Edward Via College of Osteopathic Medicine

MED 8147
Comprehensive Review Course II
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x Maxwell, R. (2011). Maxwell Quick Medical Reference, 6th ed. Minneapolis, MN: Maxwell Pub. Co. ISBN: 978-0964519145.

Guide by the assigned deadline may result in the student not being able to sit for COMPE until this assignment is completed.

D. Comprehensive Osteopathic Medical Performance Exam (COMPE)

The Comprehensive Osteopathic Medical Performance Exam (COMPE) is a summative evaluation of fundamental osteopathic clinical skills performed during the third year. The COMPE will assess the student through the context of clinical encounters with virtual patients. The examination is designed to evaluate the student's performance in medical history taking, physical examination, knowledge of osteopathic principles, and documentation (including the synthesis of clinical findings, integrated differential diagnosis, and formulation of a diagnostic and treatment plan) in a SOAP format. These patient-centered skills are evaluated in the telemedical, ambulatory, hospital, or emergent care settings, and are required to be personally performed as appropriate in a timely, efficient, safe, and effective manner.

The student will conduct six (6) virtual patient encounters, which may include acute or chronic conditions with patients who vary in age, gender, and ethnic and cultural backgrounds.

Students are required to meet minimal competency standards in the biomedical clinical skills domain. The biomedical domain categories measures skills in data-gathering, ordering diagnostic labs and imaging, counseling the patient, and documentation of the assessment and plan. The student must pass all categories iel ca

c. Order diagnostic labs and imaging.
d. Review and interpret diagnostic labs and imaging results.
e. Counsel the Patient
    i Discuss and review the diagnostic labs and imaging with the patient.
    ii Provide the patient with a diagnosis.
    iii Explain the etiology of the diagnosis and risk factors if applicable.
    iv Discuss the treatment and/or further workup if applicable.
    v Provide the disposition.
f. Assessment and secondary diagnoses
    i Provide primary assessment (which may include "health maintenance" or "well visit" as the primary diagnosis).
    ii Document any secondary diagnosis/diagnoses obtained during the encounter.
g. Documentation of plan
    i Patient disposition.
    ii Patient condition.
    iii Vital checks.
    iv Patient activity.
    v Nursing interventions.
    vi Patient diet.
    vii IV fluid maintenance.
    viii Medications.
    ix Inpatient and/or outpatient consultations or referrals.