

Longitudinal, Integrated Clerkship Education: Better for Learners and Patients

Editor's Note: This is a commentary on Norris TE, Schaad DC, DeWitt D, Ogur B, Hunt DD, and Members of the Consortium of Longitudinal Integrated Clerkships. Longitudinal integrated clerkships for medical students: An innovation adopted by medical schools in Australia, Canada, South Africa, and the United States. Acad Med. 2009;84:902–907; and Ogur B, Hirsh D. Learning through longitudinal patient care—Narratives from the Harvard Medical School—Cambridge integrated clerkship. Acad Med. 2009;84:844–850.

Since the days of Flexner, medical students' clinical training has occurred via the apprenticeship model, with students rotating in discipline-based clerkships, encountering only patients who happen to receive care on those services. This model in reality leads to short experiences with a range of supervisors, particularly residents, and random, opportunistic patient-care experiences that may not align with students' learning needs or developmental stage. Students learn enough to pass knowledge and clinical skills examinations and match into residencies, but mounting evidence suggests that, when it comes to clinical training, we can do better.

One particularly important area for improvement is in patient-physician relationships. Several studies have shown that students' patient-centeredness erodes over the course of their training, counter to societal expectations. We argue that a new model of clerkship training, the longitudinal integrated clerkship (LIC), better prepares trainees to be competent, patient-centered physicians in the current health care system than discipline-based block rotations. As Norris and colleagues¹ indicate, LICs are developing and thriving in the United States and internationally. Core features of this model include longitudinal relationships with patients, preceptors and clinical settings, and multidisciplinary clinical experiences integrated over time, typically 6 to 12 months. Evidence suggests that LIC students score higher on measures of patient-centeredness and perform at least as well as their peers on traditional assessments.

There are several reasons why LICs may be more advantageous than traditional discipline-based rotations.

1. Longitudinal relationships with patients enable students to understand the

patient experience, contribute to patients' care, and facilitate transitions of care, as described by Ogur and Hirsh.² Longitudinal relationships with faculty mentors allow modeling of professional values and provide a safe venue to address the potentially deleterious hidden curriculum embedded in clinical settings.

2. The longitudinal, integrated curriculum enhances students' learning because knowledge acquisition is progressive, with frequent reinforcement of core material. Learning core content across multiple disciplines over time allows students to encounter and address clinical problems repeatedly across disciplines at progressively more complex levels. Longitudinal preceptors can guide students' progress developmentally by selecting patients and clinical tasks appropriate to students' learning needs. Students avoid the temptation to "forget" one discipline after a clerkship exam to focus on the next. Rather, they gain rich appreciation for patients' situations from the biomedical and psychosocial perspectives.² Students in traditional block rotations typically suffer from inadequate feedback based on various attendings' or residents' different expectations, whereas LIC students are more likely to receive consistent feedback in multiple domains because faculty have ongoing opportunities to observe and monitor students' performance.

3. Assignment to a clinical setting for an extended duration minimizes the time students spend orienting and adapting to new settings. In LICs, this experience is front-loaded so that, early in the year, students become comfortable in their settings and can progress to focus on content and skills acquisition with a deeper understanding of complex systems-based practice issues such as teamwork and transitions in care. Non-LIC students waste time adapting to new settings and disciplines later in the year when they are capable of engaging in more sophisticated knowledge and skills.

What students do is directly correlated to what they learn. LIC students have more opportunities to work directly with the same patients over time and play a significant role in their care across settings. Thus, they

learn to view illness from the patient's perspective as well as the physician's. LIC students can develop a holistic approach and sense of responsibility to the patient that typifies a caring and skilled physician. Students see the course of disease and outcomes of management decisions. In contrast, students in block rotations may work alongside residents and fulfill roles that are needed but that may be of low educational value or poor representations of physicians' work in actual practice. Time spent in training should be devoted to those service responsibilities that are most beneficial to learning and forming professional values. Although paperwork and administrative duties are a reality of physicians' work, they should not subsume important training experiences.

Supporting the costs of LICs is potentially challenging, as LICs include complex schedule coordination and faculty time devoted to teaching. However, there may be learning advantages and savings to the health care system from improved patient care. More evidence is needed to elucidate and confirm the benefits of LICs and to determine the most crucial aspects of this new model that could be incorporated across training institutions. Nonetheless, the time has come to embrace longitudinal clinical learning and apply it broadly.

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