Week 2 iHuman Assignment Reflection Worksheet

Please read the assignment guidelines and rubric. Respond substantively to each self-reflection question below. **Write on this template.**

A. Assess your ability to gather information on your client within the iHuman Virtual Patient Encounter.

1. Use the iHuman score sheet to review your results for the focused health history and focused physical exam. How did you perform?

   I performed well in gathering the health history, scoring 100% in that section. I asked 119 questions, 9 of which were identified as correct according to the case criteria. In the physical exam section, I scored 83%, performing 96 exams with 12 correct findings and 3 missed exams. I did not perform any harmful actions

2. What did you find easy or difficult about navigating through the focused health history and focused physical exam sections of the case?

   Because I was unfamiliar with iHuman, I felt anxious when taking the patient's history and performing the physical exam. I wasn't sure that I had spent enough time on each system or asked all the necessary questions. This uncertainty made it challenging to feel assured in my approach, especially during the physical exam. I was often second-guessing whether I had covered everything needed for a thorough assessment. With more experience, I believe I will become more comfortable navigating the platform and more efficient in identifying key areas to focus on.

3. Describe one strategy to improve your performance in the next Virtual Patient Encounter.

   One strategy I will use is to consistently review foundational techniques and clinical reasoning frameworks, such as those outlined in *Bates' Guide to Physical Examination and History Taking*. Studies show that students who routinely practice system-based physical exam techniques and apply clinical reasoning

frameworks are significantly more accurate in selecting appropriate exams and forming differential diagnoses, even in unpredictable virtual case scenarios (Sanky et al., 2022). This approach will help me improve my performance in future encounters.

B. Assess your performance in documenting your findings on the electronic health record (EHR).

1. What did you find easy or difficult about navigating through the documentation of the history and physical within the system?

I found it difficult to document in this section because I wasn't always sure which wording or phrasing to use when recording findings. For example, in the Review of Systems (ROS), I struggled with how to properly express what the patient reported. I later realized that I should use phrases like "patient denies" for symptoms the patient did not experience, but I often used the term "negative," which may not be appropriate in that context. This made me unsure if my documentation was clear and clinically accurate.

2. Did you document all required components in the case?

   Yes, I documented all required components including the HPI, ROS, physical exam findings, medication use, and family/social history.

3. Describe one strategy to improve your performance in the next Virtual Patient Encounter.

   One effective strategy to improve my performance is to use standardized medical documentation templates and language guides before and during the encounter. These tools help ensure that I use clear, consistent, and clinically appropriate phrasing, especially for sections like the Review of Systems (ROS) and physical exam findings. For example, using phrases such as "patient denies" instead of "negative" to describe symptoms the patient does not have improves clarity and professionalism in documentation. Implementing structured and standardized documentation significantly improved the quality of electronic health record (EHR) notes in outpatient care (Ebbers et al., 2022).