Clinical Education Committee
October 2, 2015
Minutes

Attendance: see last page

Review of minutes - August - approved as is

MEDS - Fall 2015 flyer handed out
Late grades - please get any late grades in ASAP - MS4 students seeking all final grades to date for official transcripts to upload to ERAS.
Reminder to limit residency interview time away from clerkships, especially requireds.
MS4 Lottery updates - info to come

Updates

Clerkship Evaluation Reports
Refer to color handouts.

Data includes that for all courses, then each course broken out by site. Can be shared with site directors.
Duty hour data now reported in ranges.

Dr Pereira asked about balance of supervision and autonomy and student reporting of not enough autonomy (shadowing). Factors may include EHR especially in ambulatory sites. Anna Gregoire agreed that it happens more often in clinics, but that if you talk with your preceptor and offer strategies to see patients directly. Dr Kim noted that in FMCH 7600, the autonomy rating was relatively high, whereas in OBST and Neurology, the numbers are lower. Dr Fiol commented that, while the outpatient service may have less autonomy reported, shifting towards the inpatient service more would eliminate exposure to some diagnoses and procedures. Dr Kim added that more longitudinal experiences may be more conducive to higher autonomy. Dr Jewison shared that he reminds his students that, while he says he will do his best to get them enough patient encounters, it is also their responsibility to be assertive with their preceptors to obtain first-contact patient encounters. But, how do you disseminate that philosophy to the department faculty who are not participating in these discussions (CEC)? Dr Brooks shared that the complexity and volume of preceptors across experiences means that students, over time, must be trained to be comfortable engaging their attendings and setting up experiences. Dr Nixon agreed that the assertiveness of the student, in combination with the culture of the attendings and residents (and access to EMR), affect the overall autonomy level of each student. Dr Fallert shared that in FMCH 7600, Day 1 introduces the concept that 50% of patient encounters should be first-contact. Even though there are 30+ sites that students go to, that amount does seem to be possible. Dr Pereira added that she is working with MMA to understand what we can do to work better with our clinical preceptors. Results from a survey indicate that preceptors are not always clear what the students' abilities are and what the expectations of the curriculum are for each rotation. Dr Nikakhtar, referencing Dr Jewison's comment, added that much of the outcome falls on the students to be advocates for themselves - only the student knows what their previous experiences have been, current needs and goals, etc. Dr Nixon noted that in more specialized clinic settings, autonomy may become more difficult to obtain due to patient conditions. But, expectations for the encounter with a specific patient may be set prior to the student going in to see that patient (Gleich example: Find out how many times Charlie went to the bathroom last night). Feedback from preceptors is more valuable than "watching" a really good clinician see patients. Alexandra Muhar shared that many MS3's don't know how much autonomy they should be having; it has been helpful when preceptors (or the school) do set that expectation or what student should accomplish during the patient encounter.

Discussion

EMR notes by students - best practice
From the students….Anna Gregoire shared that she has had full access to the EMR in her rotations. She must do her due diligence to not repeat the previous notes in the system, but do her own H&P so that she can enter her own notes. Alexandra Muhar shared that for the most part she has had full access (had a one day blip), and that she felt more of the team contributing her own notes. But that some students may feel that because they can see the residents notes can/do copy forward the resident's notes. Partial access would be read-only, but not able to add own notes.

There are current efforts to standardize access and training for EMRs in our clinical affiliates, but leaders would like to create a best practices documents for HOW the students are using the EMR. Dr Kim completed a survey of experiences previously, and within EPIC, different profiles have different levels of access (i.e. students can sometimes enter orders, can never sign orders). There was a general guidelines document created to be shared with the affiliates (will send to CEC). Dr Michael Pitt, who is leading current efforts, will come to CEC in November to share status of EHR curriculum for MS1-2 and EPIC access/training standardization (EPIC 101). Dr Prunuske shared that AAMC is working guidelines also and could be used as a reference (link emailed to CEC members). Dr Brooks requested that future conversations clearly delineate absolute requirements and "good for education" guidelines, and that group is respectful of risk management.

Scoring rubric review
See new Disclaimer for E-value (handout): Meets Expectations doe NOT equal a failing grade - will go in Evalue AND be posted in BlackBag for all students. "Approved" by CEC.
See Final grade explanation calculations for Meet Expectations (handout)
Please review the statement for your clerkship. Contact Suzanne van den Hoogenhof if the statement is not correct for your clerkship and share update. Goal is to create a standard way of calculating overall Performance Assessment (clinical evaluation) score. Dr van den Hoogenhof's office will generate recommendation for standard calculation and present to CEC for feedback.

Clinical Course Grades, Years 1-4 policy & "pass by re-examination"
See policy and discussion handout
Current practice of failing final exam>Incomplete course grade>retake exam>passing course grade is in violation of University transcript policy. University policy requires a "T" grade be put in place (Test credit). Current Course Grades, Years 1-2 policy requires students to score 70% on final exam AND 70% of total course points. The Clinical Course Grades, Years 1-4 policy should be edited to set determination of result of pass other graded components, but fail final exam (SHELF, as well as EMMD, FMCH, etc). Clerkships must come to consensus on procedure to be followed. Student Council recommends Honors not be available grade, but Excellent and Satisfactory should still be options. Dr Kim proposed that no matter what you score on 2nd attempt, you get credit for 70% of your score, but Dr van den Hoogenhof countered that someone who scores just above passing threshold would still fail. Option of receiving the passing threshold score for that exam, regardless of exact passing score, could be possible math-wise. Another option was that highest possible course grade after two attempts is a Satisfactory.

As a residency program director, Dr Pereira commented that the "T" grade would be unfairly weighted given the clinical performance. She agrees with students in that it is unfair to other students for 2nd attempts to result in an Honors grade.

Proposal: On Course Grades policy - To pass course, must pass final exam in two attempts (but if you pass in the first attempt, you do not get to attempt twice) (also, if you are not passing overall course points, you fail clerkship and do not get to attempt final exam again). = Keeps us in compliance with University transcript policy. Dr van den Hoogenhof will draft document.

Next meeting: November 6, 2015