Electronic Patient Encounter Log

All students must keep a daily electronic log of the patients encountered during their clinical rotations. The log centers around a “must see list” developed by the faculty. This log is web-based and accessed through student portal. The log has nine fields that students must complete for each patient encounter: rotation, hospital, date, chief complaint, primary diagnosis, secondary diagnoses, clinical setting, and level of responsibility and category of illness. The log also has a optional comment section. Students can use the comment section to note relevant Communication Skills Modules, cultural issues, procedures or medical literature relevant to the patient. We recommend that the log be kept current on a daily basis. This log serves multiple functions and, as discussed below, will be used in different ways and for different purposes by students, by the clinical faculty at affiliated hospitals and by the Clinical Deans. Students are asked to remain HIPPA compliant by not using any patient identifiers, such as names, initials, date of birth, medical record numbers, or pictures.

Rationale

During the clinical years students need to develop the clinical competencies required for graduation and postgraduate training. These competencies are assessed in many different ways: by faculty observation during rotations, by communication skills assessments, by completion of web based assignments and by NBME clinical subject exams. In order to develop many of these competencies and meet the objectives required for graduation, the school needs to ensure that each student sees enough patients and an appropriate mix of patients during their clinical terms. For these reasons, as well as others discussed, below the school has developed this log.

One of the competencies that students must develop during their clinical training involves documentation. Documentation is an essential and important feature of patient care and learning how and what to document is an important part of medical education. Keeping this log becomes a student training exercise in documentation. The seriousness and accuracy with which students maintain and update their patient log will be part of their assessment during the core rotations. In terms of the log, how will students be assessed? Not by the number of diagnoses they log, but by the conscientiousness and honesty they exhibit documenting their patient encounters. All of these features of documentation – seriousness, accuracy, conscientiousness and honesty – are measures of professional behavior.

Definition of a Patient Encounter

Students should log only an encounter with or exposure to a real patient. Simulated patients, case presentations, videos, grand rounds, written clinical vignettes, etc. should not be logged even though they are all important ways to learn clinical medicine. Many of these educational experiences, along with self-directed reading, are necessary preparation for Step 2 and postgraduate training. This log, however, focuses on a unique and critical component of clinical training, namely, involvement with “real” patients. Student involvement with patients can occur in various ways with different levels of student responsibility. The most “meaningful” learning experience involves the student in the initial history and physical exam and participation in diagnostic decision making and management. A less involved but still meaningful encounter can be seeing a patient presented by someone else at the bedside. Although the level of responsibility in this latter case is less, students should log the diagnoses seen in these clinical encounters. Patient experiences in the operating or delivery room should also be logged.

For Students

The lists of symptoms (chief complaints) and diagnoses serve as guidelines for the types of patients the clinical faculty think students should see over two years of clinical training. We feel that students should have clinical exposure to about 50 symptoms (chief complaints) and about 180 diagnostic entities. These lists can also serve as the basis for self-directed learning and independent study in two ways:

1. If students see a patient and enter that patient's primary and secondary diagnoses in the log, they will be expected to be more knowledgeable about these clinical entities.
2. To do additional reading about them, including some research or review articles. If relevant, students can study and log a communication skills module.

If, at the end of the third year, students discover they have not seen some of the clinical entities on the list during the core rotations, they can arrange to see these problems in the fourth year or learn about them in other ways through online access medicine files on their own.

The different fields in the log should stimulate students to look for and document the complexities of clinical encounters when appropriate. Many patients present with multiple medical problems. For example, an elderly patient admitted with pneumonia (primary diagnosis) may also have chronic lung disease, hypertension and depression (secondary diagnoses). The patient may have fears about death that need to be discussed. We hope by keeping the log students will develop a more profound understanding of many patient encounters.

Students may, and many times should, review and edit the log (see "Instructions to access and use the log" below). The original entry might require additions if, for example a new diagnosis is discovered, the patient moves from the ED to the OR to the wards or a patient presenting with an acute condition deteriorates and presents end-of-life issues. These developments require a return to the original entry for editing.

The chief complaint and diagnosis lists do not include every possible diagnosis or even every diagnostic entity students must learn about. The list reflects the common and typical clinical entities that the faculty feels XUSOM students should experience. The same list of diagnoses is presented in two ways - alphabetically and by specialty. Both lists contain the same diagnoses and students can use whichever one is easier. If students encounter a diagnosis not on the list, they should choose the most related diagnosis from the list. By looking at "standard" diagnoses, the school can monitor the overall clinical experiences students are having at different affiliated hospitals.

Students must learn more than they will experience during clinical rotations. The log does not reflect the totality of the educational objectives during the core clerkships. Clinical experience is an important part, but only a part, of your clerkship requirements. Students need to commit themselves to the extensive reading and studying during the clinical years.
"Read about patients you see and read about patients you don't see".

The NBME Clinical Subject Exams at the end of the clerkship is not based on the log but on topics chosen by the NBME.

We encourage students to maintain this log throughout their 72 weeks of clinical training. The University requires that the logs be formally evaluated only during the clerkships. However, the list reflects those entities the faculty thinks students should encounter during their entire clinical experience in medical school, not just during the clerkships. To this end the Office of the Dean Monitors student logs throughout the clinical terms assure compliance with the required encounters.

Assessment

1. Hospital Oversight

A Program Director or faculty member reviews and assesses students' logs as part of the mid-core and final assessment. During the mid-core formative evaluation the faculty member can comment on the completeness of the log and also ascertain whether students are seeing a good mix of patients. Students with relatively insufficient entries are either not involved in the rotation or did not take the log assignment seriously. In either case such deficiencies may impact the grade students receive in Professional Behavior. Since students are responsible to answer questions about the entries in their log, we would not expect students to log cases they have not seen and studied. The clinical faculty and departments can use the collective data in the students' logs to evaluate their own program and the extent it offers students an appropriate clinical experience.

2. Central Oversight

Because of its web-based structure, all entries into the log are electronically submitted to the school and reviewed in the Office of the Clinical Dean. The Office of the Clinical Dean collects, collates and analyzes logs from all of the students and uses this data in two ways:

- a. To monitor and evaluate the clinical experience at different hospitals. In this way, the central administration of the school will be able to answer questions, for example, like "Have all of our students seen appendicitis? Have they all seen a patient with schizophrenia? Do all of our affiliated hospitals expose our students to end-of-life issues? Are all students involved in communication with children and parents?" With the data from these logs we can document for ourselves, the faculty and the student body that all of our clinical training sites provide excellent and comparable clinical experiences.
- b. To review the patient log of every clinical student that has completed their clerkship year. Students who have gaps in their clinical experience can be identified. This has been made possible by asking each of the clinical departments to provide quantified criteria for the types of patients on the "must see list". The Office of the Dean will then notify students identified in this way and point out the deficiencies in their clinical experience. Students will then be asked to remediate this deficiency by supplemental online cases or future electives.

Instructions to Students for Access and use of the Logs

To access your electronic patient log, from our main website www.Xusom.com then you can select student management service, enter your username and password, from the left menu you select clinical log, you click on that and a list of dates will appear. Make sure the correct date is selected, then you enter your patient demographics, then you select the system with chief complaints, then you chose from a diagnostic list. Students are required to document each level of assignment or can enter questions and/or comments for other cases not listed above.