UC RIVERSIDE School of Medicine

Clerkship Observed Clinical Encounter (OCE) of Medical Student by Faculty Member*

Clerkship:	Site:	Name of medical student:	Name of faculty observer completing this form:	□ **I am a faculty member completing the required OCE for this student's clerkship.** □ I am a faculty member completing an optional OCE as an added learning activity. □ I am a resident physician completing an optional OCE as an added learning activity.

*The Liaison Committee on Medical Education's Element 9.4 requires "direct observation [of] medical history-taking [and] physical examination". **Every medical student needs one faculty member to complete one OCE form during each required clerkship.** Additional optional OCEs by faculty and resident observers are encouraged.

Setting of observation: ☐ **Inpatient** ☐ **Outpatient** ☐ **Other - Please explain:**

Rotation dates: ___/___/____ - ___/___/____

Date encounter was observed: ___/___/____
Date this form was completed: ___/___/____

Note: The observed clinical encounter is a formative assessment for constructive feedback only, and should not contribute to students' clerkship grades. **Please don't discuss grades when reviewing this form!**

Instructions for faculty rater: Please select an appropriate patient then observe the medical student performing a complete history and physical examination, at least once during each clerkship.

Please select the corresponding rating that best reflects student's performance. →→→→		**Behaviors requiring corrective response** (Please provide constructive narrative comments to assist with remediation.)	**Early developing behaviors** (skill level = typical for a pre-entrustable student early in MS3 year)	**Later developing behaviors** (skill level = typical for a pre-entrustable student later in MS3 year)	**Expected behaviors for an entrustable learner** (skill level = ready for residency) Please explain in narrative comments.
Entrustable Professional Activity (EPA) 1		**1**	**2**	**3**	**4**
Gather a history and perform a physical examination.	**Obtain a complete and accurate history in an organized fashion.**	During this encounter, did not collect accurate historical data. Relied exclusively on secondary sources or documentation of others.	Gathered excessive or incomplete data. Did not deviate from a template.	Used a logical progression of questioning. Questions were prioritized and not excessive.	Obtained a complete and accurate history in an organized fashion. Sought secondary sources of information when appropriate (e.g. family, living facility). Adapted to care setting of this encounter.
	Demonstrate patient-centered interview skills.	**1**	**2**	**3**	**4**
		Was disrespectful in interaction with this patient. Disregarded patient privacy and autonomy. handled cultural differences insensitively. Did not communicate bidirectionally, including with members of other constituent societal groups.	Communicated unidirectionally. Missed verbal and nonverbal cues. May have generalized based on age, gender, culture, race, religion, disabilities, and/or sexual orientation. Did not adequately consider patient privacy/autonomy.	Demonstrated effective communication skills (silence, open-ended questions, body language, listening), and avoids jargon. Responded appropriately for age, gender, culture, race, religion, disabilities and/or sexual orientation.	Adapted communication skills to this patient's needs and characteristics. Responded effectively to patient's verbal and nonverbal cues and emotions.
	Demonstrate clinical reasoning in gathering focused information relevant to a patient's care.	**1**	**2**	**3**	**4**
		Failed to recognize this patient's central problem.	Questions were not guided by the evidence and data collected. Did not prioritize or filter information. Questions reflected a narrow differential diagnosis.	Questions were purposefully used to clarify patient's issues. Showed ability to filter signs and symptoms into pertinent positives and negatives.	Demonstrated astute clinical reasoning through targeted hypothesis-driven questioning. Incorporated secondary data into medical reasoning.
	Perform a clinically relevant, appropriately thorough physical exam pertinent to the setting and purpose of the patient visit. Note: If physical examination not required (e.g., observed history only in psychiatry), please leave this row blank. →→	**1**	**2**	**3**	**4**
		Did not consider patient's privacy and comfort during the physical examination component of this observed encounter. Incorrectly performed basic physical examination maneuvers.	Performed basic examination maneuvers correctly during this observed encounter. Did not perform examination in an organized fashion. Missed key findings.	Targeted the examination to areas necessary for this observed encounter. Identified and described normal findings. Explained examination maneuvers to patient.	Performed this observed physical examination accurately and in a logical and fluid sequence. Used the examination to explore and prioritize the working differential diagnosis. Identified and described normal and abnormal findings.

Please provide narrative comments for formative feedback, not to be included in the medical student's grade or medical student performance evaluation (MSPE/"Dean's letter"):

Please sign below to document that feedback on this observed clinical encounter was given and received. Thank you for participating in a timely and constructive assessment!

Medical student_____ Date_____	**Faculty mentor_____ Date_____**