Joint Clinical Oversight Group – Annual Report from Clerkship Directors
AY 2021-22

Discipline: Surgery
Site: UH
Clerkship Director(s): Emily Steinhagen

Update and attach Required Documents:

1. Review and update (if needed) the PowerPoint describing the current structure of the rotation. Please attach the updated PowerPoint.
2. Attach the grading/assessment rubric used in your clerkship.

Respond to Quality Metrics: (The items highlighted on your individual data form are outside of benchmark range and require discussion.)

1. Your average completion rate for mid-rotation feedback for the year is provided. Describe your plan for improvement if <100%:

   Each student meets with their senior resident to fill out a feedback form; they also complete a self-assessment and meet with the clerkship director. In the past year, every student has met with me and the form has been completed. In the past academic year, 2 students reported not receiving feedback. Based on my own data, I do not plan to necessarily change my practice. However, I will continue to meet with each clerkship student and encourage our residents to continue with their "Feedback Friday" practice, which is department wide initiative.

2. Your average rate of EOR completion within 4 weeks is provided. Describe your plan for improvement if <100%:

   In the past, our data was combined with the VA but I am not sure if this is still true this year. In the past, our rating below 100% was related to this pooled data. This is not an issue for me.

3. The following ratings are provided for your clerkship. Comment and describe your plan for improvement if outside of benchmarks, indicated below:

   - Overall rating (>80% excellent or very good)
   - Neglect (<5%)
   - Mistreatment (<5%)

   We continue to encourage reporting of mistreatment and neglect and work through our Mistreatment Curriculum with the students each block. Last spring, we also held a workshop for residents regarding mistreatment in the surgical learning environment that explored experiences of students and residents, discussed barriers to intervening, and how to intervene and report. We plan to expand this to our faculty development

series, primarily in the context of discussions about psychological safety and within our Cultural Humility curriculum, which is a department-wide initiative. We had a faculty development session on the effective use of questions in teaching, which included a discussion about how to ask questions in an approachable and non-threatening manner that maintained respect for learners. We also discussed how to respond to wrong answers. All sessions from the faculty development program are on GPS and if needed, faculty can be referred to them for remediation.

We also review all comments related to mistreatment at our department meeting and with department leadership. However, it is difficult to address when the comments are not attached to a name.

Specific individuals who were reported to mistreat students were all approached and the issues were discussed with them; in the case of a resident, it was part of her formal remediation plan and she has graduated.

You must also respond to any serious or egregious report of mistreatment regardless of your benchmark.

- Duty hours (>95%) n/a

4. Your faculty rating for teaching is provided. Describe the process you use to review the quality of faculty teaching. Provide a specific plan for improvement if the number falls below 80%.
5. Your resident rating for teaching is provided. Describe the process you use to review the quality of resident teaching. Provide a specific plan for improvement if the number falls below 80%.

Though both of our ratings were >80%, we continue to foster teaching skills amongst faculty and residents. Our robust Residents as Teachers Curriculum continues to expand. We offer a Faculty Development Workshop every other month that focuses on education topics relevant to surgeons. Faculty and residents receive recognition and awards for excellent teaching. They also receive feedback from the clerkship director about the quality of the feedback/evaluations that they write.
If residents or faculty are mentioned either as exemplary educators or ineffective, they are provided feedback. The EOR feedback is reviewed each block. Teaching scores and comments are reviewed during each faculty members' Annual Performance Review with the Department Chair.

Provide Qualitative Feedback and Reflection:

6. Are there any clinical skills and/or knowledge in which students seem underprepared?

Students seem unprepared to manage the challenges of the clinical learning environment including the patient centered nature of the clerkships. They continue to have difficulty with

presenting patients in a concise and organized fashion. Most importantly, they have difficulty viewing feedback as a growth opportunity.

Students come to the surgery clerkship with significant negative biases toward the experience that I think make it more difficult for them to have positive learning experiences.

7. What significant changes were made in the rotation last year? Were they successful?

Last year, we updated our End of Rotation Evaluation form to be more observation based. This has been more successful in both setting expectations for students, as it is more specific, and guiding faculty on how to rate and provide feedback. The feedback on this form from faculty and residents has been positive.

Another important addition to the clerkship was an "Aligning Expectations" form that all students fill out within their first 2-3 days on a team. This form is a requirement and aims to facilitate conversations between students and residents about what is expected of the student on the team, remind the resident of student obligations like didactics and clinics, and requires a discussion of student goals. The response to this has been overwhelmingly positive. Residents appreciate that it provides structure to their conversations with students and enables them to give proactive guidance. Students like that the residents expect it so initiating the conversation is easier; it also ensures that some expectations are explicitly stated. This form is mirrored by our mid-rotation feedback form, and creates a set of expectations that enables good feedback.

The Acute Care Surgery and Trauma surgery services were removed from the clerkship because there are up to 3 medical students from NEOCOM on those services. Based on previous feedback, it is more difficult for students to find appropriate learning activities, mentorship, and teaching when there are more students on the same service. In addition, they have different schedules and expectations so this would create some workflow difficulties.

While teaching was included in Annual Performance Reviews for surgical faculty this year, I am unsure if there was any impact. Plans to track educational efforts have not materialized in our department.

There was a significant effort to account for 4th year students doing AI rotations and other learners when assigning students to services this year. This seems to have been helpful as there was no negative feedback about having too many learners on a service, but again, hard to assess as the positive outcome is the absence of just a few complaints.

8. What themes did you identify in student feedback about strengths of the clerkship?

Please see my responses below organized by theme with representative quotes from the EOR forms.

Clinical Exposure

- Saw a wide breadth of surgeries. Experienced surgical care in multiple settings.
- Was an incredible experience rotating on surgical oncology and getting to see clinical/surgical management of many skin cancers, as well as other malignancies.
- balancing supervision/autonomy, allowing us ability to improve our own specific goals
- Lots of opportunities to be a part of the surgery team
- The clerkship gets students plenty of OR exposure should they wish. I was in cases far more than any individual resident/fellow which allowed me to have experiences with many different disease pathologies and facetime with different attendings.
- Chances to join surgeries and practice sutures
- One of the strengths of this clerkship was the ability to see and experience in part what the general surgery residents do.
- Seeing patients pre- and post-surgery and learning their perioperative management.
- Allows students to take a deep dive into surgery without heavy constraints or strict guidelines. Allowed for me to explore areas of interest and focus my energy on improving my personal shortcomings.
- Good exposure to the OR as well as opportunities for involvement.

Structure/Schedule

- I liked that we were able to experience two different services. I also liked that one of the services was 4 weeks long, which allowed integration into the team as well as feeling more comfortable with my role in the team.
- Overall, I appreciated the general structure of the clerkship, and the mechanisms in place for establishing expectations and soliciting feedback.

Clear Expectations

- Laying out expectations at start of service
- As the med student on the team I felt valued and felt that I had a clearly defined role and status on the team. This helped me feel comfortable and confident in being engaged.
- Expectations were clear and I appreciated how the focus was on what we were doing in the hospital vs extra tasks like CAS logs for example.
- Aligning expectations form!
- the aligning expectations sheet was helpful
- The expectation form that she provided us was very helpful to fill out with residents when we started on different services and I hope that remains in the future.

Residents and Faculty

- Residents and attendings were overall great teachers,
- Residents provide great feedback - Attendings interested in medical student learning
- There were some faculty who made the OR a very educational experience which can make a huge difference. For the most part, residents did a good job of explaining things/teaching, though they were often busy

- The people I met during this clerkship were the main reason I had a great learning experience.
- The residents, attending, and scrub nurses made this clerkship. Everyone was dedicated to learning. I felt like a present member on the team. The patient population is a great mix of unique cases and community care.
- People were generally friendly, helpful, and willing to help with learning. Anything they asked me to do served a dual purpose of helping the team and teaching me about surgery and surgical team dynamics.
- The residents (especially the chief residents) were passionate about teaching and took breaks despite being incredibly busy to teach every day. I also had attendings who made it a point to bring me into the case and walk through the process with me.
- Attendings, residents and fellows were all very encouraging and kind.
- The residents were amazing and very dedicated to teaching. They gave great feedback and seemed committed to our growth as possible future surgeons. They often looked out for us and tried to find the most educationally rich opportunities for us.
- Great residents who were very receptive to students and were committed to teaching students.

Clerkship Director

- the clerkship director was very helpful when I was diagnosed with covid
- Dr. Steinhagen is also a gem of a clerkship director and it's clear she cares about the students and their education.
- Dr. Steinhagen was very responsive and I really enjoyed the meetings we had where she checked in and asked for our feedback. It made me feel heard. She offered practical steps for problems I brought up during my midblock feedback and was very flexible with needs I expressed during my rotation.
- Dr. Steinhagen was an awesome director and I liked her directness. General surgery residents were especially good about teaching/talking with med students.

Didactics

- Didactics were consistently great. The lectures were interactive but not stressful, and the information was relevant either to our practice or our exams. …the didactics were a helpful supplement for my learning. Great for learning surgical indications and perioperative management.
- The didactics were great supplement to our clerkship.'-
- Didactic sessions were fantastic.
- I liked the didactic sessions where we checked in with each other and got to talk about our experiences and questions
- Great didactics and workshops.
- The didactics, when the instructors showed up, were largely engaging and a valuable use of time, also serving as a respite from the fast pace of the rotation.

- When our didactic lecturers were present, the sessions were very effective, and I felt that the information learned from them helped my performance on the floor/OR and on the shelf exam

9. What themes did you identify in student feedback about areas for improvement in the clerkship?

   Please see my responses below organized by theme with representative quotes from the EOR forms.

24 hour call

- Given that our clerkship was cut by two weeks, I think one 24 hour call rather than 2 would have sufficed.
- I learned a lot when I was on call, but I think I would have learned as much if it was a night shift rather than a 24. Additionally, if a 24 hour call is necessary then I think only 1 is needed and not 2.
- Instead of 24-hour shifts, students should be required to complete x amount of night shifts.
- Have accountability for 24hour shifts if they are going to be required moving forward- a lot of people skipped theirs or only showed up at night for the weekend shift
- I think 24 hour can be made optional for students who are seriously considering surgery.
- I don't fully understand the purpose of the 24 hour shifts. I just ended up being extremely tired during the night shift.

Operating room time

- The residents and attendings sent me to the OR if there was anyone operating, even after I asked for some more time going on consults and working on clinical decision making. Although I appreciated the opportunity to participate in the OR, I spent a lot of time in there that I felt was low yield in terms of learning, as the surgeons were understandably focused on the patient for so much of the procedure.
- The OR can be a waste of time for many medical students, and should not feel that way. There are times where I would stand in a surgery for 5 hours and learn 1 thing, which should not happen.

Hours

- Because the mornings started early and the days were long, I often was not able to effectively study after getting home, and felt stressed as my exams approached.

Learning Environment issues

- Addressing malignant resident behaviors as above.
- Perhaps it would be useful to communicate with residents/fellows about expectations for students based on where we are at in the year so they don't expect too little/too much.

- Continue to educate the educators on the most effective way to teach/make a good learning environment.
- I think that quality educators should be identified and students should be mainly working with them.
- I do not think that any student should have 4 weeks of surgical oncology. The surgeries are cool but the residents clearly hated it (they made comments about how it was the most depressing service and they would never want to do it all the time), several of my patients died and I grappled with that experience alone, and I basically was in the same 3 types of cases every week with no variety.
- The structure of each team varies wildly from team-to-team and that often times makes understanding the role of the student difficult. Even with filling out the aligning expectations form, it was unclear when/if I was supposed to do floor work vs see consults vs just spend all of my time in the OR.
- The expectations for how much a student gets to help also seem to vary a lot. Specialty services seem to not care so much about educating students.
- Residents/fellows need more incentives to teach medical students. I barely interacted with my residents ever, which made every day seem like a waste for learning. This was not for lack of trying. I mainly focused on surgical skills in the OR as a result and felt I did not understand the big picture of cases/medical management of patients. Attendings took some time to teach me, but with their limited schedule, it was not enough to make all the hours on this rotation productive or enjoyable. I definitely felt ignored by my residents 90% of the rotation.
- Would suggest allowing room for students to spend several days of their 4 week experience on a general surgery service as some of the other 4 week surgical experiences did not provide sufficient exposure to "bread and butter" general surgery cases.

Didactics

- Teaching sessions were alright, each lecture was different based on the teaching style of the attending.
- I think it would be better if the didactics were not all on one day but maybe spread out. It’s hard to focus on zoom didactics after 2 hours.
- Didactics felt long and didn't contribute much to my learning. A better module that would have been more engaging is doing practice oral cases followed my a short lecture afterwards which covers high key learning points. I think this will also simultaneously prepare us for the oral exams at the end of the rotation which are otherwise hard to study for if you've never done it before
- Didactics weren't all created equal (noted in the post-class surveys specifically already
- Skills lab should be done earlier in the rotation, with more skills such as scrubbing, driving the endoscope, etc being covered. An OR orientation in an actual OR (what to touch, what not to touch, roles of staff, general workflow) would also be helpful

- I felt like on my previous rotations, we were given TBL readings, and assigned to a group. We were asked question as a team, and asked to defend our logic. It was a nice way to learn, and I felt like that the material really stuck.

10. What additional challenges exist in the clerkship?

There are continued challenges to teaching related to the clinical environment. This is a very stressful time for faculty, residents, and students. Access to the operating room and the downstream effects of schedule and site changes impact both learning opportunities and the learning environment.

There are fewer cases at the main campus and often more than one resident scrubbed in a case. Faculty are encouraged to do cases and see clinic elsewhere. This creates practical challenges in terms of travel and permission for students to be at satellites.

There are still few meaningful rewards for exceptional teachers, and limited recourse to impact those who are not teaching or not doing it well.

In reviewing my answer to this question from last year, the challenges are similar: "As with previous years, time remains an issue. To keep the clerkship status-quo requires at a minimum some time dedicated to logistical organization, orientation, mid rotation meetings, and completing evaluations. Doing things like providing faculty and residents with feedback, meeting with students biweekly, and working with faculty to improve didactics also take time but are all very important. Generating curricular innovations requires time to think about them, develop a plan, implement, and assess their success…. financial support both for my time and to attend conferences or other programs to enhance my skills as an educator (separate from my clinical practice CME funds) from the medical school would be useful."

Funding for an associate clerkship director would also help.

11. What changes are planned for next year to address both feedback from students and challenges you identified?

Ongoing faculty and resident development for improving teaching and the clinical learning environment are planned.
I plan to encourage the faculty to use case-based learning. There was a student comment about incorporating TBL into the curriculum that I am considering for interested faculty members. It can be difficult to dictate the style of the didactics when asking others to teach in their area of expertise.

<u>LCME Required CQI Elements</u>

- **8.7 Comparability of Education/Assessment**

Summarize how faculty at your site are informed about learning objectives, assessment system, and required clinical encounters.	We have an annual clerkship update at our Department Meeting each August that reviews the learning objectives, assessments, and requirements. In addition, nearly all faculty at CMC are included as preceptors on a rotating basis and therefore receive learning objectives via email whenever they are assigned a student. Assessments and required encounters are sent to the faculty regularly. The clerkship director is available for questions or detailed instructions.
What methods do you use to ensure that faculty receive information about student performance and satisfaction?	Faculty receive written comments about them regularly. Their evaluations in CAS as well as written comments from the EOR feedback are included in annual performance reviews. Faculty receive a presentation each year about the clerkship, including ratings from the previous year and comparisons to previous years/other sites.

- **9.1 Preparation of Residents to Teach/Assess Medical Students**

Complete the table to describe the preparation programs available to residents to prepare for their roles teaching and assessing medical students:

9.1 Briefly summarize the program: There are 3 workshops per year as part of the Residents as Teachers program. Last year, these included Questions as a Teaching Tool, Creating Effective Teaching Presentations, and Mistreatment in the Surgical Learning Environment. This year, the first topic given during our introduction to the year was an introduction to teaching, 'You are Now a Teacher', which aimed to inspire interns, show them what they could already teach, and introduce them to techniques for teaching on the wards. There will be 3 topics again this year, some of which will repeat from previous years. These have included: Setting Expectations and Creating a Positive Learning Environment, Giving Effective Feedback, Teaching on the Wards, Teaching in the Operating Room, Promoting Psychological Safety. Other topics may be developed depending on resident and student needs. The impact of our Residents as Teachers program is routinely evaluated systematically via feedback on the workshops.	
Is the program optional or mandatory?	Mandatory
Is it sponsored by the department or institution?	Department
Who monitors participation?	Program Coordinator, Program Director

- **6.4 (inpatient/outpatient time)**

Table 6.4-1 | Percentage Total Clerkship Time*

Provide the percentage of time that medical students spend in inpatient and ambulatory settings in each required clinical clerkship. If the amount of time spent in each setting varies across sites, provide a range. Add rows as needed.		
Required Clerkship/Site	Percentage of Total Clerkship Time	
	% Ambulatory	% Inpatient
	20%	80%

- **5.11 Study/Lounge/Storage Space/Call Rooms**

A medical school ensures that its medical students at each campus and affiliated clinical site have adequate study space, lounge areas, personal lockers or other secure storage facilities, and secure call rooms if students are required to participate in late night or overnight clinical learning experiences. Please provide this information for your clerkship/site.

Study space	The Undergraduate Medical Education Office has a medical student lounge located in the basement of Bolwell in room B275 (through the door next to the Medical Access Clinic, in Radiology). The lounge has a refrigerator, 18 lockers (assigned with combinations), a couch, two desk with computer and phone access- and a sitting/eating area. This area is not shared and is dedicated to medical students only.
Secure storage space	Lockers in locker rooms in addition to the above
Call rooms availability	Students have access to shared call rooms with the night float resident team.