LSU School of Medicine

Clinical Handbook for Faculty, Residents, and Fellows

AY 2024-2025

LSU School of Medicine in New Orleans

Clinical Handbook for Faculty, Residents, and Fellows

This handbook was compiled by faculty members from the Office of Undergraduate Medical Education for all faculty, residents, and fellows who teach, supervise, and assess students in the clinical setting. This handbook is augmented by the clinical departments with specialty-specific requirements for core clinical conditions, required skills, and didactics and clinical schedules. It is updated annually and provided to all faculty, residents, and fellows via email through the departmental undergraduate medical education offices.

Table of Contents

Educational Program Objectives

Our educational program objectives (EPOs) represent our commitment to preparing our students to provide excellent and compassionate care for diverse patients and populations when they begin their graduate medical training and into their future careers. They are written broadly with the intent that more specific relevant objectives are delineated at both the course/ clerkship and the session levels.

These EPOs and their domains are derived from the *AAMC Reference List of General Physician Competencies (2013)*. The current revision is informed by the *Foundational Competencies for Undergraduate Medical Education draft (AAMC/AACOM/ACGME draft from AAMC website 2024*) and *Milestones 2.0* (*ACGME, Journal of GME 2018*).

Most recent revision and approval: Spring 2024 (Curriculum Steering Committee, Administrative Council, Faculty Assembly)

Patient Care (PC) – Our graduates provide compassionate, appropriate, effective, and safe patient-centered care that promotes patient health and integrates patient and caregiver values and preferences.

EPO PC 1 – Gather essential and accurate information about patients through considerate history-taking that includes the history of present illness, risk factors, and psychosocial contexts, utilizing multiple data sources and/or translator services when necessary.

EPO PC 2 – Gather essential and accurate information about patients through respectful, hypothesis-driven physical examination techniques, with continuous attention to the patient's comfort and safety.

EPO PC 3 – Recommend and Interpret data from laboratory, radiologic, and other diagnostic and screening tests to identify patient problems and organize priorities for patient care.

EPO PC 4 – Formulate a prioritized problem list and differential diagnosis from the available data, incorporating psychosocial and cultural influences and factors.

EPO PC 5 – Develop a diagnostic and therapeutic plan for commonly encountered conditions based on clinical data, patient preferences, up-to-date scientific evidence, and clinical judgment.

EPO PC 6 – Identify patients with urgent or emergent conditions, initiating timely evaluation and appropriate management interventions and escalating care when necessary.

EPO PC 7 – Describe the key elements of informed consent for tests and common procedures, including indications, risks, benefits, alternatives, techniques, and complications.

Knowledge for Practice (KP) – Our graduates demonstrate, apply, and integrate knowledge of foundational, clinical, and social sciences to improve health for patients and diverse populations.

EPO KP 1 – Understand and apply principles of basic sciences that are fundamental to health care for patients and populations.

EPO KP 2 – Understand and apply principles of clinical sciences to diagnostic and therapeutic decision-making and clinical problem-solving for patient care.

EPO KP 3 – Understand and apply principles of social-behavioral sciences to the provision of patient care, including psychosocial and cultural influences on patients' health.

EPO KP 4 – Understand and apply principles of biomedical ethics to patient care and research practices, including core ethical principles and professional values.

EPO KP 5 – Understand and apply principles of epidemiological and statistical sciences to identify health problems and risk factors and utilize strategies for disease prevention for patients and populations.

Systems-Based Practice (SBP) – Our graduates demonstrate and apply knowledge of the larger context of health systems into safe, high-quality patient care, including incorporation of social and structural drivers of health and utilization of appropriate healthcare resources.

EPO SBP 1 – Advocate for safe, high-quality care for patients and populations by incorporating high value care principles, such as cost consideration, resource utilization, and risk-benefit analysis, into recommendations for patient care.

EPO SBP 2 – Demonstrate and apply knowledge of social and structural drivers of health to reduce disparities in patient care and advance health equity.

EPO SBP 3 – Identify the causes and types of patient safety, system, and quality issues that contribute to quality improvement processes.

EPO SBP 4 – Identify key components of the healthcare system and demonstrate knowledge of basic healthcare payment systems.

Practice-Based Learning and Improvement (PBLI) – Our graduates demonstrate the ability to appraise and assimilate scientific evidence into patient care and engage continuously in self-evaluation and life-long learning in order to foster personal and professional growth in their roles as physicians.

EPO PBLI 1 – Locate, critically evaluate, and assimilate evidence from appropriate sources (e.g., scientific studies, clinical practice guidelines) and incorporate it in decision-making about patient care.

EPO PBLI 2 – Engage in informed self-reflection regarding own knowledge and performance to identify opportunities for growth.

EPO PBLI 3 – Strive for personal and professional excellence by seeking and accepting constructive feedback from patients, peers, faculty, healthcare team members, and supervisors.

Interpersonal Communication Skills (ICS) – Our graduates demonstrate interpersonal and communication skills with patients, caregivers, and all healthcare team members to contribute to collaborative, high-quality, and safe patient-centered care.

EPO ICS 1 – Communicate effectively with patients from a variety of backgrounds by using active listening skills and demonstrating cultural sensitivity and attention to patient preferences for communication.

EPO ICS 2 – Provide information to patients with clear, easily understandable language, utilizing written and verbal translator services when necessary.

EPO ICS 3 – Counsel patients using a patient-centered approach in a variety of contexts, including screening recommendations, grave diagnoses and prognoses, pain management, and adverse events/medical errors.

EPO ICS 4 – Communicate clinical information in an organized fashion to team members clearly and accurately in written and electronic formats.

EPO ICS 5 – Communicate relevant clinical information verbally to team members in case presentation format, utilizing respectful verbiage and adjusting language according to audience, context, or purpose (e.g., family-centered rounds).

EPO ICS 6 – Demonstrate the ability to transfer the care of a patient to another health provider utilizing an established framework for handoffs.

EPO ICS 7 - Demonstrate clear and respectful communication with all interprofessional team members to provide collaborative patient care in a positive environment.

EPO ICS 8 – Incorporate expertise and advice from team members from all involved health professionals and consultants into patient care where indicated.

Professional Behavior (PB) – Our graduates demonstrate integrity, ethical reasoning, accountability, and a commitment to their professional responsibilities with patients and caregivers, faculty and staff, colleagues, communities, and the medical profession as a whole.

EPO PB 1 – Display honesty, integrity, and accountability in all assessments and written assignments.

EPO PB 2 – Adhere to attendance and other professional requirements and complete assignments and tasks in a timely manner, in both classroom and clinical settings.

EPO PB 3 – Demonstrate sensitivity and respect for patients, families, peers, teachers, administrative staff, and healthcare team members across diverse populations in all situations.

EPO PB 4 – Maintain patient privacy and confidentiality.

EPO PB 5 – Consistently advocate in the best interest of one's patients, including fair access to care.

EPO PB 6 – Recognize and address personal well-being needs that may impact professional performance.

Required Clinical Experiences

Required Core Clinical Conditions

Family Medicine Clerkship

- Acute respiratory illness
- Chronic respiratory problem
- Dermatologic problem
- Gastrointestinal complaint
- Headache
- Hyperlipidemia
- Hypertension
- Mental health complaint
- Musculoskeletal complaint
- Preventive health care
- Substance abuse

OB/GYN Clerkship

- Abnormal Pap smear
- Contraception
- Intrapartum care
- Menopause
- Menstrual abnormality
- Obstetric problem
- Pelvic pain
- Postoperative management
- Postpartum care
- Prenatal care
- Urogenital infection

Surgery Clerkship

- Abdominal pain / acute abdomen
- Biliary tract disease - GB and bile duct disease
- Colon-benign-diverticulitis, IBD, Malignant - Colon cancer
- Hernia – groin or ventral
- Post-operative care
- Surgical critical care
- Vascular disease or injury - arterial or venous
- Hemorrhage

Internal Medicine Clerkship

- Abdominal pain
- Acute renal failure
- Acute shortness of breath
- Anemia
- Arrhythmia
- Bacteremia/sepsis
- Congestive heart failure
- Chronic obstructive pulmonary disease
- Diabetes mellitus
- Fever
- Myocardial infarction
- Syncope
- Venous thromboembolic disease

Pediatrics Clerkship

- Abdominal pain and/or vomiting
- Acute neurological illness
- Acute renal illness
- Acute respiratory illness
- Dehydration and fluid management
- Developmental delay
- Failure to thrive
- Fever
- Sickle cell disease
- Well child adolescent
- Well child infant
- Well child newborn
- Well child school age
- Physical or sexual abuse

Neurology Clerkship

- Paroxysmal disorders
- Vascular disorders
- Neuromuscular disorders
- Progressive degenerative disorders

Psychiatry Clerkship

- Addictive disorder
- Anxiety disorder
- Mood disorder
- Personality disorder
- Psychotic disorder

Required Observed Clinical Skills

<table>
<tr>
<td>Family Medicine Clerkship
Focused history of present illness
HEENT examination
Diabetic foot examination
Progress note feedback</td>
<td rowspan="2">OB/GYN Clerkship
Vaginal delivery (observed/assisted)
Speculum Exam / Pap smear (performed)
C-section (assisted)
Gynecologic surgery (assisted)
Laparoscopy (observed/assisted)
History taking
Pelvic examination
Breast examination
Progress note feedback</td>
<td rowspan="2">Surgery Clerkship
Abdominal examination
Airway assessment
Surgical timeout
Progress note feedback</td>
</tr>
<tr>
<td>Internal Medicine Clerkship
Heart and lung examination
Progress note feedback</td>
</tr>
<tr>
<td>Psychiatry Clerkship
History and mental status examination
Progress note feedback</td>
<td>Pediatrics Clerkship
Complete history and physical examination
Progress note feedback</td>
<td>Neurology Clerkship
Neurologic examination
Progress note feedback</td>
</tr>
</table>

General Clerkship Evaluation Form

(may vary slightly by clerkship)

Clerkship Evaluation Form

Student Name: _____ Clerkship: _____

Rotation/Location: _____ Rotation Date: _____

Clerkship Competencies A grade of "Does Not Meet Expectations" for Competency Domains 1-5 should prompt a meeting of the student with the Clerkship Director to develop a plan for remediation and may be grounds for failure of the clerkship. The evaluating faculty member or resident should contact the clerkship director for clarification of their assessment.	Always exceeds expectations for level of training	Sometimes exceeds expectations for level of training	Meets expectations for level of training	Does not meet expectations for level of training	Formative Feedback (Specific suggestions/recommendations for improvement - not to be included in MSPE)
1. Medical Knowledge					
Knows basic disease processes encountered in the specialty.					
Participates regularly in activities that maintain and advance competence.					
2. Patient Care					
Takes an appropriate and thorough history					
Examines patients as thoroughly as necessary, providing for the patient's comfort and safety					
Identifies and prioritizes patients' problems					
Develops a differential diagnosis for patients' symptoms					
Develops appropriate plans for laboratory and radiologic evaluation					
Develops appropriate plans for management					
Identifies and recommends health prevention measures where appropriate					
Provides effective care with respect to patient preferences and cultural beliefs					
Performs procedures with appropriate technique					
Clearly and accurately presents patient findings to team members					
Maintains clear, complete, accurate, timely, and legible written records					
3. Interpersonal Relationships and Communication					
Consults and takes advice from colleagues when appropriate					
Demonstrates effective communication with patients and families					
Shows empathy and respect to patients and families					
4. Practice Based Learning and Improvement					
Uses evidence from practice guidelines and scientific studies to develop care plans					
Shows evidence of supplemental reading about patients' diseases					

Institutional Program Objectives			Meets expectations for level of training	Does not meet expectations for level of training	Formative Feedback (Specific suggestions/recommendations for improvement - not to be included in MSPE)
5. Systems Based Practice					
Advocates for safe care and efficient use of resources					
Effectively incorporates the services of non-physician care providers					
6. Professional Behavior					
Maintains honesty and integrity in documentation and presentations			*	*	
Establishes professional relationships with patients and families			*	*	
Reliably fulfills patient care responsibilities without frequent reminders			*	*	
Functions as a respectful and helpful team member			*	*	
Arrives on time and leaves only when work is done or for didactic sessions			*	*	
Seeks feedback and/or responds well to constructive criticism in order to improve performance			*	*	

*A grade of "Does Not Meet Expectations" for Professional Behavior shall prompt a Physicianship Evaluation Form, which will be completed by the Clerkship Director and discussed with the student. The evaluating faculty member must contact the Clerkship Director for clarification. This may be grounds for failure of the clerkship.

Summative Evaluation Comments (To be included in MSPE):

_____

_____

_____

_____

☐ I have met with this student to provide narrative feedback concerning their performance during their clerkship.

Signature/Name of person providing this evaluation: _____Date_____

Signature/Name of Attending Physician:_____Date_____

Signature of student: _____Date_____

This section to be completed by the Clerkship Director or Clerkship Coordinator: Numerical score_____ Grade for this rotation _____

General Mid-Clerkship Feedback Form

(may vary slightly by clerkship

Mid-rotation Feedback Form

Complete Student Self-Assessment rating, then review with at least 1 resident/faculty who you have spent significant time on your rotation.

*Student:*_____ *Evaluator:*_____

*Date:*_____

FEEDBACK ON STUDENT PERFORMANCE	***STUDENT SELF ASSESSMENT***		***RESIDENT/FACULTY ASSESSMENT***		
	Competent/ Advanced	*Needs Improvement*	*Competent/ Advanced*	*Needs Improvement*	*Unacceptable: Requires Attention*
Patient Care					
Medical Knowledge					
Progress Notes					
Timeliness					
Teamwork					
Professional demeanor					

☐ *I am making adequate progress on my core clinical conditions and required clinical skills.*

☐ *I have been adequately supervised by faculty and residents on this clerkship.*

Student Comments (Anything that I need to improve /I do well):

_____

_____

_____

_____

Resident/Faculty Comments (Anything that the student needs to improve /student does well):

_____

_____

_____

_____

_____ _____

Student Signature *Evaluator Signature*

Policies Relevant to Clinical Education

APPROPRIATE TREATMENT OF STUDENTS

The institutional policy on appropriate treatment of students is Chancellor's Memorandum CM-56. The link to this policy is here:

https://www.lsuhsc.edu/administration/cm/cm-56.pdf

In addition, the School of Medicine has its perspective and procedures on its Student Affairs website, seen below and at the following link:

https://www.medschool.lsuhsc.edu/student_affairs/conduct_treatment.aspx

Introduction

The Louisiana State University School of Medicine in New Orleans is dedicated to providing its students, residents, faculty, staff, and patients with an environment of respect, dignity, and support. The diverse backgrounds, personalities, and learning needs of individual students must be considered at all times in order to foster appropriate and effective teacher-learner relationships. Honesty, fairness, evenhanded treatment, and respect for students' feelings are the foundation of establishing an effective learning environment.

Students have the right to be treated with respect and integrity. Mistreatment and abuse of students by faculty, residents, staff, or fellow students is contrary to the educational objectives of LSUHSC-NO and will not be tolerated. Mistreatment and abuse include, but are not limited to, berating, belittling, or humiliation; physical punishment or threats; intimidation; sexual harassment; harassment or discrimination based on race, gender, gender identity, sex, sexual orientation, age, religion, or disability; assigning a grade for reasons other than the student's performance; assigning tasks for punishment or non-educational purposes; requiring the performance of personal services; or failing to give students credit for work they have done.

Promulgation of Policies to Prevent Mistreatment of Medical Students:

The importance of professionalism, role modeling, and appropriate instructional techniques will be promulgated by faculty development activities for new faculty, and discussions at Administrative Council, Faculty Assembly Delegates Meetings, Faculty Assembly/ General Faculty Meetings, and meetings of Course Directors.

Residents and Staff will receive instruction at their orientation and in their departments on avoidance of mistreatment and abuse of others and how to proceed if they themselves feel that they have been treated unprofessionally.

Students will be informed about how to deal with incidents that they feel are or may be abusive at their orientations, in the Student Handbook, on the School of Medicine Student Affairs website, and on the **LSU CARES** webpage.

CLERKSHIP ATTENDANCE

Policy Statement/Purpose:

A student's responsibilities in clinical rotations include caring for patients on teams and therefore take precedence over other activities. However, situations may arise when a student will need to request a brief absence from daily responsibilities on a required clerkship or other clinical rotation. The guidelines listed below give insight as to what might be considered an acceptable request, and they include visiting students on senior rotations. These are institutional guidelines, and some of the clerkships and departments may have more specific policies. Details regarding absences in individual rotations, such as means of notifying the clerkship/rotation director, and policies on make-up work, are outlined in clerkship and rotation orientations.

Policy Guidelines:

All requests for leave must be presented to the clerkship/rotation director; it is the student's responsibility to make certain that they are approved. Directors of shorter clerkships/rotations will use their discretion in approving absences for non-emergencies in these rotations.

Sufficient remediation for absences will be established at the discretion of the clerkship/rotation director. Remediation may involve additional call nights, additional weekend responsibilities, clinical work on days normally set aside for NBME preparation, or make-up assignments for missed didactics. A clerkship/rotation director may require remediation of some work for absences of less than two days if they deem that learning opportunities are significantly affected by the absence.

Over the course of the clerkship/rotation, any leave totaling more than two days (for a single absence or for repeated absences, regardless of the reason) will require remediation prior to completion of the clerkship/rotation.

Requested absence days are included in the "one day in seven free of clinical work and required education averaged over the duration of the rotation," as outlined in the student work hour policy.

Adherence to these policy guidelines is considered a matter of professionalism, therefore excessive absences or non-emergent absences may be reflected in the evaluation of the student's work habits or professionalism.

1. **Emergent Absence (such as illness or funeral):**

Students will be excused from clinical activities if they are ill or need to seek health services. Students should notify the clerkship/rotation director as soon as possible. If possible, the student should also notify their team (residents, interns, and attending). Leave of more than two days will require remediation prior to completion of the clerkship. Clerkship/rotation directors may require a note from the treating provider for absence due to illness. Make-up work may be assigned if the absence involves required didactics.

2. **Non-emergent Absence (such as weddings, presentations at national conferences, or school business):**

Students must request these absences from the clerkship/rotation director via e-mail prior to the start of the clerkship. The student should also notify their team (residents, interns, and attending) as soon as possible. Leave of more than two days will require remediation prior to the completion of the clerkship. Make-up work may be assigned if the absence involves required didactics.

3. **Residency interviews (for seniors):**

Students must request these absences from the clerkship/rotation director via e-mail prior to the start of the rotation or as soon as the interview is scheduled. The student should also notify their team (residents, interns, and attending) as soon as possible. Leave of more than two full days or four half days will require remediation prior to the completion of the rotation. Absences for interviews should be minimized, and students should make every attempt to schedule residency interviews at other times e.g., flex blocks. We recognize that this is not always possible.

4. **Circumstances not stated in the above categories:**

Students must request absences for other extenuating circumstances from the clerkship/rotation director via e-mail as soon as possible (before the start of the clerkship/rotation if possible), and approval is at the discretion of the clerkship/rotation director. As above, the student must notify their team and make up any work assigned by the clerkship/rotation director if the absence is approved.

Student Responsibilities on Holidays:

Unless otherwise stated, students will be free from clinical duties on the days below. Students are expected to perform clinical duties if assigned on the weekends associated with the holidays e.g., Saturday and Sunday before Labor Day. If a student is on their acting internship, they should not consider themselves exempt from working holidays and should consult with their clerkship/rotation director at the start of the rotation.

- July 4th
- Labor Day (off Monday)
- Martin Luther King, Jr. (off Monday)
- Mardi Gras (off Monday and Tuesday)
- Easter (off Friday, Saturday, Sunday)
- Thanksgiving (off Thursday, Friday, Saturday, Sunday)
- Christmas (off 2 weeks around holidays -- off Christmas Day & New Years Day only if doing senior rotation in block 7)
- Memorial Day (off Monday)

CLINICAL SUPERVISION OF STUDENTS

Policy Statement/Purpose:

Medical students must be appropriately supervised during clinical clerkships and other clinical experiences. This is a matter of both student and patient safety. The level of student responsibility must be appropriate to the student's level of training, and the activities supervised must be within the scope of practice of the supervising health professional.

Policy Guidelines:

Students will participate in patient care under the direct supervision of LSU Health Sciences Center faculty members, residents, and/or other mutually agreed upon and appropriately credentialed health providers. Students may participate in activities including, but not limited to, the following:

- Take histories from and perform physical examinations on patients in the emergency room, inpatient units, and outpatient clinics
- Document patient findings in the medical record as a student note
- Communicate evaluation results and plans of care with patients as deemed appropriate by faculty with respect to situation
- Scrub in on surgeries and procedures in the surgical suites and labor and delivery units
- Perform minor procedures as deemed appropriate by faculty with respect to training and ability

History taking, physical examinations, medical record documentation, and communicating evaluation results and plans of care are activities that students may perform without the direct accompaniment of a physician or other supervising health provider. Students who perform any procedure must have the appropriate training to do so and must be supervised by a faculty member, resident, or other mutually agreed upon and appropriately credentialed health provider.

Non-physician providers may have student teaching responsibility as assigned by faculty physicians who are available by phone or on site to assist with care if needed. If a non-physician health provider supervises a student in clinical activities, the level of responsibility delegated to the student must be appropriate to the student's level of training, and the activities supervised must be within the scope of practice of the supervising health provider.

If students have concerns that they have not been adequately supervised in clinical activities, they should contact the clerkship director as soon as possible. If students are not comfortable contacting the clerkship director, they should contact the Director of the Clinical Sciences Curriculum, the Associate Dean for Undergraduate Medical Education, the Assistant Dean for Student Affairs, or the Associate Dean for Student Affairs. Students also have the opportunity to report concerns about their level of clinical supervision anonymously on the end-of-clerkship Aesculapian evaluations, which are reviewed quarterly with clerkship directors.

STUDENT WORK HOURS

Policy Statement/Purpose:

The clerkship phase of the curriculum includes patient care activities as well as didactic learning activities. The clerkship directors developed this policy to be similar to ACGME requirements for residency duty hours.

Policy Guidelines:

Students on required clinical rotations should not spend more than 80 hours per week (on average over the duration of the clerkship) in clinical and didactic learning activities. Students who are assigned to overnight call in the hospital should not have patient care responsibilities after 1:00 PM on the following day. However, students are expected to attend mandatory didactic activities even after overnight call. In-house call must occur no more frequently than every third night, averaged over the rotation. Students must have a minimum of one day in seven free of clinical work and required education averaged over the duration of the rotation. Weekends, school holidays, and absences are included in this "one day in seven" guideline.

If a student has concerns that their duty hours have been exceeded, they should contact the clerkship director as soon as possible. If students are not comfortable contacting the clerkship director, they should contact the Director of the Clinical Sciences Curriculum, the Assistant Dean for Undergraduate Medical Education, the Director of Student Affairs, the Associate Dean for Student Affairs, or one of the Assistant Deans for Student Affairs.

FORMATIVE FEEDBACK

Policy Statement/Purpose:

Formative feedback provides students with the opportunity to gauge their cognitive or non-cognitive performance in a course or clerkship before the final assessment or evaluation. This allows students the opportunity for self-assessment and improvement. LSUHSC School of Medicine in New Orleans provides formative feedback to students in all courses that are required and graded.

Policy Guidelines:

Required core clerkships that are 4 weeks or longer in duration provide students with formal mid-clerkship feedback. Clerkship directors or other designated supervisors meet with each student to discuss their performance and completion of required clinical experiences to date and to give reinforcing and constructive feedback. Clerkship directors provide additional guidance for improvement to students who are not meeting expectations. The clerkship director or supervisor completes a Mid-Clerkship Feedback Form and submits it to the clerkship coordinator. Each clerkship coordinator monitors adherence to this policy and reports completion quarterly to the Clerkship Director Committee.

SUMMATIVE ASSESSMENT

Policy Statement/Purpose:

The medical school provides students with fair and timely summative assessments in all courses and clerkships.

Policy Guidelines:

Summative assessments are based on the course and clerkship objectives and individual session learning objectives in all courses and clerkships. Students receive scores on summative assessments as soon as they are available. Students receive their final grades in all courses and clerkships within 6 weeks of the last day of the course or clerkship.

NARRATIVE ASSESSMENT

Policy Statement/Purpose:

Written narrative feedback and assessment provides students with the opportunity to reflect on their performance, including non-cognitive attributes and skills. This contributes to their growth and improvement as professionals. Students receive meaningful narrative feedback and assessment wherever it is feasible based on faculty-student interaction, most notably in the circumstances noted below in the policy guidelines.

Policy Guidelines:

In the clinical curriculum phase, written narrative assessment is a component of all clerkship evaluation forms, regardless of clerkship length. Faculty are required to write a global narrative evaluation of the student's performance for inclusion in the student's Medical Student Performance Evaluation (MSPE). Formative narrative comments that are meant only for the student are provided separately. These comments are intended to give the student constructive or reinforcing feedback and are not included in the MSPE.

In all phases of the curriculum, written narrative feedback may be provided to students based on their performance related to objectives for professional behavior. This includes both outstanding professional behaviors, as well as professional lapses, and is accomplished through the process of the school's Physicianship Enhancement Form (PEF).

The Clerkship Director Committee ensures that narrative assessment is provided on all evaluations through quarterly clerkship coordinator reports as part of its monitoring process.

STUDENT RESPONSIBILITY IN EMERGENCIES

Policy Statement/Purpose:

This policy is intended to provide guidance for students if one or more of the campuses of LSU School of Medicine in New Orleans is closed for an emergency, such as a weather-related event. The safety of our students is our priority, but students should be allowed to continue their clinical work if they feel safe to do so and if circumstances at the campuses allow it. Students are not essential workers and therefore are not included in Code Gray planning for hospitals.

Policy Guidelines:

All students should be familiar with the Chancellor's Memorandum-51 on weather-related emergency procedures, in particular:

"All employees and students are required to update their personal contact information on the LSUHSC-NO registry. The registry will become available online via the LSUHSC-NO website once a state of emergency has been declared by the Chancellor. Faculty staff and students failing to update their contact information on the registry will be subjected to disciplinary action up to and including being charged with an unauthorized absence."

In the event of an emergency closure of one of the campuses of the LSU School of Medicine in New Orleans:

- Students on clinical rotations at the affected campus will be officially excused from school and their clinical responsibilities pending further notice through the emergency website or through the relevant communication channels at those sites.

- Students on clinical rotations at other campuses who have families or personal property in the city or region of the affected campus will be excused from school and their clinical responsibilities for up to 48 hours if needed to take care of their families or property. Students without the need to travel to the affected site to care for family or property may choose to continue their clinical work at their assigned site if they feel safe to do so. Students needing more than 48 hours to care for their family or personal property should contact their clerkship/rotation director to request additional time off. Students should also communicate with their clerkship/rotation directors if there are concerns or questions about safe return to clinical duties.

NEEDLESTICK INJURY

All supervisors must be familiar with the institutional procedures associated with a needlestick injury. The link to the policy can be found here:

https://www.lsuhsc.edu/orgs/studenthealth/needlestickinjury.aspx

Tips for Teaching in the Clinical Setting

One-Minute Preceptor

Authored by: PAEA's Committee on Clinical Education

PUBLISHED FEBRUARY 2017

1-PAGERS for PRECEPTORS

The One-Minute Preceptor teaching method guides the preceptor-student encounter via five microskills. This method is a brief teaching tool that fosters assessment of student knowledge as well as provision of timely feedback. The strengths of this teaching method include: increased involvement with patients, increased clinical reasoning by the students, and the student recieving concise, high-quality feedback from the preceptor.

When to use this: During the "pregnant pause" (i.e., when you find yourself wanting to rush things along and give the students the answer, rather than asking for their thoughts)
What not to do: Ask the student for more information about the case or fill in all of the gaps that you noted in the student's knowledge base and presentation skills at once

Microskills

1 Get a Commitment

Focus on one learning point. Encourage students to develop their critical thinking and clinical reasoning skills. Actively engage the student, establishing their readiness and level of competence. Push the student just beyond their comfort zone and encourage them to make a decision about something, be it a diagnosis or a plan.

Ex: "So, tell me what you think is going on with this patient."

2 Probe for Supporting Evidence

Uncover the basis for the student's decision — was it a guess or was it based on a reasonable foundation of knowledge? Establish the student's readiness and level of competency.

Ex: "What other factors in the HPI support your diagnosis?"

3 Reinforce What Was Done Well

The student might not realize they have done something well. Positive feedback reinforces desired behaviors, knowledge, skills, or attitudes.

Ex: "You kept in mind the patient's finances when you chose a medication, which will foster compliance, thereby decreasing the risk of antibiotic resistance."

4 Give Guidance About Errors/Omissions

Approach the student respectfully while concurrently addressing areas of need/improvement. Without timely feedback, it is difficult to improve. If mistakes are not pointed out, students may never discover that they are making these errors and hence repeat them.

Ex: "I agree, at some point PFTs will be helpful, but when the patient is acutely ill, the results likely won't reflect his baseline. We could gain some important information with a peak flow and pulse ox instead."

5 Teach a General Principle

Sharing a pearl of wisdom is your opportunity to shine, so embrace the moment! Students will apply what is shared to future experiences. Students tend to recall guiding principles, and often the individual patient may serve as a cue to recall a general rule that was taught.

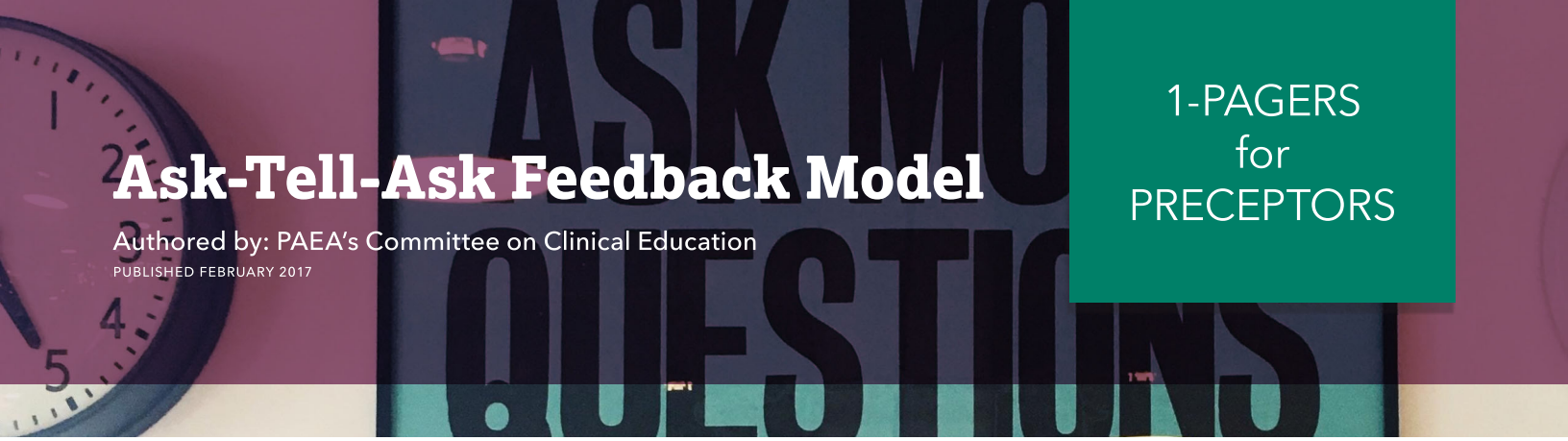
Ex: "Deciding whether or not someone with a sore throat should be started on empiric antibiotics prior to culture results can be challenging. Fortunately, there are some tested criteria that can help…"

Summarize

Consider summarizing or concluding, ending with next steps (e.g., plan for the patient, reading assignment for the student, schedule for follow-up with the student, etc.).

REFERENCE
Neher J, Gordon K, Meyer B, Stevens N. A five-step "microskills" model of clinical teaching. *Journal of American Board of Family Practice*, 1992; 5: 419-424.

PAEA



Ask-Tell-Ask Feedback Model

Authored by: PAEA's Committee on Clinical Education

PUBLISHED FEBRUARY 2017

1-PAGERS for PRECEPTORS

The Ask-Tell-Ask Feedback method fosters students' abilities to identify their own strengths and areas for improvement as well as provides preceptors with the opportunity to share positive and constructive feedback to students. The strengths of this model include that it is learner-centered, fosters students' self-assessment skills, increases students' accountability for learning, gives the preceptors insight into students' perceptions of performance, encourages preceptors to provide specific feedback, and can be used across a variety of settings.

First:	ASK	*"What went well?"*	→ TELL	*"This is what I think went well."*
Then:	ASK	*"What could be improved?"*	→ TELL	*"This is what I think could be improved."*

Example 1

Setting: Outpatient
Task Area: Patient Assessment (History-Taking, Physical Exam)

Preceptor: What parts of your assessment of the patient went well?

Student: My problem-focused history-taking seemed complete and only took about five minutes to do.

Preceptor: I agree, your history-taking was thorough and efficient. You also clarified important information that the patient shared during the pertinent review of systems.

Preceptor: What do you think could be improved?

Student: My approach to the physical exam felt disjointed and took longer than I thought necessary.

Preceptor: Yes, while you included essential elements of the physical exam, it was not systematic and the patient had to be repositioned several times. A strategic way to avoid this in the future is to develop a plan for the physical exam before you initiate the exam.

Example 2

Setting: Inpatient
Task Area: Medical Knowledge, Clinical Reasoning

Preceptor: What elements of the diagnosis and treatment planning went well?

Student: I am confident in the most likely diagnosis, and the first-line therapy was appropriate for this patient.

Preceptor: Yes, I believe you came to the correct conclusion about the diagnosis. In addition to knowing which medication is first-line therapy, remember to specify dose/route/frequency and any patient education that is indicated.

Preceptor: What do you think could be improved?

Student: Well, I only had three disorders on my differential diagnosis.

Preceptor: I agree that it is important to have a broader differential diagnosis. I encourage you to read more about the most likely diagnosis and related conditions tonight, then tomorrow we can discuss the clinical reasoning about the diagnosis.

PAEA

The Right Stuff: Priming Students to Focus on Pertinent Information During Clinical Encounters

Elizabeth Stuart, MD, MSEd,[a] Janice L. Hanson, PhD,[b] Robert Arthur Dudas, MD[c]

Prioritization of relevant information during clinical encounters is a skill that is critical to learn but not easy to teach. In this article, from the Council on Medical Student Education in Pediatrics series on strategies used by great clinical teachers, we offer a framework for coaching students to understand clinical relevance and increase their efficiency in patient care.

THINKING LIKE DOCTORS

Medical students face several challenges when moving from the classroom to the clinical setting. In addition to new roles, responsibilities, and approaches to learning, the transition brings a shift in how students are expected to process and attend to clinical information.[1,2] To work and learn effectively among clinician supervisors, students must move from thinking like students to thinking like doctors.

In particular, students who are new to the clinical setting often notice a change in expectations for history taking, physical examinations, and case presentations. Preclinical training typically encourages a comprehensive, systematic, and formulaic approach to data gathering. As a result, students' early case presentations tend to be highly structured and thorough. Once they enter the time-constrained, practically oriented clinical setting, students are often asked to streamline, work efficiently, and focus on pertinent details.[3]

A key challenge for clinical teachers is to help students transition their approach. Although the ability to focus on relevant information is one of the most essential elements of medical reasoning and communication, experts have observed that is also one of the most difficult to learn and teach.[2]

LEARNING AND TEACHING WHAT IS PERTINENT

Haber and Lingard[4,5] have looked closely at how students learn to make "relevance decisions" in the context of the development of oral case presentation skills. In observations of inpatient rounds, they noted that supervisors frequently gave students feedback to focus on pertinent or relevant information but rarely defined clinical relevance or provided instruction on how to identify pertinent details. Without explicit guidance, students misinterpreted instructions to streamline their communication, drawing inaccurate conclusions about why specific information was deemed pertinent or not. In the case of a patient with a complicated social history, for example, 1 student interpreted instructions to "Just give me the social context stuff when it's warranted" as an

COMSEP
Excellence in Medical Student Education in Pediatrics

[a]*Department of Pediatrics, Stanford School of Medicine, Stanford University, Stanford, California;* [b]*Office of Education, Washington University School of Medicine in St Louis, St Louis, Missouri; and* [c]*Department of Pediatrics, Johns Hopkins University School of Medicine, Baltimore, Maryland*

Dr Stuart conceptualized and designed this article and drafted, revised, and finalized the manuscript; Drs Hanson and Dudas conceptualized and designed this article, reviewed it critically, and contributed substantially to revisions; and all authors approved the final version to be published and agree to be accountable for all aspects of the work.

DOI: https://doi.org/10.1542/peds.2019-1311

Accepted for publication Apr 24, 2019

Address correspondence to Robert Arthur Dudas, MD, Department of Pediatrics, Johns Hopkins All Children's Hospital, 601 5th St South, Suite 606, St Petersburg, FL 33701. E-mail: rdudas@jhmi.edu

PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

FINANCIAL DISCLOSURE: The authors have indicated they have no financial relationships relevant to this article to disclose.

FUNDING: No external funding.

POTENTIAL CONFLICT OF INTEREST: The authors have indicated they have no potential conflicts of interest to disclose.

To cite: Stuart E, Hanson JL, Dudas RA. The Right Stuff: Priming Students to Focus on Pertinent Information During Clinical Encounters. *Pediatrics.* 2019;144(1):e20191311

TABLE 1 Pre-encounter Priming Examples

Scenarios	Examples of Preceptor Prompts, Coaching	Explanation
• Inexperienced student or student seeing a patient with an unfamiliar problem • Limited time for pre-encounter priming and coaching	• This patient is coming back to clinic for follow-up of ADHD. • Our key goals are to determine if the medication seems to be working as expected and whether there are any side effects. • With those goals in mind, we'll want to review input from the patient, teacher, and parent about attention, behavior, and ability to complete school work. Be sure to ask for the parent and teacher follow-up questionnaires that were given at the last visit. To identify any medication side effects, you'll particularly want to look at growth and ask about changes in appetite or sleep.	Preceptor works through all 3 steps in the framework for the student: • States the key problem • Lists goals for the visit • Explains what key information is needed and how details connect to the broad goals of care.
• More experienced student or student seeing a patient with relatively familiar problem • Time for discussion-based pre-encounter priming and coaching	• This infant is being admitted with a febrile UTI. Tell me what you think should be on his problem list and what our goals should be for managing each problem. • Good. I would add identifying any underlying anatomic predisposition to UTI to our list of goals. • Now, based on your understanding of our goals for this patient, what details do you think are going to be most critical to gather and present?	Preceptor prompts the student to go through all 3 steps in the framework: • Checks the student's understanding of the broad clinical picture (problem list and goals) • Provides feedback on student's ideas for problems and goals. • Coaches student to identify and prioritize pertinent clinical data
• Experienced student, familiar problem, and/or limited time	• When you preround on our patient with bronchiolitis this morning, remember to keep in mind our problem list and the goals for each problem. • Before you see the infant, decide what details are going to be most critical to gather and present on rounds so that we can assess progress and make decisions for each problem and goal.	Preceptor provides a quick reminder or frame. • Articulates steps in the framework • Encourages student to think deliberately about which details are most pertinent to clinical decision-making.

ADHD, attention-deficit/hyperactivity disorder; UTI, urinary tract infection.

idiosyncratic preference of the supervisor ("Some people just don't have an interest in people's social lives…"). The student was later confused when the same supervisor wanted to hear detailed social information as the patient was nearing discharge.[5] When expert clinicians in the study were interviewed, they were unable to articulate a process for determining if a particular detail was relevant. Their understanding of relevance was tacit, intuitive, and therefore difficult to teach. On the basis of these observations, the authors recommended that clinical teachers work deliberately to unpack their tacit understanding, "communicating clearly and repeatedly" to students how the broad context of a medical encounter determines which details are most relevant.[5]

Priming is an educational strategy that offers an opportunity to do just that.

PRIMING STUDENTS TO FOCUS ON PERTINENT INFORMATION: FROM PROBLEMS TO GOALS TO DETAILS

Priming refers to any intervention taken to prepare a learner for an educational experience or task. In the medical education literature, priming typically involves brief coaching just before a patient encounter. It may include telling the student what information to collect, how much time to spend, what the supervisor's role will be, or how information should be presented.[6,7]

Priming can also help students decide what details will be most pertinent to a case. The following problems-goals-details framework for priming is grounded in the idea that relevance is dictated by the goals for the encounter. Of note, although priming can help students judge relevance in the context of diagnostic reasoning, we will focus our attention here on clinical decision-making for patients with established diagnoses in clinic or on the ward.

The framework emphasizes 3 questions for the student to consider before seeing the patient:

1. What are the patient's problems?
2. What are the goals (established or anticipated) for managing each problem?
3. What details will be most important (pertinent) in assessing progress toward each goal?

For example, in the case of an infant being seen in clinic for suspected viral gastroenteritis, an anticipated problem might be dehydration. A key goal could be articulated as "assess hydration status," and pertinent details would be those that the provider needs to make that assessment (eg, fluid intake and output, change in weight, heart rate, and examination findings reflecting hydration).

Having anticipated which information will be most relevant, on the basis of an understanding of problems and goals, the student reviews the chart and sees the patient, making sure to gather and focus on pertinent details. The case presentation after the encounter emphasizes those same details.

The role of the teacher in priming can be varied according to the student's level of experience, the complexity of the patient, and the amount of time available for coaching. For example, the preceptor can model the process by thinking out loud about problems, goals, and links to pertinent details. Alternatively, the preceptor can question the student about goals and relevant data, or simply provide a reminder to consider context as a guide for how to focus. Table 1 provides examples of these different approaches.

Priming before every clinical encounter is not necessary. Preceptors in the outpatient setting might opt to introduce the problems-goals-details framework at the start of a clinic session and refer back to it when providing feedback during case presentations. Inpatient supervisors might present the framework as a tool for prerounding and planning presentations, either verbally or as a written worksheet that prompts students to articulate problems, goals, and details. Priming need not occur just before a patient is seen but can involve a brief discussion during downtime to verify students' understanding of their patients' problems, goals, and relevant data.

Regardless of the exact approach taken, students who are primed by using the problems-goals-details framework begin clinical encounters with a mental roadmap that outlines the big picture, with links to relevant data. Priming students in this manner, although it takes a bit of time up front, can increase students' efficiency in seeing patients while helping them build skill in determining clinical relevance.

CONCLUSIONS

Learning to identify and communicate pertinent information is an essential task for clinical learners. Over time, this skill may develop naturally, but it is known to present a challenge. Priming before clinical encounters, with deliberate attention to establishing links between problems, goals, and related details, may enhance learners' gradual progress in making the shift from thinking like a student to thinking like a doctor. Ultimately, empowering students to recognize and focus on pertinent information enables them to align with supervisors' needs, work more efficiently, and contribute more authentically and meaningfully to patient care.

REFERENCES

1. O'Brien B, Cooke M, Irby DM. Perceptions and attributions of third-year student struggles in clerkships: do students and clerkship directors agree? *Acad Med*. 2007;82(10):970–978
2. Han H, Roberts NK, Korte R. Learning in the real place: medical students' learning and socialization in clerkships at one medical school. *Acad Med*. 2015; 90(2):231–239
3. Dell M, Lewin L, Gigante J. What's the story? Expectations for oral case presentations. *Pediatrics*. 2012;130(1): 1–4
4. Lingard LA, Haber RJ. What do we mean by "relevance"? A clinical and rhetorical definition with implications for teaching and learning the case-presentation format. *Acad Med*. 1999; 74(suppl 10):S124–S127
5. Haber RJ, Lingard LA. Learning oral presentation skills: a rhetorical analysis with pedagogical and professional implications. *J Gen Intern Med*. 2001;16(5):308–314
6. Heidenreich C, Lye P, Simpson D, Lourich M. The search for effective and efficient ambulatory teaching methods through the literature. *Pediatrics*. 2000; 105(1 pt 3):231–237
7. Grover M. Priming students for effective clinical teaching. *Fam Med*. 2002;34(6): 419–420