PATIENT ENCOUNTER LOG POLICY

Rationale

During the clinical clerkships, students begin developing the clinical competencies required for graduation and post-graduate training. These competencies are evaluated in many different ways: by faculty observation during rotations, by oral examinations, by NBME Subject Examinations, and by the USMLE Step 2 Examinations. In order to develop many of these competencies and meet the objectives required for graduation, the school needs to ensure that each student sees an appropriate mix of patients during their clerkships to achieve the learning objectives. For these reasons, as well as others discussed below and to meet accreditation standards, the school has developed this patient encounter log policy.

One of the medical student learning objectives students must achieve during their training involves documentation. Documentation is an essential and important feature of patient care and learning how and what to document is an important part of medical education. Keeping this log becomes a student training exercise in documentation. The accuracy with which students maintain and update their patient log will be part of their evaluation during the clerkships.

Process of Patient Encounter Log Review:

- Mid-Clerkship/End of Clerkship Review: The Clerkship Directors and/or Clerkship Administrators are monitoring the data on an ongoing basis to ensure that students are meeting clerkship objectives. See clerkship administration for a clerkship-specific list. They will also be reviewing student logs at mid-clerkship evaluation times. Individual meetings and/or email communications will be sent to address student progress at the mid-point of the clerkship. At the end of the clerkship the logs will be reviewed to ensure they are completed.

- Annual Reviews: Annually, a report will be prepared by the Office of Medical Education. The report will be reviewed by the Clerkship Directors Committee to determine if the specified patient encounters need to be revised in any way. This is then reported to the Curriculum Committee to ensure that the clinical experiences are meeting the objectives of the clerkship and to assess the comparability of experiences at various sites.

Clerkship Administration Responsibility

- Review students patient encounters regularly, at a minimum for mid rotation and end of rotation (If, for example, the Pediatrics Clerkship Administration notices that students are not experiencing patients with rhinorrhea, steps can be taken early in the clerkship to remedy the situation).
- The Clerkship Director is responsible for reviewing the progress of student logs mid-clerkship.
- Discuss encounters with the students.
- Identify if students are meeting course objectives.
- Identify areas needing supplementation.
- Develop and implement a remediation plan for students not completing required patient encounters or procedures. Clerkship directors are to submit the plan to the Curriculum Committee for approval. Remediation must be completed by the end of Phase 2.

Student Responsibility

- Document appropriate history and physical examinations that are directly observed by a physician as determined by the specific clerkship. Students are encouraged to log live patient encounters before using simulated encounters.
- Document all required patient encounters (and procedures if applicable).
- Document information in a timely manner. Students should develop a habit of logging patient encounters daily. Evidence of logging is required prior to the mid-clerkship meetings. Completion of the encounter log for each clerkship is due the last day of the clerkship. **Failure to complete logs will result in a failing grade for this portion of the clerkship and will be documented on the Student Performance Evaluation form.**
- If an excused circumstance presents wherein the student is unable to complete the log during a specific clerkship, the student will be responsible to participate in a clinical elective wherein the remaining items on the checklist may be completed.

Patient Encounter Log Items

The following items are required for the clerkship-specific patient encounters/procedures. Failure to complete these will be considered incomplete. You will have to complete all items in order to receive credit for the encounter.

- Date of encounter
- Supervisor (MD/DO, Fellow, Resident, NP, PA)
- Setting: Hospital, Clinic, Emergency Dept., Non-patient care activity (simulation, case discussion, etc.), or Other (skilled nursing facility, home visit, etc.)
- Type: Acute, Chronic, or Wellness Visit
- Gender Identity: Female, Male, Transgender, Non-binary or other
- Age Range: Pediatric (0-11 yrs), Adolescent (12-18 yrs), Adult (19-65 yrs), or Geriatric (>65 yrs)
- Student Role*:
  - Full: Student completes the history, physical examination, and clinical reasoning/medical decision-making (generates the differential diagnosis and/or proposed management), reported verbally or in writing to attending or resident.
  - Partial: Student completes the history and/or physical examination only.
  - Observe: Student is present for the clinical encounter, but is not a meaningful contributor to patient care provided.
  - Simulated: Student participates in module or other non-clinical activity.
- My supervisor was present at the clinical site during this encounter and provided oversight and direct feedback. (Y/N)

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