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1. MD PROGRAM CURRICULUM

The MD Program Curriculum builds from a framework that aligns with the Accreditation Council for Graduate Medical Education’s (ACGME) six core competencies and adds Discovery as a seventh competency. Alignment of the school-wide competencies and objectives with clerkship and session objectives also meets the requirements of the educational standards of the Liaison Committee on Medical Education (LCME).
Written goals and objectives for each course and clerkship arise from the underlying MD Program Core Competencies and Objectives.

MD Program Core Competencies and Objectives

MEDICAL KNOWLEDGE • PATIENT CARE • INTERPERSONAL COMMUNICATION • PRACTICE-BASED LEARNING AND IMPROVEMENT • SYSTEMS-BASED PRACTICE • PROFESSIONALISM • DISCOVERY

Course Goals and Objectives

Session Objectives

Session Objectives

Session Objectives

Clerkship Goals and Objectives

Clinical Assignments

Session Objectives

Patient Log Diagnosis List

Session Objectives

Session Objectives
The following competencies and their associated educational objectives serve as a guide for curriculum development and evaluation of the success of the training program and its graduates:

1. **Patient Care**
   Provide patient-centered care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health

   1.1 Perform all medical, diagnostic, and surgical procedures considered essential for the area of practice
   1.2 Gather essential and accurate information about patients and their conditions through history-taking, physical examination, and the use of laboratory data, imaging, and other tests
   1.3 Organize and prioritize responsibilities to provide care that is safe, effective, and efficient
   1.4 Interpret laboratory data, imaging studies, and other tests required for the area of practice
   1.5 Make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment
   1.6 Develop and carry out patient management plans
   1.7 Counsel and educate patients and their families to empower them to participate in their care and enable shared decision-making
   1.8 Provide appropriate referral of patients including ensuring continuity of care throughout transitions between providers or settings, and following up on patient progress and outcomes
   1.9 Provide health care services to patients, families, and communities aimed at preventing health problems or maintaining health
   1.10 Provide appropriate role modeling
   1.11 Perform supervisory responsibilities commensurate with one’s roles, abilities, and qualifications

2. **Knowledge for Practice**
   Demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care

   2.1 Demonstrate an investigatory and analytic approach to clinical situations
   2.2 Apply established and emerging bio-physical scientific principles fundamental to health care for patients and populations
   2.3 Apply established and emerging principles of clinical sciences to diagnostic and therapeutic decision-making, clinical problem-solving, and other aspects of evidence-based health care
   2.4 Apply principles of epidemiological sciences to the identification of health problems, risk factors, treatment strategies, resources, and disease prevention/health promotion efforts for patients and populations
   2.5 Apply principles of social-behavioral sciences to provision of patient care, including assessment of the impact of psychosocial and cultural influences on health, disease, care seeking, care compliance, and barriers to and attitudes
toward care
2.6 Contribute to the creation, dissemination, application, and translation of new health care knowledge and practices

3. Practice-Based Learning and Improvement
Demonstrate the ability to investigate and evaluate one’s care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning

3.1 Identify strengths, deficiencies, and limits in one’s knowledge and expertise
3.2 Set learning and improvement goals
3.3 Identify and perform learning activities that address one’s gaps in knowledge, skills, and/or attitudes
3.4 Systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement
3.5 Incorporate feedback into daily practice
3.6 Locate, appraise, and assimilate evidence from scientific studies related to patients’ health problems
3.7 Use information technology to optimize learning
3.8 Participate in the education of patients, families, students, trainees, peers, and other health professionals
3.9 Obtain and utilize information about individual patients, populations of patients, or communities from which patients are drawn to improve care 3.10 Continually identify, analyze, and implement new knowledge, guidelines, standards, technologies, products, or services that have been demonstrated to improve outcomes

4. Interpersonal and Communication Skills
Demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals

4.1 Communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds
4.2 Communicate effectively with colleagues within one’s profession or specialty, other health professionals, and health related agencies
4.3 Work effectively with others as a member or leader of a health care team or other professional group
4.4 Act in a consultative role to other health professionals
4.5 Maintain comprehensive, timely, and legible medical records
4.6 Demonstrate sensitivity, honesty, and compassion in difficult conversations, including those about death, end of life, adverse events, bad news, disclosure of errors, and other sensitive topics
4.7 Demonstrate insight and understanding about emotions and human responses to emotions that allow one to develop and manage interpersonal interactions

5. Professionalism
Demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles

5.1 Demonstrate compassion, integrity, and respect for others
5.2 Demonstrate responsiveness to patient needs that supersedes self-interest
5.3 Demonstrate respect for patient privacy and autonomy
5.4 Demonstrate accountability to patients, society, and the profession
5.5 Demonstrate sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation
5.6 Demonstrate a commitment to ethical principles pertaining to provision or withholding of care, confidentiality, informed consent, and business practices, including compliance with relevant laws, policies, and regulations

6. Systems-Based Practice
Demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care

6.1 Work effectively in various health care delivery settings and systems relevant to one’s clinical specialty
6.2 Coordinate patient care within the health care system relevant to one’s clinical specialty
6.3 Incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care
6.4 Advocate for quality patient care and optimal patient care systems
6.5 Participate in identifying system errors and implementing potential systems solutions
6.6 Perform administrative and practice management responsibilities commensurate with one’s role, abilities, and qualifications

7. Interprofessional Collaboration
Demonstrate the ability to engage in an interprofessional team in a manner that optimizes safe, effective patient- and population-centered care

7.1 Work with other health professionals to establish and maintain a climate of mutual respect, dignity, diversity, ethical integrity, and trust
7.2 Use the knowledge of one’s own role and the roles of other health professionals to appropriately assess and address the health care needs of the patients and populations served
7.3 Communicate with other health professionals in a responsive and responsible manner that supports the maintenance of health and the treatment of disease in individual patients and populations
7.4 Participate in different team roles to establish, develop, and continuously enhance interprofessional teams to provide patient- and population-centered care that is safe, timely, efficient, effective, and equitable

8. Personal and Professional Development
Demonstrate the qualities required to sustain lifelong personal and professional growth

8.1 Develop the ability to use self-awareness of knowledge, skills, and emotional limitations to engage in appropriate help-seeking behaviors
8.2 Demonstrate healthy coping mechanisms to respond to stress
8.3 Manage conflict between personal and professional responsibilities
8.4 Practice flexibility and maturity in adjusting to change with the capacity to alter one's behavior
8.5 Demonstrate trustworthiness that makes colleagues feel secure when one is responsible for the care of patients
8.6 Provide leadership skills that enhance team functioning, the learning environment, and/or the health care
delivery system
8.7 Demonstrate self-confidence that puts patients, families, and members of the health care team at ease
8.8 Recognize that ambiguity is part of clinical health care and respond by utilizing appropriate resources in dealing with uncertainty

9. Discovery
9.1 Critically analyze existing literature in a field of inquiry and formulate new investigative questions
9.2 Formulate a high-quality research question and hypothesis
9.3 Describe and employ appropriate research methods to answer a specific investigative question
9.4 Describe and apply the requirements for ethical conduct of scientific inquiry
9.5 Communicate clearly and accurately new knowledge obtained from scientific inquiry
PEDIATRICS 300A CLERKSHIP OBJECTIVES 2014-15

PATIENT CARE
- Perform a complete, developmentally appropriate history and physical exam on an infant, a child, and an adolescent
- Perform focused interviews and exams when appropriate, particularly in the ambulatory setting
- Based on a patient’s age and chief complaint
  - Identify key features to elicit or explore on history and exam
  - Develop a differential diagnosis
  - Select and interpret results of appropriate diagnostic tests.
  - Synthesize patient data to formulate an initial treatment plan
- Elicit and account for the patient’s perspective in diagnostic decision-making
- Involve the patient in therapeutic decision-making, explaining the risks and benefits of treatment versus the relevant alternatives
- Organize and prioritize responsibilities in both the inpatient and outpatient settings to provide care that is safe, effective and efficient
- Participate in requesting a consultation and identifying the specific questions to be addressed

INTERPERSONAL COMMUNICATION
- Modify communication to the developmental stage and individual needs of patients
- Recognize the need for foreign language interpretation and demonstrate effective use of interpreters
- Present patients to colleagues and supervisors in a focused, logical manner during family-centered rounds, in clinic and during sign-out
- Create complete, accurate, and well-organized written or electronic notes, including admission, progress, discharge, and outpatient clinic notes
- Write clear and accurate orders, including admission orders for hospitalized patients and outpatient prescriptions

KNOWLEDGE FOR PRACTICE
Core topics
- For each problem or diagnosis in the PEDS 300A core topics list, summarize essential clinical features and essential elements of diagnosis and management
- Identify factors that determine whether each problem should be managed in the inpatient or outpatient setting
- Discuss the pathophysiology underlying each problem in the core topics series
- Discuss risk factors, screening, and prevention strategies for each problem in the core topics list

Health Supervision
- Describe the typical sequence of health supervision visits from birth to adolescence.
- List recommended immunizations from birth to adolescence
- For each age group, provide examples of major developmental milestones (gross motor, fine motor, problem-solving, communication, personal-social) and age-appropriate anticipatory guidance (injury prevention, nutrition, behavior, development)
Growth
- Identify the sexual maturity of adolescent male and female patients using the Tanner method
- Demonstrate the use of standard growth charts to track weight, height, head circumference, and body mass index
- Identify growth that deviates from expected patterns, based on the family growth history and the child’s previous growth, and explain the initial assessment

Issues Unique To The Newborn
- List and perform unique key components of the newborn physical exam
- List aspects of the maternal prenatal history and labor and delivery course that have implications for the health of the newborn
- Provide anticipatory guidance about routine newborn care, including feeding, elimination patterns, sleep, safety, newborn screening, and immunizations

Issues Unique To Adolescence
- Describe unique features of the physician-patient relationship during adolescence, including confidentiality and consent.
- Interview an adolescent patient using the HEADDS framework to ask questions about lifestyle choices that affect health and safety

Acute Illness
- Recognize an acutely ill child who requires immediate medical attention

Chronic Illness
- Discuss how chronic illness can influence a child’s growth, development, educational achievement, and psychosocial functioning
- Discuss the impact of chronic illness on family emotional, economic, and psychosocial functioning

Child Abuse
- List features of the pediatric history and exam that should trigger concern for possible child abuse
- Describe California laws for mandatory reporting of suspected abuse and procedures for reporting

PROFESSIONALISM
- Demonstrate compassion, integrity, and respect for others
- Demonstrate responsiveness to patient needs that supersedes self-interest
- Demonstrate respect for patient privacy and autonomy
- Demonstrate accountability to patients, society and the profession
- Demonstrate tolerance of patient, parent, and family attitudes, behaviors, and lifestyles, paying particular attention to cultural and socioeconomic influences
- Identify assumptions, norms, and operating principles of the medical professional culture
- Recognize professional cultural norms that are unique to pediatrics
- Think critically about messages sent as part of the “hidden curriculum” in medical training, and contrast them with formal recommendations for professional behavior
• Explain how encounters with patients are invariably cross-cultural, particularly when professional cultural expectations are taken into account
• Demonstrate steps that can be taken to bridge cultural gaps between doctor and patient

INTERPROFESSIONAL COLLABORATION
• Describe the unique contributions of each member of a multidisciplinary team in caring for children with acute and chronic illness
• Collaborate effectively with peer, supervisors, staff, and patients in both the inpatient and outpatient settings

PRACTICE-BASED LEARNING AND IMPROVEMENT
• Identify and engage in learning activities to address gaps in one's knowledge, skills, or attitudes.
• Incorporate feedback into daily practice
• Articulate an answerable clinical question related to a patient seen in clinic or on the ward rotation; Locate and evaluate information to address the clinical question; Communicate newly acquired information to colleagues; Reflect on cultural and practical factors that facilitate or impede application of new information to clinical decision-making

SYSTEMS-BASED PRACTICE
• Contrast the values and practices of different areas of pediatric practice, (e.g. general vs. specialty, inpatient vs. ambulatory, general ward vs. ICU)
• Participate in coordination of care within the broader health care system, including communication with consultants, referring physicians, PCPs, and outside agencies
• Advocate for quality patient care and optimal patient care systems

PERSONAL AND PROFESSIONAL DEVELOPMENT
• Use self-awareness of knowledge, skills and emotional limitations to engage in appropriate help-seeking behaviors
• Manage conflict between competing personal and professional responsibilities
Key Topics in Pediatrics

As you read, consider pathophysiology, diagnosis, and management, including follow-up and patient education.

**Newborn:**
- Neonatal hyperbilirubinemia
- Newborn rashes
- Circumcision
- Congenital Heart Disease
- Apnea/Acute Life Threatening Event

**Infectious Disease:**
- Bronchiolitis
- Croup
- Pneumonia
- Upper Respiratory Tract Infection
- Urinary Tract Infection
- Pharyngitis
- Sinusitis
- Acute Gastroenteritis / Dehydration
- Otitis Media
- Meningitis

**Cardiology**
- Benign Heart murmurs
- Kawasaki Disease
- Syncope
- Chest Pain

**Pulmonary**
- Asthma (acute v. chronic)
- Respiratory distress
- Cystic Fibrosis

**Dermatology**
- Eczema
- Tinea capitis and corporis
- Impetigo
- Exanthems (measles, parvovirus, roseola...)

**Adolescent**
- STD's
- Acne
GI/ Surgery:
- Abdominal Pain
- Vomiting (age based v. disease based)
- Gastroesophageal Reflux
- Appendicitis
- Hirschsprung's
- Pyloric Stenosis
- Intussusception
- Hernia/hydrocele
- Testicular torsion
- Failure to Thrive
- Henoch-Schonlein Purpura

Endocrine:
- Diabetes mellitis
- Diabetic Ketoacidosis
- Short Stature
- Pubertal Delay
- Thyroid Disease

Heme/Onc:
- Anemia
- Common malignancies

Renal:
- Nephrotic syndrome
- HUS

Neuro:
- Cerebral palsy
- Guillain-Barre syndrome
- Febrile Seizures
- Non-febrile seizures

Genetics:
- Trisomy 21

Other:
- Fever without a Source
- Joint Pain / Limping Child
PATIENT LOG REQUIREMENTS FOR STUDENTS

PATIENT LOG DIAGNOSIS LIST: **Peds 300A Pediatrics**
(Adapted from the Council on Medical Student Education in Pediatrics Clinical Encounter Table)

<table>
<thead>
<tr>
<th>Logged</th>
<th>Diagnostic Category or Specific Diagnosis</th>
<th># of patients to be seen</th>
<th>Minimum level of involvement*</th>
<th>Clinical setting+</th>
<th>Alternative: CLIPP case**</th>
</tr>
</thead>
<tbody>
<tr>
<td>❑</td>
<td>Acute illness requiring emergency stabilization or intensive care</td>
<td>1</td>
<td>Direct pt care</td>
<td>O,I</td>
<td>23,25</td>
</tr>
<tr>
<td>❑</td>
<td>Chronic illness (e.g. congenital heart disease, IBD, diabetes, cystic fibrosis, JRA, leukemia, sickle cell disease)</td>
<td>1</td>
<td>Direct pt care</td>
<td>O,I</td>
<td>16,26,27,29,30,31</td>
</tr>
<tr>
<td>❑</td>
<td>CNS (e.g. seizures, meningitis, head injury, headache)</td>
<td>1</td>
<td>Direct pt care</td>
<td>O,I</td>
<td>19,20,24,28,29,30,31</td>
</tr>
<tr>
<td>❑</td>
<td>Dermatologic (e.g. eczema, urticaria, contact dermatitis, acne)</td>
<td>1</td>
<td>Direct pt care</td>
<td>O,I</td>
<td>3,11,21</td>
</tr>
<tr>
<td>❑</td>
<td>GI (e.g. abdominal pain, gastroenteritis, pyloric stenosis, appendicitis, GERD)</td>
<td>1</td>
<td>Direct pt care</td>
<td>O,I</td>
<td>15,16,22,27</td>
</tr>
<tr>
<td>❑</td>
<td>Growth (e.g. FTT, newborn feeding difficulty, obesity, short stature)</td>
<td>1</td>
<td>Direct pt care</td>
<td>O,I</td>
<td>4,26</td>
</tr>
<tr>
<td>Topic</td>
<td>Count</td>
<td>Care Type</td>
<td>OB</td>
<td>Patient Log</td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------------------</td>
<td>-------</td>
<td>----------------</td>
<td>----</td>
<td>-------------</td>
<td></td>
</tr>
<tr>
<td>Musculoskeletal (e.g. injury, infection, inflammatory process)</td>
<td>1</td>
<td>Direct pt care</td>
<td>O,I</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>Respiratory, lower - not asthma (e.g. bronchiolitis, pneumonia, RDS)</td>
<td>1</td>
<td>Direct pt care</td>
<td>O,I</td>
<td>12,7</td>
<td></td>
</tr>
<tr>
<td>Respiratory, upper (e.g. pharyngitis, viral URI, herpangina, allergic rhinitis, otitis)</td>
<td>1</td>
<td>Direct pt care</td>
<td>O,I</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td>1</td>
<td>Direct pt care</td>
<td>O,I</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Fever without localizing signs</td>
<td>1</td>
<td>Direct pt care</td>
<td>O,I</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Neonatal jaundice</td>
<td>1</td>
<td>Direct pt care</td>
<td>O,I</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Non-accidental trauma (confirmed or suspected)</td>
<td>1</td>
<td>Direct pt care</td>
<td>O,I</td>
<td>25</td>
<td></td>
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<td>Newborn</td>
<td>1</td>
<td>OB</td>
<td>O</td>
<td>1</td>
<td></td>
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<tr>
<td>Infant or Toddler</td>
<td>1</td>
<td>OB</td>
<td>O</td>
<td>2</td>
<td></td>
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<tr>
<td>School Age</td>
<td>1</td>
<td>OB</td>
<td>O</td>
<td>3,4</td>
<td></td>
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<tr>
<td>Adolescent</td>
<td>1</td>
<td>OB</td>
<td>O</td>
<td>5,6</td>
<td></td>
</tr>
<tr>
<td>Write-in Dx (include details in Notes)</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

* OB = observation


** CLIPP cases should be completed for any clinical problem not encountered during clinical experiences

+ O – outpatient; I – inpatient

Patient log lists reflect the subset of clerkship learning objectives that are ideally met through patient encounters.
2. PERFORMANCE ASSESSMENT IN REQUIRED CLERKSHIPS

At the start of the 2010-11 academic year the School of Medicine launched a new system of student performance evaluation in required clerkships. The information that follows provides a brief overview of the current system, including the role of residents, fellows, and faculty in evaluating student performance.

For additional information, see the CBES Website at:

EVALUATION ESSENTIALS

- Criterion-based vs. norm-based evaluation
- Pass with Distinction (PWD)
- Criteria for PWD
  - Exceptional Patient Care
  - Exceptional Professionalism and Interpersonal Communication
  - Final Exam
- Clerkship Evaluation Teams
- Role of resident, fellow, and faculty evaluators
- Fairness, Accuracy, & Timelines
- Brief interactions
CRITERION VS. NORM-BASED EVALUATION

• Stanford’s performance evaluation system in required clerkships is criterion-based.
• All students whose performance meets established criteria can earn a Pass with Distinction, regardless of how other students perform.
• This is in contrast to a curved or norm-based system, where only a certain proportion of students can earn the top descriptor of performance.

PASS WITH DISTINCTION (PWD)

• Prior to 2010, all clerkships at Stanford assigned final grades of Pass, Marginal Pass, or Fail.
• Since 2010, students are eligible to earn a Pass with Distinction in each of three domains:
  o Patient Care
  o Professionalism and Interpersonal Communication
  o Final Exam
• Grades for each domain are reported separately in the MSPE

PATIENT CARE

• The School of Medicine has adopted the RIME framework (Pangaro, 1999) to describe performance in Patient Care.
• The RIME framework is based on the understanding that students move through a sequence of developmental stages:
  – Reporter
  – Interpreter
  – Manager
  – Educator
• Students must function in the Interpreter stage to pass each core clerkship.
• Pass with Distinction requires functioning in the Manager stage.
• Managers must consistently demonstrate strong Reporting and Interpreting skills.
EXPECTED TRANSITIONS

Core clerkship students are expected to be in the Interpreter stage. Functioning as a Manager – during a required clerkship – earns a Pass with Distinction for Patient Care.
RIME STAGE DESCRIPTIONS


REPORTER

- Focus at this stage: Reliable, accurate, complete data-gathering and presentation of clinical information.
- Emphasis on the S/O (Subjective/Objective) part of SOAP.
- Student is able to answer the “What” questions (What’s the patient’s blood pressure? What medications is he taking? What findings are present on physical exam?)
- Students are expected move through the reporter stage during preclinical training, i.e. Practice of Medicine.

INTERPRETER

- Focus at this stage: Diagnostic reasoning.
- Emphasis on the A (Assessment) part of SOAP.
- Student can answer the Why questions: e.g. Why does this patient have chest pain? What does this exam finding means?
- Begins to see how details fit together.
- Data-gathering and reporting become more purposeful, more focused on pertinent positive and negative information and exploring diagnostic possibilities.
- Students are expected to move into the interpreter stage during their core clinical training.

MANAGER

- Focus of this stage: treatment planning - including diagnostic testing and therapy.
- Emphasis on the P (Plan) in SOAP.
- Student can answer the How or What Next questions: e.g. How do we solve or treat this clinical problem? What do we need to do next for the patient?
• Data-gathering and decision-making become more flexible, individualized, patient centered. Student thinks critically about recommendations, takes a more sophisticated approach to using medical literature to support patient care.

• Students at the Manager stage take primary responsibility for ensuring patients’ well-being and making sure care plans are carried through. Patients, fellow team members, and staff view the student as patients’ primary provider.

• Students are expected to move into the manager stage at the sub-internship level and beyond.

EDUCATOR*

• At the Educator stage, students
• Reflect on experiences to identify learning needs
• Define important questions to learn about in more depth
• Takes ownership for self-improvement

*Features of the Educator stage are threaded through all other stages.

PROFESSIONALISM AND INTERPERSONAL COMMUNICATION

• To earn a Pass with Distinction for Professionalism and Interpersonal Communication, students must demonstrate:
  – An absence of behavior that raises significant or consistent concerns
  – Consistent evidence of exceptional Professionalism and Interpersonal Communication with both patients and the medical team

• In addition, students must request multisource feedback from patients, peers, and non-MD staff
EXAMPLES OF EXCEPTIONAL PROFESSIONALISM AND INTERPERSONAL COMMUNICATION

- Student:
  - Extends him/herself beyond usual duties to ensure patients' comfort or well-being
  - Advocates on behalf of patients
  - Puts patients at ease
  - Makes an extra effort to support or help fellow students excel
  - Without prompting, takes on extra work to help the team
  - Supports the team by paying attention to the needs and care plans of patients other than those assigned
  - Adapts well to changing circumstances
  - Maintains composure in difficult situations
  - Manages conflict in a collegial manner
  - Makes an extra effort to participate in learning opportunities beyond those required

- Patients, families or non-MD staff offer unsolicited praise regarding the student's contribution to team functioning or patient care

FINAL EXAM

- In clerkships using the NBME Subject Exam, an exam score between the 75th-80th percentile earns a Pass with Distinction for the final exam.
- Clerkships using non-NBME exams have set comparable thresholds for Pass with Distinction.
- Clinical application of knowledge and efforts to expand knowledge are assessed as part of Patient Care and Professionalism.
CLERKSHIP EVALUATION TEAMS

- Each clerkship has established an Evaluation Team to review student performance data and assign final grades.
- Evaluation Teams are required to submit final grades and evaluations within 4 weeks of the end of each rotation.

ROLE OF RESIDENTS, FELLOWS AND FACULTY

- Individual residents, fellows, and faculty will not be asked to assign final grades or judge whether students should earn Pass with Distinction.
- The role of each individual evaluator is to:
  - Respond promptly to requests for input on student performance
  - Describe observations of student performance
  - Provide feedback directly to students on observations of performance

RESPONDING TO REQUESTS FOR INPUT

- Individual clerkships may use any or all of the following mechanisms to gather input on student performance:
  - Electronic forms (E*Value)
  - Paper forms
  - Email
  - Team meetings

An example of the online Patient Care-Professionalism Evaluation Form can be found at: http://med.stanford.edu/md/curriculum/CBEI/information_tools.html
FAIRNESS, ACCURACY AND TIMELINESS

• To ensure that student performance evaluations are as fair and accurate as possible, clerkships must collect information from the full range of residents, fellows, and faculty who work with each student.

• Please respond promptly to clerkship directors’ and coordinators’ requests for information about student performance.

A NOTE ON BRIEF INTERACTIONS

• Q: What if I didn’t have enough contact to decide whether a student functioned as a Manager or demonstrated exceptional professionalism?

• A: Clerkship Evaluation Teams will review and synthesize descriptions of student performance from multiple evaluators. Multiple brief observations from multiple evaluators will fall together as themes and trends. ALL input is valuable.

CONTACTS AND ADDITIONAL INFORMATION

• For more information about the Criterion-Based Evaluation System, including articles and Frequently Asked Questions, see the CBES website (http://med.stanford.edu/md/curriculum/CBEI/index.html) or contact one of the following:
  – Elizabeth Stuart, MD MSEd, Assistant Dean, Clerkship Education, aestuart@stanford.edu
  – Sara Clemons, MEd, Assistant Director, Clerkship Education, sclemons@stanford.edu
  – Gretchen Shawver, Pediatrics Clerkship Coordinator, gshawver@stanford.edu
3. SCHOOL OF MEDICINE POLICIES PERTINENT TO CLERKSHIP EDUCATION

- Definition of the medical student practice role
- Absences during clerkships
- Student duty hours and the work environment
- Student participation in clinical activities involving personal risk
- Universal precautions, needlestick and exposures protocol
- Respectful educator and mistreatment policy
Definition of the Medical Student Practice Role

The Medical Board of California requests that medical students be carefully instructed about what they may and may not do in terms of writing orders or prescriptions for patients. Thus, Educational Programs and Services, in collaboration with the clinical department chairs, Stanford-affiliated hospitals, and nursing offices, has prepared the following description of the appropriate role of the Stanford medical student on a patient care team.

California state law allows specific exceptions for medical students to the general code, which requires that all medical acts must be performed by licensed physicians. The exception specifies that a student may do all things that a physician may do with the following two provisos:

1. That any medically-related activity performed by students be part of the course of study of an approved medical school; and
   That any medically-related activity performed by students be under the proper direction and supervision of the faculty of an approved medical school.
2. Where clinically and educationally appropriate, physicians who are supervising medical students may delegate responsibility for some elements of teaching and supervision to non-physician care providers, e.g. allied health professionals, nurses, respiratory therapists, etc. within the institution. It will be the responsibility of each supervising physician to determine which learning experiences are appropriately delegated in this manner and to ensure that non-physicians providing such supervision are working within their scope of practice.

Medical students may therefore write orders for drugs, treatments, etc., provided that:

The provisions of number 2 above are observed:

• The students are assigned to or are consultants to the service on which the order pertains; and
• a licensed physician countersigns all orders before the orders are executed. Telephone orders of counter-signatures will be accepted from licensed physicians (including licensed housestaff). Medical students may locate and solicit the licensed physician’s verification by telephone, but the licensed physician must speak directly to the registered nurse and must actually sign the order before going off duty. The counter-signature is recorded as a telephone order. Routine admission orders are not exempted from the above provisions.

Medical students acting as subinterns are still subject to the above provisions.
Medical students will identify their signatures with CC (Clinical Clerk) or MS (Medical Student), just as licensed physicians identify their signatures with MD. Medical students will also wear badges identifying them as medical students.

Medical students are not to be involved in any portion of the medical care of other medical students.

**Absences during Clerkships**

Students must contact the clerkship director to obtain explicit advance approval for any planned absence from the clerkship. Unanticipated absences for illness or emergency must be communicated to the clerkship director as promptly as possible.

Students are expected to seek necessary health care to maintain their physical and mental well-being. Examples of necessary health care include preventive health services and screening (e.g., annual check-ups, routine dental cleaning, vaccinations), new and follow-up visits for acute illness, ongoing care for chronic illnesses, physical therapy, and counseling and psychological services. Students have a right to privacy when seeking care.

For planned absences related to healthcare, students must contact the clerkship director, site director and preceptor or patient care team in advance to coordinate time away from the clerkship. Students need not disclose the specific type of healthcare that is being sought. A student’s decision to seek healthcare during a clerkship should have no impact on his or her performance evaluation.

Students who are absent more than two days during a four- or six-week rotation or more than three days during an eight-week rotation – for any reason - will be required to make up missed time.

Students who will miss more than 20% of the total duration of a clerkship – for any reason – will be asked to reschedule the clerkship.

Failure to communicate with the clerkship director about unavoidable absences is a potential reason for failing the clerkship.
**Student Duty Hours and Work Environment**

Providing students with a sound academic and clinical education must be carefully planned and balanced with concerns for patient safety and student well-being.

Supervision of students

1. All patient care must be supervised by qualified physicians or non-physician designees operating within their scope of practice.
2. Faculty, residents and students must be educated to recognize the signs of fatigue, and adopt and apply policies to prevent and counteract the potential negative effects.

Duty hours are defined as all clinical and academic activities related to the students, i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.

Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.

Students must be provided with one day in seven free from all educational and clinical responsibilities, averaged over a four-week period, inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.

In-house call activities

The objective of all call activities is to provide students with continuity of patient care experiences throughout a 24-hour period. In-house call is defined as those duty hours beyond the normal workday when students are required to be immediately available in the assigned institution.

In-house call must occur no more frequently than every third night, averaged over a four-week period.

Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours.
Students must have a minimum of 8-hours free of duty between scheduled duty periods. Students must have a minimum of 14-hours free of duty after 24-hours of in-house duty.

**Student Participation in Clinical Activities Involving Personal Risk**

The Stanford University School of Medicine has long had the policy that medical students learn to be physicians by participating in the care of patients under faculty supervision. Some of these patients may have an infectious or other disease that provides some risk to caretakers, including students. While every effort will be made to provide appropriate training and safeguards for students so that these risks are minimized, they cannot be totally eliminated.

Students are required to participate in patient care as one of their fundamental responsibilities during a clinical clerkship. Students are expected at all times to follow universal safety precautions in order to safeguard their own health. Under certain rare and extenuating circumstances where the risk to the student significantly outweighs either the educational benefit to the student or the health-care benefit to the patient, a supervising physician may suggest that a student be exempted from, or a student may ask permission from the supervising physician to be excused from, participation in certain aspects of patient care.

The clerkship director is responsible for providing clarification of this statement and resolving any disputes. In the event a dispute is unsatisfactorily resolved from the standpoint of either the student or the supervising physician, the matter may be referred to an Advising Dean for final review.

**Universal Precautions and Needlestick Protocol**

Universal Precautions apply to the handling of all blood, body fluids, and human tissue. Body fluids, also known as other potentially infectious materials (OPIM), include: semen, vaginal secretions, cerebrospinal, synovial, pleural, peritoneal, pericardial, and amniotic fluids, feces, urine, sputum, nasal secretions, saliva, tears, vomitus or any other body fluid or tissue that is visibly contaminated with blood. Appropriate protection including gloves, mask and gown should be worn to protect oneself from exposure.
If you believe you have had a significant exposure to blood or OPIM, IMMEDIATELY wash wound or exposed tissue thoroughly with soap and water. Rinse copiously. Then call the The Exposure and Needle Stick hotline 650-723-8222 then pager 1-STIX (222 then 1-STIX from hospital or medical school phone) to talk to a staff person 24/7 who is trained and on call specifically for this purpose. This hotline has been set up for medical students and Stanford employees. Records are confidential in accordance with applicable laws. There is no charge for blood tests, medications, or follow-up care following a blood or OPIM exposure. If you have any problem using this hotline, please call Dr. Smith-Coggins immediately - regardless of time of day or night. Dr. Smith-Coggins can be reached through hospital page system 650-723-6661 on pager 1-3481.

NOTE: Students requiring antibiotic prophylaxis after exposure to illness (e.g. pertussis) may also contact the Needlestick Hotline for assistance.

**Respectful Educator and Mistreatment Policy**

I. Standards

A. Stanford School of Medicine (SoM) is committed to providing a work and educational environment that is conducive to teaching and learning, research, the practice of medicine and patient care. This includes a shared commitment among all members of the SoM community to respect each person’s worth and dignity, and to contribute to a positive learning environment where medical students are enabled and encouraged to excel. Given their roles in the educational process and their inherently unequal positions vis a vis students, all instructional personnel (including faculty, residents, and other members of the healthcare team) are to treat students with courtesy, civility and respect and with an awareness of the potential impact of their behavior on such students’ professional futures.

B. Conduct inconsistent with this policy can occur in a variety of forms and may seriously impair learning. In particular, instructional personnel are expected to create an environment in which feedback regarding their performance can be given openly by students without concern for reprisal, and which is free of exploitation, harassment, impermissible discriminatory treatment, humiliation, or other mistreatment or abuse of medical students. Examples of conduct inconsistent with these standards might include:
- Sexual harassment
- Physical or verbal abuse
- Assigning duties as punishment rather than education
- Requiring a student to perform personal services (such as shopping or babysitting)
- Unwarranted exclusion from reasonable learning or professional opportunities
- Evaluation or grading on inappropriate criteria (or threatening to do so)
- Harassment or discrimination on the basis of sex, race, age, color, disability, religion, sexual orientation, gender identity, national or ethnic origin, or any other characteristic protected by applicable law

C. Note: The expectations stated in this policy primarily relate to the standards of conduct for instructional personnel. For their part, medical students are expected to adhere to similar standards of respectful and professional behavior, including (but not limited to) the standards of conduct for students set forth in the MD Program Handbook and Policy Manual.

Full policy and procedures available at:
http://med.stanford.edu/md/mdhandbook/respectfuleducatorandmistreatmentpolicy.html