Senior Resident Guidelines for Supervising Clinical Clerkship

Introduction

As Senior Residents on the Clinical Teaching Units (CTUs), you are the educational “heart and soul” of the clinical internal medicine undergraduate teaching program and part of the foundation on which the McGill University Teaching Hospital Network (JGH, MUHC & SMH) maintains its reputation as providing among the best clinical educational experiences in the world.

The following guidelines are meant to orient and/or update JARs (R2s) and SARs (R3s) on how to go about supervising medical students on an acute care internal medicine CTU. Each CTU will have its own way of applying these general suggestions to its particular context, and readers must consult the orientation letters that each CTU director has created to supplement these generic guidelines.

Although these guidelines are divided into separate Patient Care, Education and Learning Environment/Context sections, please keep in mind that in reality these 3 are highly interdependent and integrated concepts.

PLEASE NOTE: This year there are new on-call guidelines. Also please see attached some guidelines for evaluation of clerks.

Patient Care

General Guidelines for Safe Clinical Supervision on the CTUs

• Personally examine and speak to patients and speak directly with other health care workers when there is a significant change in patients’ conditions, and as required to provide safe, efficient, effective and compassionate medical care.
• Review all patients (especially Vital Signs, Medications, Laboratory and Radiology test results, tubes and lines, thromboprophylaxis) on admission and before discharge or transfer to other services. Anticipate danger: Unexpected bad clinical events are most likely to occur within the first 24 hours of CTU admission or first 24 hours of CTU discharge: Personally see these patients early and pay special attention to their vital signs, even if they are “sold” to the team as “stable” or “not needing surgery”. Most in-hospital adverse events occur because of medications: narcotics, anti-diabetic agents and anticoagulants are the commonest culprits.
• Review and co-sign consultation notes, admission notes, progress notes and discharge summaries. Regularly review level of care / level of intervention orders, patient orders and prescriptions.
• Help with difficult issues (disagreements with other hospital services, access to limited hospital resources, conflicts with other health care workers and difficult patients and families) as they may arise.
• Anticipate the need for increased patient monitoring and communicate this with nursing. For example, patients receiving Chemotherapy or Biologics (like Remicade) require prescriptions written well in advance and signed by an Attending.
• Judge and adjust the intensity of supervision you provide to each trainee according to his/her level, demonstrated capabilities, and the clinical context.
• Briefly meet the Head Nurse and Assistant Head nurse at the beginning, middle and end of your time on service to ensure that all members of the ward team work effectively together and to get a different and highly valuable perspective on how students are performing.
Education

Basic “Educational Anatomy” for the Senior Resident

• Before you start
  o Familiarize yourself with the clerks’ learning objectives, evaluation methods and rules
  o Consider a teaching plan to cover main topics in Internal Medicine
• First day on service: Review general and set personal learning objectives
  o Meet with each student briefly and individually to share your expectations and their
    learning needs and to review the program’s learning objectives
  o Assign specific times dedicated to planned teaching, taking into account the
    availability of team members’ clinics, half days and other meetings.
• Teaching (See general teaching guidelines below)
• Mid-way through:
  o Participate in midway feedback to the students by providing your input to the
    Attending and/or meet with the student alongside the Attending individually and in
    private to share feedback
  o Communicate any concerns about students to the Attending and then to the Internal
    Medicine Site Director (whenever the concern arises)
• Teaching (See General Education Guidelines below)
• Near the end of your time on service:
  o Participate in final feedback to the students by providing your input to the Attending
    and/or meet with the student alongside the Attending individually and in private to
    share your summative evaluation

General Education Guidelines

Teaching Methods.
There are many effective ways of teaching clinical clerks (see references below for ideas). All of
these methods depend upon the following general rules:
• Directly observe your learners and teach by asking questions based upon what you have
  observed: The most effective teachers choose what and how to teach based upon collected
  “educational samples” of learners’ observed performances “in the field”: These may range
  from taking a history, performing aspects of the physical exam, doing procedures and
  communicating with patients, families, other team members and other health care workers to
  advocating for patients, teaching more junior learners, running team meetings and organizing
  discharges.
• Synchronize your choices of teaching methods with each CTU work schedule. The following
general approaches tend to be among the most effective:
  o Walk-around rounds, to review patients efficiently, role model priority setting and do
    focused bedside teaching. These should generally be done when there are a lot of
    new patients, early in the day. They should not take longer than 1 ½ to 2 hours, as
    longer rounds leave no time to get more detailed work done.
  o Review new patients with the team in more detail than during walk-around rounds
    and incorporate bedside teaching and didactic case-based discussions.
  o Assign short presentations (10 to 15 minutes) by the students and residents based
    on questions arising from patient care. This is commonly done before or after sign-
    out rounds.
• How much time to spend in “teaching” activities is a common question: It is difficult to provide
  hard and fast guidelines since “teaching” is best done as an integral part of everyday
  practice, and the quality of learners’ thinking and reflection is far more important educationally
  than time spent in “formal” teaching. Discussions as part of practice are often not perceived
  by learners as teaching. One effective approach to this dilemma is to ask your learner(s),
after any activity to summarize for you, for themselves or for the group what their own “take
home” messages were from that activity.
Feedback.

- This is the MOST IMPORTANT part of any educational system and the single most important activity that you can do for learners.
- It must be given face-to-face in private halfway through your time on service (after the first week of a 2-week service period or after the second week of a 4-week service period). The Attending should document what you have told each learner if possible. Most learners will not need a major long feedback meeting. However, a few minutes spent doing this mid-way through can save you a huge amount of time and bother after the rotation, especially if the learner had difficulties during the rotation.
- Give feedback on both strengths and growth areas you observed.
- Weaker students must be given the direction and time to improve in response to feedback on their growth areas. Many learners improve rapidly and on a very steep curve if they receive and act on good feedback.
- Stronger students need to hear that they are good at something. For stronger students, feedback reinforces what they are doing well, decreases anxiety and points out smaller growth areas that they may not be aware of and can greatly influence eventual career choices.
- No final evaluation should ever come as a surprise to a student or to the Site Clerkship Director.

The student who appears to be in difficulty

- You may encounter a student who appears to not meet expectations despite feedback for one or more evaluation criteria.
- Your role is to let your Attending Physician and the Site Clerkship Director know that you perceive a student in difficulty as soon as possible and work with him or her to sort out the situation, all the while strictly respecting due process for the student.
- Like any symptom expressed by a patient this requires a disciplined “diagnostic” approach (Steinert, 2008): You will have to work collaboratively with the student, residents, the CTU Director and the Site Clerkship Director by considering the answers to the following questions:
  1. Is this a problem? This is similar to deciding if a symptom is a variant of normal or pathologic.
  2. What is the problem? This is similar to deciding what the real “chief complaint” is.
  3. Whose problem is it? This is like generating an initial differential diagnosis of the chief complaint:
     The “student in difficulty” could be the presenting manifestation of a problem with the attitudes, skills and/or knowledge of the student, the teacher (this could be you and/or the student’s residents) and/or the system respectively.
  4. What additional information is needed? Participate in careful data gathering and documentation to rule in or out each of the possibilities in the “educational differential diagnosis” generated from the analysis in step #3. This involves you and the Site Coordinator interviewing the student, residents supervising the student and other health care practitioners working with the student. It will also require doing an “educational physical exam” in the form of direct observation of the student in appropriate clinical situations. You will have to write down your observations similar to the progress notes you would write for a patient care situation.
  5. What is the appropriate “educational therapy” for the student, teachers, and/or system? How do we assure “due process” to guarantee fairness, confidentiality and informed consent for the student, residents, teachers and system? McGill adheres to a “NO FEED FORWARD” policy for medical students’ evaluations. That is, evaluators cannot share their ratings and perceptions of any student with those supervising the student later on during the Internal Medicine clerkship. For instance, you may be assigned a new student who has not done well in his/her just completed surgery clerkship. You are not allowed to know about this unless the student volunteers the information. Similarly,
if one of your former students had difficulty during the internal medicine clerkship, you
cannot share this information with anyone who did not work with or supervise the
student during the internal medicine clerkship.

Summative (“Final”) Evaluations

• The Attending physician must fill in a written evaluation for each clinical clerk in one
  software by the end of his or her time on service. They may consult with you prior to doing so.
• This evaluation should be a fair summary of the observations and opinions of CTU residents
  and nurses who worked with the clerk.
• The Narrative Comments section of the evaluation forms are summarized by the Clerkship
  Site Director into a final evaluation summary on one which then becomes a part of the
  student’s permanent record. Many would argue that this is the most important part of the
  final written evaluation. Your comments, if echoed by others who have supervised the
  student, will appear in the student’s Dean’s Letter at graduation. This letter is an essential
  part of a student’s application for residency training.
• For students you think are “Exceeds Expectations” or “Superior” in any given criterion, writing
  out examples of behaviors you observed that support your rating is important if you want your
  evaluation to be believable.
• For students you rate as “Below Expectations” or “Unsatisfactory” in any criterion it is
  CRITICAL that you communicate examples of behavior observed that support your rating. It
  will also help you be more concrete in the feedback you give to a student in difficulty, make it
  impossible for a student to say “no one ever told me that I was below expectations in…”, and
  give the Associate Dean of Medical Education and Student Affairs evidence that a student is
  or is not responding to feedback.

Specific Education Guidelines for Clinical Supervisors

• At each site there is an orientation to the specifics of education (schedules, rounds, how
  things work, computer passwords, etc) on the CTU. This may come from the CTU Director or
  the Residency Training Director and/or the Site Clerkship Director by email, letter or direct
  conversation. Contact the Site Clerkship Director if questions arise with regard to the medical
  students on the CTU with you.

Learning Environment/Context

Service to education balance

The correct service to education balance provides students with meaningful clinical experience
and responsibility for patient care as well as time to reflect on and read around their experiences.
Excess patient loads and/or work hours tip this balance toward service with inadequate time for
reading and reflection. However, students need to have a minimum number and variety of clinical
experiences in order to stimulate growth of their expertise. Monitor the teamwork of your
residents and students and make sure that the student workload policy (see below) is respected.
Not all service is “scut”. Many types of clinical responsibility can be made meaningful by
supervisors who explicitly point out the educational value of what can be seen as mundane
clinical tasks. Some examples of this include:
• Writing a Discharge Summary: This exposes students to the principles of safe handoffs
  and medication reconciliation.
• Contacting a radiologist to book a critical test: This teaches students how to prioritize
  their work and communicate succinctly with and learn from a consultant.
• For example, a clerk who is committed to a career as a surgeon could interpret
  summarizing a complex past medical history as “scut”. A perceptive and skilled
  supervisor can show such a student how important this skill will be for preoperative
  assessment, due diligence and deciding whether or not surgery is indeed the best
  course for a given patient at a given time.
Clerkship

What clerks can and cannot be expected to do

- Clinical clerks cannot prescribe medications nor order tests without a countersignature by an Attending or a Resident. R1s should not cosign medical student orders as they are not expected to be able to judge whether or not the order is appropriate for the student’s patient.
- Clinical clerks cannot obtain consent, establish advance directives, give bad news, deal with an angry family, patient, or consultant nor perform procedures without the supervision of a resident or Attending.
- Under no circumstance can a student discharge a patient from a ward, ER or outpatient clinic setting without that patient having been seen and the discharge summary countersigned by a resident or an Attending. In a ward setting, the average clerk can be expected to care for up to 4-6 patients under the supervision of a Resident or Attending.

Worktime Policy for Clinical Clerks in Internal Medicine

General Principles

- No clerk is to be on call without adequate, appropriate and on-site supervision and backup.
- The on-call will not be so excessive that the clerk’s ability to meet other objectives of the rotation is compromised. The on-call will not result in a situation where the clerk’s ability to learn and function is compromised due to sleep deprivation.
- Should a clerk miss more than 5 non-statutory days from a 4-week rotation block for any reason (health, religious observance, conference etc.), the block is an automatic incomplete and must be repeated. (For clerkships that are 8 weeks in length, these are divided into two 4-week blocks as per the resident rotation schedule.) A clerk who misses 5 days or less for any reason may be required to make up the time by the clerkship director and depends upon the clerkship director’s judgment as to whether or not the goals of the clerkship have been met. This time may be made up on weekends. The student must be notified by the last Friday of the clerkship rotation (with a copy to the associate dean) if he/she is required to make up missed days.
- Clerks must immediately report any deviation from the Workload policy to the site Clerkship Directors Office via email.

Specific Worktime Guidelines

- Clerks should not work more than 16 hours consecutively
- Instead, the new call schedule will include:
  - Two overnight calls (8pm to 8 am on a consecutive Friday and Saturday)
  - Two weekend day calls (8 am to 8 pm on a consecutive Saturday and Sunday)
  - Two evening calls (end 8 pm)
  - This means each student will be absent one Friday during the day
  
- There are no post-call days
- Clerks should not be on call in hospital more than 6 days in a 28-day period.
- Clerks should get at least 2 weekends off per month.
- Clerks’ work week should not exceed 60 hours per week excluding call: If the clerk arrives to start work at 7:30 AM they should go home ideally by 6 PM and certainly no later than 7:30 PM on days that they are not staying late for evening call.
- Clerks may be put on call the first day of a new rotation and are warned to arrive prepared
- Clerks should not be on call after 8 PM on the last Sunday of a rotation; on the day before a whole class teaching session (e.g. ACLS, Physicianship3); nor before an exam. Indeed with the exception of overnight call, all calls generally end by 8 pm (they are either 8am to 8pm or 8pm to 8am) Clerks may request to not work on certain days for religious reasons:
  - If it is a regular day when the student is not on call AND the clerkship director has determined that patient care will not be adversely affected by the absence AND the student has not missed more than 5 non statutory during any 4 week rotation block for any reason
If it is an on-call day AND the ward team is able to accommodate the request AND the ward team has been notified by the student a reasonable period in advance.

"Medical students...cannot refuse this responsibility for religious reasons."

Mistreatment Policy for Clinical Clerks/Residents in Internal Medicine

"Mistreatment" is defined as:

- **Harassment**: Any vexatious behavior by one member of the University Community towards another member of the University Community under the control and authority of the University in the form of repeated hostile or unwanted conduct, verbal comments, actions or gestures, that affects the dignity, psychological or physical integrity of a member of the University Community and that result in a harmful environment for such an individual.

- **Sexual harassment**: Any conduct of a sexual nature by one member of the University Community towards another member of the University Community where this conduct is
  - made an explicit or implicit term or condition of an individual’s employment or status in a course, program, or activity or
  - used as a basis for an employment or educational decision affecting an individual or
  - discriminatory or hostile to a person because of his or her sex in a manner; and that is known or ought reasonably to be known to create for such a person an intimidating, hostile, or offensive working or learning environment

- **Discrimination**: Any action, behavior, or decision based on race, color, sex (including gender identity), pregnancy, sexual orientation, civil status, age (except as provided by law), religion, political conviction, language, ethnic or national origin, social condition, a disability or the use of any means to palliate a disability which results in the exclusion or preference of an individual or group within the University community.

"Teacher" is defined as:

- Any individual having a recognized affiliation with the University who is involved in the teaching, supervision or mentoring of students. This includes professors, lecturers, supervisors, small-group leaders, attending physicians, and residents.

The teacher is expected to:

- respect professional boundaries and not place herself/himself in unethical situations or conflicts of interest
- not engage in or tolerate any harassment of students (including emotional, sexual, physical, etc.)
- recognize and appreciate the power differential between teacher and learner
- not misuse or abuse this power differential (e.g., for personal gain, intimidation, punishment, etc.)

Hospital staff are expected to:

- treat patients and their families, colleagues, students and residents with courtesy, fairness and understanding regardless of race, religion, ethnic origin, culture, social status, gender, sexual orientation or health status.
- provide a safe, civil environment free of mistreatment and protected from reprisals for reporting mistreatment.

Mistreatment or Code of Conduct Violations

By Teachers should be brought to the attention of the
- Clerkship/Residency Site Director OR
- Assistant Dean, Office of Student Affairs (514-398-5557) OR
- Associate Dean, Medical Education and Student Affairs OR
- University Ombudsperson (514-398-7059)

All complaints will be treated confidentially and appropriate individuals will be contacted only when acceptable to both parties. If acceptable, a meeting may be set up with both parties in an effort to mediate.

By Hospital Staff should be brought to the attention of the
- Clerkship/Residency Site Director OR
- Medical Examiner for the institution where the violation took place.
Evaluations: Here are guidelines to assist in evaluations.

Finally, thank you for your valuable commitment to teaching.

References

- Lake, F. R. & multiple other authors. Teaching on the run tips series:

Thanks

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Yours Sincerely,
Dr. Peter Ghali
Chair, Internal Medicine Undergraduate Education Committee
Site Clerkship Director, RVH

Dr. Scott Owen
Site Clerkship Director, MGH

Dr. Beth Cummings
Site Clerkship Director, JGH

Dr. Leslie Meissner
Site Clerkship Director, SMH