UNIVERSITY OF KENTUCKY
COLLEGE OF HEALTH SCIENCES
PHYSICIAN ASSISTANT STUDIES - SUMMATIVE EXAM

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INTRODUCTION

The student will be presented with a virtual patient scenario, via standardized patient. The student will be evaluated in a summative fashion eliciting their clinical, professional, presenting, personal, and communicative skills when confronted with a routine yet moderately complex patient problem with a cardiopulmonary chief complaint and underlying chronic medical problems poorly controlled.

TIME	Prof. 1	Prof. 2	Prof. 3	Prof. 4	Prof. 5	Prof. 6	Prof. 7	Prof. 8
8:00-9:00								
9:00-10:00								
10:00-11:00								
11:00-12:00								
12:00-1:00 Break----------								
1:00-2:00								
2:00-3:00								
3:00-4:00								
4:00-5:00								

FORMAT FOR SCHEDULE

FLOW

20 Min.- History and Physical

20:00-25:00 -Gather thoughts and notes or finish exam if needed

25:00-30:00- Present case to faculty : including history , exam findings, Differential diagnosis and likely Assessment at this point.

30:00-40:00 -Give student labs and x-ray findings, allow them to formulate a reformulated assessment. Student will explain this to you before educating the patient of the diagnoses (primary and secondary).

40:00-60:00-- 20- minutes to write a brief SOAP note.

Case

- COPD / Chronic bronchitis exacerbation (primary)
- Hypertension- uncontrolled (secondary)
- Diabetes Mellitus- uncontrolled

MALE CASE

Case Name: PAS-AWl
Chief Complaint: Progressive Shortness of Breath
Patient Name: Jerry Grayson
Age: 71
Gender: Male
Ethnicity: any
Employment: Semi-retired Bank & Finance Executive
SP Affect, behavior, dress, manner: Older male who is stoic in nature.

His wife has been trying to get him to retire completely for 5 years. He has lived as a work-a-holic who finds his importance in Life in his work and does not want to give it up. He enjoys also golf and playing poker at the country club. He appears uncomfortable from chest tightness and trouble breathing but is in only mild-moderate distress, sitting forward in tripod position.

FEMALE CASE

Case Name: PAS-AW2
Chief Complaint: Progressive Shortness of Breath
Patient Name: Mary
Age: 67
Gender: Female
Ethnicity: any
Employment: Retired
Place of visit: Urgent Treatment center next to the hospital

SP Affect, behavior, dress, manner: Older female who is retired, married and involved in a lot of civic activities in her community which she very much enjoys. She has always lived a very active life and views her health problems as an obstacle which she tries to downplay. Her husband has been trying to get her to slow down for several years. She has been poorly compliant with her medications and has been in a somewhat state of denial about her medical problems.

Medication:

Accupril (quinapril) 10 mg qd
Albuterol MDI 2 puffs q6prn
Metformin 500 mg qd

Allergies:

Sulfa (rash from Bactrim)

Vitals:

BP 178/94;P 108 ;RR 20; T 99F;Sat 87% RA
Re-checked BP= 182/96, Re-checked P= 110; RR – 20/min labored

LABORATORY:

Results will be given to the student after presentation

CBC
Chemistry
ABG
HbA1C
CXR
PFT's

SIGNIFICANT FINDINGS SUMMARIZED:

Stoic elderly female who is sick but wants to minimize illness, although is ultimately ready to accept treatment due to severity of dyspnea

- Anxiety secondary to SOA
- Poorly compliant with chronic medications (undertreated HTN & DM)
- Moderate and acute SOA / dyspnea at rest
- Moderate respiratory distress with hypoxia and hypercarbia on oximetry and ABG
- Severe wheezes in all lobes of both lungs with scattered ronchi suggestive of COPD exacerbation with bronchitis (no evidence of pneumonia yet)
- Recent URI / sinusitis from history (not treated)
- HTN with moderate high blood pressure and non-compliance
- DM-2 with hyperglycemia, polyuria, elevated HbA1C and poorly compliant with diet and meds
- PFT's indicate obstructive lung disease

ASSESSMENT:

COPD with acute bronchitis

- Evolving respiratory failure / Hypoxemia
- HTN poorly controlled
- DM Type 2, out of control with hyperglycemia
- CAD currently stable but at risk with hypoxia
- Non-compliance
- Tobacco Abuse

PLAN:

(this is an example of a potential management plan)

- Initial Treatment
o Start IV with saline lock or kvo NS
o Continue to monitor vital signs and pulse oximetry
o Albuterol / Atrovent Nebulizer Tx with Peak flow after
o Solumedrol 125 mg IV
o Oxygen, start with face mask 40% or 2L NC and titrate to pulse ox
- Management
o Transfer to hospital for admission
o Plan to treat for acute COPD exacerbation, management of blood sugars with sliding scale insulin or increased oral hypoglycemic medications, dietary consult, Increase Accupril to 20 mg daily or add second agent and monitor blood pressure
o Consider IV or oral broad spectrum antibiotics until sputum culture results are returned
o Repeat CBC & ABG
o Smoking cessation
o Deal with patient compliance

College of Health Sciences
Physician Assistant Program
Summative/Masters: Part A
Case PS-AW1(Male)

SP Assessment Checklist
Preliminary

Objective	Yes	No
Greets the patient by name		
Appropriate & effective communication		
Introduces self by giving name, title and role		
Washes hands before beginning exam		

History

Objective	Yes	No
Asked open-ended questions about chief complaint		
Asked about character /quality, chronology (onset), duration		
Asked about alleviating / aggravating factors		
Asked about severity of dyspnea		
Asked about presence of chest pain		
Asked about similar symptoms in the past		
Listens to patient &provides eye contact		

Asked about progression of symptoms (worse with exertion)		
Asked about cough		
Asked about hemoptysis (blood in sputum)		
Asked about details of sputum (color, amount, consistency)		
Asked about fatigue / weakness		
Asked about palpitations or racing heart beats		
Asked about fever / chills or symptoms of infection		
Asked about smoking history		

Asked about weight loss or gain		
Asked about previous heart & lung problems		
Asked about exercise or current tolerance of physical activity		
Asked about medication allergies		
Asked about home medications		
Asked about past medical problems		
Asked about past surgical problems, hospitalizations		
Asked about routine health maintenance (for HTN or DM)		
Asked about Family History		

Physical Exam

Faculty Checklist

Presentation

	Yes	No
Begins presentation with appropriate patient identifiers		
Encapsulates the patient history & physical with a summative synopsis at the start		
Presentation follows a logical progression in thought		
Summarizes the HPI with reasonable depth & accuracy		
Highlights pertinent historical facts		
Highlights pertinent examination findings		
Develops a logical / reasonable differential diagnosis		
Communicates a working likely diagnosis, assessment & diagnostic plan		

Clinical Problem Solving

Develops Appropriate Differential Diagnosis		
Primary & secondary diagnoses developed		
Soap Note follows correct form		
Ordered appropriate tests for chief complaint		
Understands level of acuity (patient needs aggressive treatment of COPD exacerbation with possible admission to hospital?)		
Conveys an initial assessment & plan consistent with the case findings: (ie. Includes COPD /Obstructive lung disease with hypoxia as primary and Triages HTN & NIDDM as secondary problems to be addressed as well)		

Patient Education

	Yes	No
Discusses working diagnosis (COPD) & hypoxia		
Explains test results to patient (in layman terms)		
Discusses secondary diagnosis (Hypertension): either discusses need to take blood pressure medicine or increases dose of Accupril, or similar measure		
Discusses secondary diagnosis (Diabetes): discusses compliance with medication or adds a second agent		
Explains initial treatment plan for COPD: including B2 agonist nebulizer, IV steroids, need for oxygen, possible need for admission		
Discusses need for compliance to medications		
Explains need to stop smoking (set a date) offers medication		
Discusses diabetic diet and need to adhere to ADA diet