

I understand the motivation for using the Social Security Act's definition in the CoP is a result of concerns brought to your attention by podiatrists. Podiatrists with advanced training may be qualified to perform an H&P. I oppose this proposed change and suggest that the CoP should be revised to include a doctor of medicine or osteopathy, an oral and maxillofacial surgeon for patients admitted for oral and maxillofacial surgery, and if they are trained to perform a complete H&P, a doctor of podiatric medicine who has completed an accredited podiatric residency program for patients admitted for podiatric surgery.

Thank you for consideration of these comments.

Sincerely,

Mark A. Egbert, DDS
Chief, Division of Pediatric OMS
Seattle Children's Hospital

CMS-3122-P-78

Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. Alan Peet

Date & Time: 05/11/2005

Organization : USAF, Wilford Hall Medical Center, Lackland AFB TX

Category : Other Health Care Professional

Issue Areas/Comments**GENERAL**

GENERAL

I am an oral and maxillofacial surgeon, and have reviewed the proposed change to the CMS Conditions of Participation (CoP) related to H&Ps that would allow this service to be performed by a physician as defined by the Social Security Act. The Social Security Act defines physicians as doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors. Although I support the use of this definition in most contexts, I am concerned that applying this definition to the H&P will cause hospital medical staffs to limit this privilege exclusively to MD/DOs and, as a result, negatively impact patient care. Some medical staffs are already attempting to change their bylaws to limit this privilege to MD/DOs, often because of their unfamiliarity with the education and training standards of non- MD/DO practitioners. Limitations or withdrawal of oral and maxillofacial surgeons' H&P privileges would limit access for my patients, as well as maxillofacial trauma patients who would need my services, and would threaten the accreditation status of the 100 accredited oral and maxillofacial surgery residency training programs.

I understand the motivation for using the Social Security Act's definition in the CoP is a result of concerns brought to your attention by podiatrists. Podiatrists with advanced training may be qualified to perform an H&P. I oppose this proposed change and suggest that the CoP should be revised to include a doctor of medicine or osteopathy, an oral and maxillofacial surgeon for patients admitted for oral and maxillofacial surgery, and if they are trained to perform a complete H&P, a doctor of podiatric medicine who has completed an accredited podiatric residency program for patients admitted for podiatric surgery.

Thank you for consideration of these comments.

Sincerely,

Alan L. Peet
Deputy Commander, Oral and Maxillofacial Surgery Residency
Wilford Hall Medical Center
Lackland AFB, TX

CMS-3122-P-79

Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. Andrew Kanter

Date & Time: 05/11/2005

Organization : PA Oral & Maxillofacial Surgery, Ltd.

Category : Physician

Issue Areas/Comments**GENERAL**

GENERAL

Re: CMS-3122-P, Completion of the Medical History and Physical Examination

I am an oral and maxillofacial surgeon, and have reviewed the proposed change to the CMS Conditions of Participation (CoP) related to H&Ps that would allow this service to be performed by a physician as defined by the Social Security Act. The Social Security Act defines physicians as doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors. Although I support the use of this definition in most contexts, I am concerned that applying this definition to the H&P will cause hospital medical staffs to limit this privilege exclusively to MD/DOs and, as a result, negatively impact patient care. Some medical staffs are already attempting to change their bylaws to limit this privilege to MD/DOs, often because of their unfamiliarity with the education and training standards of non- MD/DO practitioners. Limitations or withdrawal of oral and maxillofacial surgeons' H&P privileges would limit access for my patients, as well as maxillofacial trauma patients who would need my services, and would threaten the accreditation status of the 100 accredited oral and maxillofacial surgery residency training programs.

I understand the motivation for using the Social Security Act's definition in the CoP is a result of concerns brought to your attention by podiatrists. Podiatrists with advanced training may be qualified to perform an H&P. I oppose this proposed change and suggest that the CoP should be revised to include a doctor of medicine or osteopathy, an oral and maxillofacial surgeon for patients admitted for oral and maxillofacial surgery, and if they are trained to perform a complete H&P, a doctor of podiatric medicine who has completed an accredited podiatric residency program for patients admitted for podiatric surgery.

Thank you for consideration of these comments.

Sincerely,

Andrew L. Kanter, DMD

CMS-3122-P-80 Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. Michael Bianchi

Date & Time: 05/11/2005

Organization : PAOMS, LTD

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS-3122-P, Completion of the Medical History and Physical Examination

I am an oral and maxillofacial surgeon, and have reviewed the proposed change to the CMS Conditions of Participation (CoP) related to H&Ps that would allow this service to be performed by a physician as defined by the Social Security Act. The Social Security Act defines physicians as doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors. Although I support the use of this definition in most contexts, I am concerned that applying this definition to the H&P will cause hospital medical staffs to limit this privilege exclusively to MD/DOs and, as a result, negatively impact patient care. Some medical staffs are already attempting to change their bylaws to limit this privilege to MD/DOs, often because of their unfamiliarity with the education and training standards of non- MD/DO practitioners. Limitations or withdrawal of oral and maxillofacial surgeons' H&P privileges would limit access for my patients, as well as maxillofacial trauma patients who would need my services, and would threaten the accreditation status of the 100 accredited oral and maxillofacial surgery residency training programs.

I understand the motivation for using the Social Security Act's definition in the CoP is a result of concerns brought to your attention by podiatrists. Podiatrists with advanced training may be qualified to perform an H&P. I oppose this proposed change and suggest that the CoP should be revised to include a doctor of medicine or osteopathy, an oral and maxillofacial surgeon for patients admitted for oral and maxillofacial surgery, and if they are trained to perform a complete H&P, a doctor of podiatric medicine who has completed an accredited podiatric residency program for patients admitted for podiatric surgery.

Thank you for consideration of these comments.

Sincerely,

Michael A. Bianchi, DDS

CMS-3122-P-81**Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations****Submitter : Dr. Thomas Nordone****Date & Time: 05/11/2005****Organization : PAOMS, LTD.****Category : Physician****Issue Areas/Comments****GENERAL**

GENERAL

Re: CMS-3122-P, Completion of the Medical History and Physical Examination

I am an oral and maxillofacial surgeon, and have reviewed the proposed change to the CMS Conditions of Participation (CoP) related to H&Ps that would allow this service to be performed by a physician as defined by the Social Security Act. The Social Security Act defines physicians as doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors. Although I support the use of this definition in most contexts, I am concerned that applying this definition to the H&P will cause hospital medical staffs to limit this privilege exclusively to MD/DOs and, as a result, negatively impact patient care. Some medical staffs are already attempting to change their bylaws to limit this privilege to MD/DOs, often because of their unfamiliarity with the education and training standards of non- MD/DO practitioners. Limitations or withdrawal of oral and maxillofacial surgeons' H&P privileges would limit access for my patients, as well as maxillofacial trauma patients who would need my services, and would threaten the accreditation status of the 100 accredited oral and maxillofacial surgery residency training programs.

I understand the motivation for using the Social Security Act's definition in the CoP is a result of concerns brought to your attention by podiatrists. Podiatrists with advanced training may be qualified to perform an H&P. I oppose this proposed change and suggest that the CoP should be revised to include a doctor of medicine or osteopathy, an oral and maxillofacial surgeon for patients admitted for oral and maxillofacial surgery, and if they are trained to perform a complete H&P, a doctor of podiatric medicine who has completed an accredited podiatric residency program for patients admitted for podiatric surgery.

Thank you for consideration of these comments.

Sincerely,

Thomas P. Nordone, DMD

CMS-3122-P-82 Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. Ronen Gold

Date & Time: 05/11/2005

Organization : PAOMS, LTD.

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS-3122-P, Completion of the Medical History and Physical Examination

I am an oral and maxillofacial surgeon, and have reviewed the proposed change to the CMS Conditions of Participation (CoP) related to H&Ps that would allow this service to be performed by a physician as defined by the Social Security Act. The Social Security Act defines physicians as doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors. Although I support the use of this definition in most contexts, I am concerned that applying this definition to the H&P will cause hospital medical staffs to limit this privilege exclusively to MD/DOs and, as a result, negatively impact patient care. Some medical staffs are already attempting to change their bylaws to limit this privilege to MD/DOs, often because of their unfamiliarity with the education and training standards of non- MD/DO practitioners. Limitations or withdrawal of oral and maxillofacial surgeons' H&P privileges would limit access for my patients, as well as maxillofacial trauma patients who would need my services, and would threaten the accreditation status of the 100 accredited oral and maxillofacial surgery residency training programs.

I understand the motivation for using the Social Security Act's definition in the CoP is a result of concerns brought to your attention by podiatrists. Podiatrists with advanced training may be qualified to perform an H&P. I oppose this proposed change and suggest that the CoP should be revised to include a doctor of medicine or osteopathy, an oral and maxillofacial surgeon for patients admitted for oral and maxillofacial surgery, and if they are trained to perform a complete H&P, a doctor of podiatric medicine who has completed an accredited podiatric residency program for patients admitted for podiatric surgery.

Thank you for consideration of these comments.

Sincerely,

Ronen Gold, DDS

CMS-3122-P-83**Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations****Submitter :** Dr. German Trujillo**Date & Time:** 05/11/2005**Organization :** AAOMS**Category :** Other Health Care Professional**Issue Areas/Comments****Issue**

Categories of providers permitted to perform a history and physical examination

Re: CMS-3122-P, Completion of the Medical History and Physical Examination

I am an oral and maxillofacial surgeon in WA, and have reviewed the proposed change to the CMS Conditions of Participation (CoP) related to H&Ps that would allow this service to be performed by a physician as defined by the Social Security Act. The Social Security Act defines physicians as doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors. Although I support the use of this definition in most contexts, I am concerned that applying this definition to the H&P will cause hospital medical staffs to limit this privilege exclusively to MD/DOs and, as a result, negatively impact patient care. Some medical staffs are already attempting to change their bylaws to limit this privilege to MD/DOs, often because of their unfamiliarity with the education and training standards of non-MD/DO practitioners. Limitations or withdrawal of oral and maxillofacial surgeons' H&P privileges would limit access for my patients, as well as maxillofacial trauma patients who would need my services, and would threaten the accreditation status of the 100 accredited oral and maxillofacial surgery residency training programs.

I understand the motivation for using the Social Security Act's definition in the CoP is a result of concerns brought to your attention by podiatrists. Podiatrists with advanced training may be qualified to perform an H&P. I oppose this proposed change and suggest that the CoP should be revised to include a doctor of medicine or osteopathy, an oral and maxillofacial surgeon for patients admitted for oral and maxillofacial surgery, and if they are trained to perform a complete H&P, a doctor of podiatric medicine who has completed an accredited podiatric residency program for patients admitted for podiatric surgery.

Thank you for consideration of these comments.

Sincerely,

German Trujillo

CMS-3122-P-84**Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations****Submitter : Dr. Jeffrey Knorr****Date & Time: 05/11/2005****Organization : Oral Surgery Specialist of Macomb****Category : Other Health Care Professional****Issue Areas/Comments****GENERAL**

GENERAL

Re: CMS-3122-P, Completion of the Medical History and Physical Examination

I am an oral and maxillofacial surgeon, and have reviewed the proposed change to the CMS Conditions of Participation (CoP) related to H&Ps that would allow this service to be performed by a physician as defined by the Social Security Act. The Social Security Act defines physicians as doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors. Although I support the use of this definition in most contexts, I am concerned that applying this definition to the H&P will cause hospital medical staffs to limit this privilege exclusively to MD/DOs and, as a result, negatively impact patient care. Some medical staffs are already attempting to change their bylaws to limit this privilege to MD/DOs, often because of their unfamiliarity with the education and training standards of non- MD/DO practitioners. Limitations or withdrawal of oral and maxillofacial surgeons' H&P privileges would limit access for my patients, as well as maxillofacial trauma patients who would need my services, and would threaten the accreditation status of the 100 accredited oral and maxillofacial surgery residency training programs.

I understand the motivation for using the Social Security Act's definition in the CoP is a result of concerns brought to your attention by podiatrists. Podiatrists with advanced training may be qualified to perform an H&P. I oppose this proposed change and suggest that the CoP should be revised to include a doctor of medicine or osteopathy, an oral and maxillofacial surgeon for patients admitted for oral and maxillofacial surgery, and if they are trained to perform a complete H&P, a doctor of podiatric medicine who has completed an accredited podiatric residency program for patients admitted for podiatric surgery.

Thank you for consideration of these comments.

Sincerely,
Jeffrey C. Knorr, DDS,MBA

CMS-3122-P-85**Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations****Submitter : Dr. Alexander Kim****Date & Time: 05/11/2005****Organization : Newport Oral and Maxillofacial Surgery****Category : Physician****Issue Areas/Comments****GENERAL**

GENERAL

To whom it may concern:

I am an oral and maxillofacial surgeon, and have reviewed the proposed change to the CMS Conditions of Participation (CoP) related to H&Ps that would allow this service to be performed by a physician as defined by the Social Security Act. The Social Security Act defines physicians as doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors. Although I support the use of this definition in most contexts, I am concerned that applying this definition to the H&P will cause hospital medical staffs to limit this privilege exclusively to MD/DOs and, as a result, negatively impact patient care. Some medical staffs are already attempting to change their bylaws to limit this privilege to MD/DOs, often because of their unfamiliarity with the education and training standards of non- MD/DO practitioners. Limitations or withdrawal of oral and maxillofacial surgeons' H&P privileges would limit access for my patients, as well as maxillofacial trauma patients who would need my services, and would threaten the accreditation status of the 100 accredited oral and maxillofacial surgery residency training programs.

I understand the motivation for using the Social Security Act's definition in the CoP is a result of concerns brought to your attention by podiatrists. Podiatrists with advanced training may be qualified to perform an H&P. I oppose this proposed change and suggest that the CoP should be revised to include a doctor of medicine or osteopathy, an oral and maxillofacial surgeon for patients admitted for oral and maxillofacial surgery, and if they are trained to perform a complete H&P, a doctor of podiatric medicine who has completed an accredited podiatric residency program for patients admitted for podiatric surgery.

Thank you for consideration of these comments.

Sincerely,

Alexander Y. Kim D.D.S., M.D.

CMS-3122-P-86**Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations****Submitter : Dr. Michael O'Neil****Date & Time: 05/11/2005****Organization : Dr. Michael O'Neil****Category : Other Health Care Professional****Issue Areas/Comments****GENERAL**

GENERAL

I am an oral and maxillofacial surgeon, and have reviewed the proposed change to the CMS Conditions of Participation (CoP) related to H&Ps that would allow this service to be performed by a physician as defined by the Social Security Act. The Social Security Act defines physicians as doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors. Although I support the use of this definition in most contexts, I am concerned that applying this definition to the H&P will cause hospital medical staffs to limit this privilege exclusively to MD/DOs and, as a result, negatively impact patient care. Some medical staffs are already attempting to change their bylaws to limit this privilege to MD/DOs, often because of their unfamiliarity with the education and training standards of non- MD/DO practitioners. Limitations or withdrawal of oral and maxillofacial surgeons' H&P privileges would limit access for my patients, as well as maxillofacial trauma patients who would need my services, and would threaten the accreditation status of the 100 accredited oral and maxillofacial surgery residency training programs.

I understand the motivation for using the Social Security Act's definition in the CoP is a result of concerns brought to your attention by podiatrists. Podiatrists with advanced training may be qualified to perform an H&P. I oppose this proposed change and suggest that the CoP should be revised to include a doctor of medicine or osteopathy, an oral and maxillofacial surgeon for patients admitted for oral and maxillofacial surgery, and if they are trained to perform a complete H&P, a doctor of podiatric medicine who has completed an accredited podiatric residency program for patients admitted for podiatric surgery.

Thank you for consideration of these comments.

Sincerely,

Michael L. O'Neil, DMD

CMS-3122-P-87**Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations****Submitter : Dr. Richard Torchia****Date & Time: 05/11/2005****Organization : AAOMS****Category : Other Practitioner****Issue Areas/Comments****GENERAL**

GENERAL

Re: CMS-3122-P, Completion of the Medical History and Physical Examination

I am an oral and maxillofacial surgeon, and have reviewed the proposed change to the CMS Conditions of Participation (CoP) related to H&Ps that would allow this service to be performed by a physician as defined by the Social Security Act. The Social Security Act defines physicians as doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors. Although I support the use of this definition in most contexts, I am concerned that applying this definition to the H&P will cause hospital medical staffs to limit this privilege exclusively to MD/DOs and, as a result, negatively impact patient care. Some medical staffs are already attempting to change their bylaws to limit this privilege to MD/DOs, often because of their unfamiliarity with the education and training standards of non- MD/DO practitioners. Limitations or withdrawal of oral and maxillofacial surgeons' H&P privileges would limit access for my patients, as well as maxillofacial trauma patients who would need my services, and would threaten the accreditation status of the 100 accredited oral and maxillofacial surgery residency training programs.

I understand the motivation for using the Social Security Act's definition in the CoP is a result of concerns brought to your attention by podiatrists. Podiatrists with advanced training may be qualified to perform an H&P. I oppose this proposed change and suggest that the CoP should be revised to include a doctor of medicine or osteopathy, an oral and maxillofacial surgeon for patients admitted for oral and maxillofacial surgery, and if they are trained to perform a complete H&P, a doctor of podiatric medicine who has completed an accredited podiatric residency program for patients admitted for podiatric surgery.

Thank you for consideration of these comments.

Sincerely,

Richard Torchia, D.D.S.
Oral & Maxillofacial Surgery

CMS-3122-P-88

Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. Michael Apfel

Date & Time: 05/11/2005

Organization : Private practice

Category : Other Practitioner

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS-3122-P. Completion of the Medical History and Physical Examination

I am an oral and maxillofacial surgeon, and have reviewed the proposed change to the CMS Conditions of Participation (CoP) related to H&Ps that would allow this service to be performed by a physician as defined by the Social Security Act. The Social Security Act defines physicians as doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors. Although I support the use of this definition in most contexts, I am concerned that applying this definition to the H&P will cause hospital medical staffs to limit this privilege exclusively to MD/DOs and, as a result, negatively impact patient care. Some medical staffs are already attempting to change their bylaws to limit this privilege to MD/DOs, often because of their unfamiliarity with the education and training standards of non- MD/DO practitioners. Limitations or withdrawal of oral and maxillofacial surgeons' H&P privileges would limit access for my patients, as well as maxillofacial trauma patients who would need my services, and would threaten the accreditation status of the 100 accredited oral and maxillofacial surgery residency training programs.

I understand the motivation for using the Social Security Act's definition in the CoP is a result of concerns brought to your attention by podiatrists. Podiatrists with advanced training may be qualified to perform an H&P. I oppose this proposed change and suggest that the CoP should be revised to include a doctor of medicine or osteopathy, an oral and maxillofacial surgeon for patients admitted for oral and maxillofacial surgery, and if they are trained to perform a complete H&P, a doctor of podiatric medicine who has completed an accredited podiatric residency program for patients admitted for podiatric surgery.

Thank you for consideration of these comments.

Sincerely,

CMS-3122-P-88**Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations****Submitter : Dr. Michael Apfel****Date & Time: 05/11/2005****Organization : Private practice****Category : Other Practitioner****Issue Areas/Comments****GENERAL**

GENERAL

Re: CMS-3122-P, Completion of the Medical History and Physical Examination

I am an oral and maxillofacial surgeon, and have reviewed the proposed change to the CMS Conditions of Participation (CoP) related to H&Ps that would allow this service to be performed by a physician as defined by the Social Security Act. The Social Security Act defines physicians as doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors. Although I support the use of this definition in most contexts, I am concerned that applying this definition to the H&P will cause hospital medical staffs to limit this privilege exclusively to MD/DOs and, as a result, negatively impact patient care. Some medical staffs are already attempting to change their bylaws to limit this privilege to MD/DOs, often because of their unfamiliarity with the education and training standards of non- MD/DO practitioners. Limitations or withdrawal of oral and maxillofacial surgeons' H&P privileges would limit access for my patients, as well as maxillofacial trauma patients who would need my services, and would threaten the accreditation status of the 100 accredited oral and maxillofacial surgery residency training programs.

I understand the motivation for using the Social Security Act's definition in the CoP is a result of concerns brought to your attention by podiatrists. Podiatrists with advanced training may be qualified to perform an H&P. I oppose this proposed change and suggest that the CoP should be revised to include a doctor of medicine or osteopathy, an oral and maxillofacial surgeon for patients admitted for oral and maxillofacial surgery, and if they are trained to perform a complete H&P, a doctor of podiatric medicine who has completed an accredited podiatric residency program for patients admitted for podiatric surgery.

Thank you for consideration of these comments.

Sincerely,

CMS-3122-P-89

Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. Spencer Wilson

Date & Time: 05/11/2005

Organization : AAOMS

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

I am an oral and maxillofacial surgeon, and have reviewed the proposed change to the CMS Conditions of Participation (CoP) related to H&Ps that would allow this service to be performed by a physician as defined by the Social Security Act. The Social Security Act defines physicians as doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors. Although I support the use of this definition in most contexts, I am concerned that applying this definition to the H&P will cause hospital medical staffs to limit this privilege exclusively to MD/DOs and, as a result, negatively impact patient care. Some medical staffs are already attempting to change their bylaws to limit this privilege to MD/DOs, often because of their unfamiliarity with the education and training standards of non- MD/DO practitioners. Limitations or withdrawal of oral and maxillofacial surgeons' H&P privileges would limit access for my patients, as well as maxillofacial trauma patients who would need my services, and would threaten the accreditation status of the 100 accredited oral and maxillofacial surgery residency training programs.

I understand the motivation for using the Social Security Act's definition in the CoP is a result of concerns brought to your attention by podiatrists. Podiatrists with advanced training may be qualified to perform an H&P. I oppose this proposed change and suggest that the CoP should be revised to include a doctor of medicine or osteopathy, an oral and maxillofacial surgeon for patients admitted for oral and maxillofacial surgery, and if they are trained to perform a complete H&P, a doctor of podiatric medicine who has completed an accredited podiatric residency program for patients admitted for podiatric surgery.

Thank you for consideration of these comments.

Sincerely,

Spencer Wilson, DDS

CMS-3122-P-90

Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. Steven Whitney

Date & Time: 05/11/2005

Organization : Northern Montana Oral and Maxillofacial Surgery

Category : Other Practitioner

Issue Areas/Comments

GENERAL

GENERAL

I am an oral and maxillofacial surgeon, and have reviewed the proposed change to the CMS Conditions of Participation (CoP) related to H&Ps that would allow this service to be performed by a physician as defined by the Social Security Act. The Social Security Act defines physicians as doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors. Although I support the use of this definition in most contexts, I am concerned that applying this definition to the H&P will cause hospital medical staffs to limit this privilege exclusively to MD/DOs and, as a result, negatively impact patient care. Some medical staffs are already attempting to change their bylaws to limit this privilege to MD/DOs, often because of their unfamiliarity with the education and training standards of non- MD/DO practitioners. Limitations or withdrawal of oral and maxillofacial surgeons' H&P privileges would limit access for my patients, as well as maxillofacial trauma patients who would need my services, and would threaten the accreditation status of the 100 accredited oral and maxillofacial surgery residency training programs.

I understand the motivation for using the Social Security Act's definition in the CoP is a result of concerns brought to your attention by podiatrists. Podiatrists with advanced training may be qualified to perform an H&P. I oppose this proposed change and suggest that the CoP should be revised to include a doctor of medicine or osteopathy, an oral and maxillofacial surgeon for patients admitted for oral and maxillofacial surgery, and if they are trained to perform a complete H&P, a doctor of podiatric medicine who has completed an accredited podiatric residency program for patients admitted for podiatric surgery.

Thank you for consideration of these comments.

Sincerely,

Steven J. Whitney, DDS
Oral and Maxillofacial Surgeon

CMS-3122-P-91

Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. Brian Lilien

Date & Time: 05/11/2005

Organization : American Assoc. of Oral & Maxillofacial Surgeons

Category : Other Health Care Provider

Issue Areas/Comments**GENERAL**

GENERAL

I am an oral and maxillofacial surgeon, and have reviewed the proposed change to the CMS Conditions of Participation (CoP) related to the H&P's that would allow this service to be performed by a physician as defined by the Social Security Act. The Social Security Act defines physicians as doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors. Although I support the use of this definition in most contexts, I am concerned that applying this definition to the H&P will cause hospital medical staffs to limit this privilege exclusively to MD/DOs and , as a result, negatively impact patient care. Some medical staffs are already attempting to change their bylaws to limit this privilege to MD/DOs, often because of their unfamiliarity with the education and training standards of non-MD/DO practitioners. Limitations or withdrawal of oral and maxillofacial surgeons' H&P priveleges would limit access for my patients, as well as maxillofacial trauma patients and fascial space infection patients, who would need my services, and would threaten the accreditation status of the 100 accredited oral and maxillofacial surgery residency training programs.

I understand the motivation for using the Social Security Act's definition in the CoP is a result of concerns brought to your attention by podiatrists. Podiatrists with advanced training may be qualified to perform an H&P. I opposed this proposed change and suggest that the CoP should be revised to include a doctor of medicine or osteopathy, an oral and maxillofacial surgeon for patients admitted for oral and maxillofacial surgery, and if they are trained to perform a complete H&P, a doctor of podiatric medicine who has completed an accredited podiatric residency program for patients admitted for podiatric surgery.

Thank you for consideration of these comments.

Sincerely,

Brian A. Lilien, DDS

CMS-3122-P-93

Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. Jerome Holbrook

Date & Time: 05/11/2005

Organization : Indian Health Service, US Public Health Service

Category : Federal Government

Issue Areas/Comments

GENERAL

GENERAL

Re: CMS-3122-P, Completion of the Medical History and Physical Examination

I am an oral and maxillofacial surgeon, and have reviewed the proposed change to the CMS Conditions of Participation (CoP) related to H&Ps that would allow this service to be performed by a physician as defined by the Social Security Act. The Social Security Act defines physicians as doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors. Although I support the use of this definition in most contexts, I am concerned that applying this definition to the H&P will cause hospital medical staffs to limit this privilege exclusively to MD/DOs and, as a result, negatively impact patient care. Some medical staffs are already attempting to change their bylaws to limit this privilege to MD/DOs, often because of their unfamiliarity with the education and training standards of non- MD/DO practitioners. Limitations or withdrawal of oral and maxillofacial surgeons' H&P privileges would limit access for my patients, as well as maxillofacial trauma patients who would need my services, and would threaten the accreditation status of the 100 accredited oral and maxillofacial surgery residency training programs.

I understand the motivation for using the Social Security Act's definition in the CoP is a result of concerns brought to your attention by podiatrists. Podiatrists with advanced training may be qualified to perform an H&P. I oppose this proposed change and suggest that the CoP should be revised to include a doctor of medicine or osteopathy, an oral and maxillofacial surgeon for patients admitted for oral and maxillofacial surgery, and if they are trained to perform a complete H&P, a doctor of podiatric medicine who has completed an accredited podiatric residency program for patients admitted for podiatric surgery.

Thank you for consideration of these comments.

Sincerely,

Jerome Holbrook, DDS
CAPT, IHS, USPHS

CMS-3122-P-94**Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations****Submitter : Dr. Michael Singer****Date & Time: 05/11/2005****Organization : American Association Of Oral And Maxillofacial Sur****Category : Other Practitioner****Issue Areas/Comments****GENERAL**

GENERAL

Re: CMS-3122-P, Completion of the Medical History and Physical Examination

I am an oral and maxillofacial surgeon, and have reviewed the proposed change to the CMS Conditions of Participation (CoP) related to H&Ps that would allow this service to be performed by a physician as defined by the Social Security Act. The Social Security Act defines physicians as doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors. Although I support the use of this definition in most contexts, I am concerned that applying this definition to the H&P will cause hospital medical staffs to limit this privilege exclusively to MD/DOs and, as a result, negatively impact patient care. Some medical staffs are already attempting to change their bylaws to limit this privilege to MD/DOs, often because of their unfamiliarity with the education and training standards of non- MD/DO practitioners. Limitations or withdrawal of oral and maxillofacial surgeons' H&P privileges would limit access for my patients, as well as maxillofacial trauma patients who would need my services, and would threaten the accreditation status of the 100 accredited oral and maxillofacial surgery residency training programs.

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Thank you for consideration of these comments.

Sincerely,
Michael D. Singer, DMD

CMS-3122-P-95**Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations****Submitter :** Dr. Michael Werner**Date & Time:** 05/11/2005**Organization :** South Sound Oral Surgery**Category :** Other Health Care Professional**Issue Areas/Comments****GENERAL**

GENERAL

I am a practicing oral and maxillofacial surgeon who has had credentials to admit my patients at five different hospitals in five different states over my 27 year career. Although I have only a dental degree, my residency training included instruction on performing history and physicals for my patients. I am concerned that the proposed wording in this change might confuse some hospital credentials committees who already have attempted to limit admission and history and physical credentials for some of my colleagues. This change might have the effect of decreasing rather than increasing the availability of care for my patients, especially my trauma patients.

I understand that this change was promulgated by my podiatric colleagues who have encountered problems of the same manner, but by using the term 'physician' this would include many dentists and podiatrists who do not have proper training in the taking of histories and performing physical examinations. The most appropriate wording would include doctors of medicine and osteopathy and oral surgeons and podiatrists who are trained in the taking of histories and providing physical examinations but only for their patients.

Thanks for working so hard to provide appropriate care for all our patients.

Sincerely,

Michael E. Werner

CMS-3122-P-96**Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations****Submitter : Dr. Ronald Morris****Date & Time: 05/11/2005****Organization : Downriver Surgery Center****Category : Health Care Professional or Association****Issue Areas/Comments****Issue**

Categories of providers permitted to perform a history and physical examination

Re: CMS-3122-P, Completion of the Medical History and Physical Examination

I am an oral and maxillofacial surgeon, and have reviewed the proposed change to the CMS Conditions of Participation (CoP) related to H&Ps that would allow this service to be performed by a physician as defined by the Social Security Act. The Social Security Act defines physicians as doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors. Although I support the use of this definition in most contexts, I am concerned that applying this definition to the H&P will cause hospital medical staffs to limit this privilege exclusively to MD/DOs and, as a result, negatively impact patient care. Some medical staffs are already attempting to change their bylaws to limit this privilege to MD/DOs, often because of their unfamiliarity with the education and training standards of non- MD/DO practitioners. Limitations or withdrawal of oral and maxillofacial surgeons' H&P privileges would limit access for my patients, as well as maxillofacial trauma patients who would need my services, and would threaten the accreditation status of the 100 accredited oral and maxillofacial surgery residency training programs.

I understand the motivation for using the Social Security Act's definition in the CoP is a result of concerns brought to your attention by podiatrists. Podiatrists with advanced training may be qualified to perform an H&P. I oppose this proposed change and suggest that the CoP should be revised to include a doctor of medicine or osteopathy, an oral and maxillofacial surgeon for patients admitted for oral and maxillofacial surgery, and if they are trained to perform a complete H&P, a doctor of podiatric medicine who has completed an accredited podiatric residency program for patients admitted for podiatric surgery.

Thank you for consideration of these comments.

Sincerely, Ronald P Morris, DDS Oral and Maxillo-facial Surgeon

CMS-3122-P-97**Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations****Submitter : Dr. Daniel Sampson****Date & Time: 05/11/2005****Organization : OMS Specialists, P.A.****Category : Physician****Issue Areas/Comments****GENERAL**

GENERAL

Re: CMS-3122-P, Completion of the Medical History and Physical Examination

I am an oral and maxillofacial surgeon, and have reviewed the proposed change to the CMS Conditions of Participation (CoP) related to H&Ps that would allow this service to be performed by a physician as defined by the Social Security Act. The Social Security Act defines physicians as doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors. Although I support the use of this definition in most contexts, I am concerned that applying this definition to the H&P will cause hospital medical staffs to limit this privilege exclusively to MD/DOs and, as a result, negatively impact patient care. Some medical staffs are already attempting to change their bylaws to limit this privilege to MD/DOs, often because of their unfamiliarity with the education and training standards of non- MD/DO practitioners. Limitations or withdrawal of oral and maxillofacial surgeons' H&P privileges would limit access for my patients, as well as maxillofacial trauma patients who would need my services, and would threaten the accreditation status of the 100 accredited oral and maxillofacial surgery residency training programs.

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Thank you for consideration of these comments.

Sincerely,

Daniel Sampson D.D.S., M.D.

CMS-3122-P-98

Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. W. Frederick Stephens

Date & Time: 05/11/2005

Organization : AAOMS

Category : Physician

Issue Areas/Comments**GENERAL**

GENERAL

Re: CMS-3122-P, Completion of the Medical History and Physical Examination:

To Whom it May Concern,

I am an oral and maxillofacial surgeon, and have reviewed the proposed change to the CMS Conditions of Participation (CoP) related to H&Ps that would allow this service to be performed by a physician as defined by the Social Security Act. The Social Security Act defines physicians as doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors. Although I support the use of this definition in most contexts, I am concerned that applying this definition to the H&P will cause hospital medical staffs to limit this privilege exclusively to MD/DOs and, as a result, negatively impact patient care. Some medical staffs are already attempting to change their bylaws to limit this privilege to MD/DOs, often because of their unfamiliarity with the education and training standards of non- MD/DO practitioners. Limitations or withdrawal of oral and maxillofacial surgeons' H&P privileges would limit access for my patients, as well as maxillofacial trauma patients who would need my services, and would threaten the accreditation status of the 100 accredited oral and maxillofacial surgery residency training programs.

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Thank you for consideration of these comments.

Cordially,

Dr. W. Frederick Stephens
Diplomate, American Board of Oral & Maxillofacial Surgery
Director, The Pacific Coast Center for Oral & Facial Surgery
Medical Director, Pasadena Ambulatory Surgery Center, Inc.

CMS-3122-P-99

Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. David Wlody

Date & Time: 05/06/2005

Organization : SUNY-Downstate Medical Center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

It is stated that the only authorized personnel have access to locked areas. The regulation should state that authorized personnel do not need to be physicians or nurses, but rather may include other personnel such as engineering, housekeeping staff, etcetera.

CMS-3122-P-100

Hospital Conditions of Participation: History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations

Submitter : Dr. John Seidel

Date & Time: 05/11/2005

Organization : Dr. John Seidel

Category : Health Care Professional or Association

Issue Areas/Comments**GENERAL**

GENERAL

Re: CMS-3122-P, Completion of the Medical History and Physical Examination

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Thank you for consideration of these comments.

Sincerely,

John Seidel, DDS