

**UNIVERSITY OF VIRGINIA
SCHOOL OF MEDICINE**

April 1, 2011

RECOMMENDATIONS TO THE CURRICULUM COMMITTEE:

CLINICAL PERFORMANCE DEVELOPMENT II: CLERKSHIPS

WORKING GROUP ON CLINICAL SKILLS EDUCATION

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UVA Clerkship Directors 2010-11

Faculty of the Center for Biomedical Ethics & Humanities

The UVA Student Medical Education Committee

The UVA Committee for Interprofessional Education

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**Recommendations to the Curriculum Committee:
Clinical Performance Development: II Clerkships**

The following recommendations for developing CPD II activities are built upon four organizing principles:

I. That all CPD experiences are designed for the explicit purpose of enhancing student clinical skill performance throughout the 12 domains of clinical competency *.

II. That all clerkship experiences must be student - patient centered.

- Maximize daily patient contact from the outset of and throughout the clerkship
- Minimize non patient-centered experiences, including:
 - Lecturing especially in large group sessions
 - Non-clinical time
- Design all large and small group sessions to be patient/case and/or clinical skill focused

III. That there must be student-teacher continuity.

IV. That CPD I, II and III must be an integrated educational experience.

RECOMMENDATIONS:

1. Establish a CPD leadership process in the School of Medicine:

A. Create a CPD leadership committee in the SOM to provide centralized and integrated oversight of CPD design & implementation, administration, program evaluation and accountability.

Recommended CPD leadership committee members:

- CPD I Co-Directors
- CPD II Co-Directors
- CPD III Director
- Clerkship Directors
- Student Medical Education Committee (SMEC) representation
- Clinical Performance Education Center representation
- Overall CPD Director

B. Designate one overall CPD director who reports to the Associate Dean for Undergraduate Medical Education.

This reorganization (A & B) will help ensure that students' clinical performance education is an integrated, longitudinal and developmental experience.

C. Appoint CPD II co-directors who, working with clerkship directors, are directly responsible for oversight of CPD activities within clerkships. This will include providing for clerkship director input, standardized clerkship design & implementation, coordinated administration, program evaluation and accountability.

The CPD II Co-Directors are also responsible for overseeing decision making and management as it relates to the following:

- OASIS database utilization in the clerkships
- Financial support issues
- Clerkship accountability
- Faculty development and resident teaching skills programs
- Technical support (website, online cases, etc)

This leadership structure should replace the current Clinical Medicine Committee.

2. Standardize clerkship experiences.

The CPD II leadership should oversee the design and implementation of a standardized clerkship experience. Ultimately this should emphasize maximum patient care involvement and continuity of student-teacher mentoring. To this end the following should be implemented in this effort:

Administration:

- Develop clerkship-specific learning objectives
- Approve clerkship-specific student schedules
- Set expectations for the degree of student autonomy
- Limit orientation time/content to maximum of 1 day
- Establish student on-call requirements

Clinical Performance Documentation :

- Provide guidelines/expectations for student note-writing, documentation and review by attending physicians and residents
- Review and coordinate clerkship passports, and establish uniform criteria for sign-off procedure.
- Specify guidelines for utilization of the Student Learning Portfolio for tracking clinical experiences, recording personal reflections, and documentation of student evaluation & feedback by clinical mentors (CPD I-II-III)

Patient Contact:

- Assure that daily student-patient contact responsibilities occur from the beginning of and throughout the clerkship period
- Specify the number and kind of clinical case exposure (ED2)
- Require a specified number of independently performed student History and Physical Examinations including write-up (student autonomy issue)
- Set expectations for both inpatient and outpatient patient experiences in each clerkship discipline

Teaching Responsibilities:

- Designate faculty who are available to students throughout each clerkship period who are responsible for individual student evaluation and feedback
- Designate responsibility for attending-student rounds in each clerkship
- Identify specific clinical skills to be *learned and practiced* throughout the year
- Develop clinical skills workshops in all clerkships.
- Offer Systems-Based Practice experiences in all clerkships (e.g., ethics, medico-legal, interprofessional, health system)
- Encourage teaching-by-student time and include evaluation & feedback on such student performance by attending physician, peers (also a CPD III goal)
- Advance attending expectations of students' clinical performance as the year progresses (developmental principle)
- Maintain basic science learning/involvement in each clerkship
- Ensure continuity of CPD mentoring throughout four years (CPD I-II- III)

3. Standardize clerkship student assessment:

The CPD II leadership should design and implement a standard approach to student assessment. It is recommended that clinical performance evaluation should comprise the majority of any clerkship grading procedure, with written examinations contributing less than 50% to the overall grade:

Suggested elements to consider in clerkship grading procedures:

- Shelf/written examination
- OSCEs in all clerkships
- Preceptor evaluation (Uniform Clerkship/CPD III evaluation form)
- Mid clerkship evaluation and feedback process/form)
- Resident evaluation
- Peer evaluation
- Self evaluation
- The use of all 12 clinical competency objectives categories
- Proportionality of elements for grading to be determined

4. Design a longitudinal/continuity clinical experience

The Curriculum Committee should appoint a subcommittee to develop a plan for the design and implementation of a longitudinal clinical experience for all medical students within the four year curriculum.

Considerations should include any combination of outpatient or inpatient experiences. Multiple selective options should also be considered. For example:

- Weekly outpatient clinic attendance any time within the 4-year curriculum
- A longitudinal clerkship experience
- A longitudinal CPD III experience
- Longitudinal care of patients which includes transitional care opportunities (long-term care, nursing home, rehabilitation hospital care)

This longitudinal experience is required in order to ensure that student-patient continuity is contained in the School of Medicine curriculum. This is an essential underlying principle of both contemporary clinical practice as well as that required for clinical performance development education.

*

The twelve UVA medical education objectives, which correspond to the twelve basic clinical competency domains:

1. *Professionalism*
2. *Patient engagement and relationship development*
3. *Scientific knowledge and method*
4. *Clinical history-taking*
5. *Mental & physical examination*
6. *Clinical testing & imaging*
7. *Basic clinical procedure performance*
8. *Clinical information management*
9. *Diagnosis, differential diagnosis & problem list creation*
10. *Clinical intervention (prevention, treatment, palliation)*
11. *Clinical prognosis & future health care planning*
12. *Placing patient care within practical context*

APPENDIX A: Submitted Clerkship Director Considerations

Family Medicine

- Need more preceptors, particularly with broader FM practice spectrum (ob, peds), and help in recruitment of by UVA outreach/marketing
- More writing orders practice for students
- Models for anatomical teaching and practice (budget issue)
- Consider longitudinal clerkship idea

Medicine, Inpatient

- Expand to two inpatient months (1 general, 2-2 week electives)
- Cardiology, a mandatory inpatient selective for all students
- GI, Heme-Onc, inpatient selectives
- 4 weeks Clin Skls Educ Prog (2 hrs x 4 wks)
- Concerns @ students' Roanoke experience
- Years 3&4 as one "flowing" experience

Medicine, Ambulatory

- Web-based clinical skill database for preceptor faculty development
- Faculty development enhancements (CME programs, web-based resources)
- Standardize and enhance clinical performance assessment
- Preceptor assessments should be formative, narrative
- Create more summative assessments in-house
- Address more effectively institutional/healthsystem barriers to students' participation in patient care (eg., skill performance, documentation)

Medicine, Geriatrics

- Expand to 4 weeks ("some students want more time in geriatrics")
- More student responsibility for direct patient care (less shadowing)
- Need more geriatric preceptors

Neurology

- 4 wks, 2x2 rotations ok
- Faculty time for student bedside teaching rounds not done. Needed.
- GME and Epic driven demands take priority
- Majority of students do not have any ambulatory time:
- Clinical productivity, staffing levels and "statutorily defined" student autonomy issues limits
- Need more financial support for faculty to participate more in student skills teaching
- Students need more emergency care experiences

Obstetrics & Gynecology

- Re- expand to at least 6 weeks (?eight) with 3x2 week subrotations {outpatient, inpt ob, inpt gyn}
- GME skills learning priorities, limited patient volume and increasing class size limits UME skills learning opportunities
- Limits on student documentation is an issue
- More faculty-led bedside teaching time needed (support issue)
- Some patient-initiated gender discrimination issues
- Need some basic science infusion in clerkship
- Resident & faculty teaching skills development
- Enhance/expand web-based learning opportunities
- Concern regarding Roanoke resident teaching

Perioperative & Acute Care Medicine (Anes, EM)

Anesthesia week

- Robust basic acute care skills emphasis
- Limited resident continuity
- Limited clerkship duration (1 week)

Emergency Medicine week

Robust didactic (20 hrs) and skills learning sessions
 Patient continuity (complete clinical assessment) is limited since about half student clerkship time is spent in direct patient care for about ½ week

Pediatrics

[More peds in preclerkship curriculum]
 More elective/selective time
 More outpatient sites needed (larger class size challenge)
 More Peds EM time
 Longitudinal clerkship idea attractive but ?unrealistic

Psychiatry

Prefer 6 week continuous clerkship experience
 Limited faculty numbers
 Insufficient student-specific rounds/bedside teaching
 Reduction in psychiatry bed numbers may be a challenge

Surgery

Expand to 10 weeks general surgery
 At present, limited formal clinical performance assessment
 Enhance opportunities for resident & faculty teaching skills development
 Address more effectively institutional/healthsystem role and barriers to students’ participation in patient care (eg., skill performance, documentation)
 Better define/standardize clinical performance expectations & assessment
 More emergency medicine experience

APPENDIX B: Center for Biomedical Ethics & Humanities

[13 October 2010]

Re: Ethics, law and professionalism learning activities in formal curriculum of clerkships

As requested, here is a brief (and likely incomplete) summary of what is currently provided in the formal curriculum of the core clerkships with regard to ethics, law, and professionalism, and what is planned so far as I am aware. I am sending it somewhat incomplete in the interest of time. If you want something more, please let me know. It might be worth surveying the clerkship directors about what they are doing in this regard.

Ethics, Law, and Professionalism in Third Year Clerkships

Medical students learn about ethical, legal, and professional aspects of the practice of medicine during these clerkships in the formal, informal, and hidden curricula. In the formal curriculum, the Center for Biomedical Ethics and Humanities coordinates with some clerkship directors to provide ethics/law learning activities; in other clerkships, these activities are developed and provided by the Departments. Below, is a brief (and likely incomplete) summary of these activities in the formal curriculum of the various 3rd-year clerkships (as ascertained from the clerkship websites, or speaking directly with individuals involved).

Clerkship	Activity coordinated with/provided by Center	Activity provided by Department
Family Medicine (4 wks)		(In the last year or two, a resident spoke with several Center faculty about his interest in developing something, but I am not aware if anything was implemented)
Geriatric Medicine (2wks)	Coordinated by Julie Connelly (includes	

	multiple Center faculty) <ul style="list-style-type: none"> • 90 minute seminar (student cases) • Written assignment • Reading: 1 article • Attended by all 3rd year students 	
Medicine (8 wks)	Coordinated by Walt Davis <ul style="list-style-type: none"> • 60 minute seminars (2nd and 4th Thursdays of month, student cases) • Attended by students rotating at UVA 	
Neurology (4wks)	Coordinated by Donna Chen & Lois Shepherd <ul style="list-style-type: none"> • 90 minute seminar (student cases and learning objectives covering brain death and disorders of consciousness) • Optional extra credit written assignment • Recommended readings (4 articles covering ethical, legal and cultural aspects of brain death and disorders of consciousness) 	
Obstetrics and Gynecology (4 wks)	Donna Chen has had discussions with Megan Bray about the Center contributing an activity to clerkship (have discussed with Center faculty, aiming for 2011-12 year)	
Pediatrics (8 wks)		Lecture/seminar with Bob Boyle
Peri-operative and Acute Care Medicine (2 wks)		?
Psychiatry (4 wks)	(There was some discussion of the Center faculty also contributing an activity, but this may not be highest priority given what the Department already does. Will reassess.) (May be an opportunity to try a centralized activity that students from other sites can “attend” via distance learning technology)	Several Lectures/seminars covering topics such as risk assessment, capacity assessment, legal/ethical issues in psychiatry (varies by clerkship location)
Surgery (8 wks)		Session/lecture on professionalism by Dr. Friel (all students attend lectures at UVA during first week of clerkship before going to other locations)

Ideas for future ethics/law learning activities during clinical clerkships (core and advanced)

Over the years, several ideas have been put forth for future consideration. Examples include:

- Ethics rounds/case conferences in ACE
- Ethics/Law in Clinical Connections (or whatever new “institutional” curriculum is implemented during the clinical years)
- Coordinate with clerkship directors and respective departments on faculty development to enhance the departments’ ability to provide these learning activities alone, or together with faculty from the Center for Biomedical Ethics and Humanities
- Enhance student reflection experiences (eg., documented in the Student Learning Portfolio)
- UME-GME joint experiences
- Capstone course, 2 weeks, 4th year, final intersession? (“calls of medicine”, death in America”)

APPENDIX C: Student Medical Education Committee (SMEC)**Clerkship Case Exposure: Venues of Clinical Care**

Question: what percentage of cases in which students are directly involved in the care of the patient, are they involved in these 7 standard venues of care?

	Emergent	Acute Outpt	Acute Inpt	Critical	Chronic	End of Life Care	Well/ Preventive	Population/ Pub Hlth
Ambulatory IM	0-1	15-40			30-60	0-5	10-30	
Family Medicine	3-10	15-35	0-10	0-10	35-65	5-10	15-30	
Geriatrics	0-5	0-10	0-30	0-10	30-70	10-40	5-40	0-5
IM Inpatient	0-10		70-100		10	10-20		
Neurology	0-20	0-30	20-60	5-20	10-95	0-10	0-10	
ObGyn*		5-25	0-50		5-20		10-40	
PACMed	5-20		10-30	0-20				
Pediatrics	5-20	0-20	20-60	5-10	15-30		10-35	
Psychiatry	0-20	0-15	40-90		5-40			
Surgery	5-25	0-15	50-70	5-25	0-20	0-5	0-15	
Range Total	0-25	0-40	0-90	0-25	0-95	0-40	0-40	
Average/+	10	17	49	11	35	11	20	
Number of zeros (n=66)	44	50	33	64	34	62	46	
Average % overall	5.6	7.8	37	2.5	24	3.1	10.5	<1

* ObGyn: ave labor & delivery = 40% (range 25-60)

APPENDIX D: Advanced Clinical Performance Development (CPD III)

4TH Year considerations:

1. Individualized educational program—balance of electives/requirements
2. Specialty choice determination
3. ERAS preparation—USMLE2 CK/CS, LORs, scheduling, possible auditions, time off for interviews
4. Specific preparation for residency
5. 12 UVA competencies
6. 5 IOM competencies

Keeley Suggestions to consider:

1. Maintain most of current elective offerings, require course supervisors to develop learning objectives to include with course descriptions and reflect in evaluations of students and of courses.
2. Assess selective requirements and offerings. Ensure educational value of 2 week experiences. Learning objectives will be required.
3. Longitudinal patient care experience—this may be easier to accomplish logistically at our institution in the 4th year. CPD mentors would be responsible for assigning patients and mentoring the experience. Clinical Encounter Portfolio/reflection.
4. Required teaching and Q/I/patient safety experience.. Students would teach 1st and 2nd years in CPD groups of their mentors. Could also be involved in MCM or Systems depending on interest and/or developing teaching modules for clerkship students. Student could be required to do online IHI course on quality and patient safety., perhaps do their own PDSA cycle project.

5. Advanced Clinical Elective—more standardized curricula/expectations/learning objectives. Students will develop ILPs for their ACE experience to be monitored and adjusted with the course supervisor.
6. Develop recommended or required “Gateway Courses” (Capstone implies completion—the last piece, these courses are the transition to the next phase of training) Medicine, Surgery, OB, Pediatrics—broad specialty options.
 These courses may include: Specialty specific clinical/procedural skills, use of evidence based medicine, application of quality improvement, interdisciplinary teamwork, simulation of clinical scenarios—discharge planning, family meetings, transition of care, bad news, dictation, medication reconciliation, EMR use, ethical issues
 Could include OSCEs: standardized residents, standardized electronic medical records, standardized/simulated patients.

APPENDIX E: AAMC CurrMIT clerkship data, 2011

This is something CurrMIT can answer, some schools show clerkships as running 52 weeks. The following is what we come up with:

	Median	Minimum	Maximum	UVA
Family Medicine	6	2	12	4 4 inpt 4 AIM
Internal Medicine	8	4	12	2 Ger
Neurology	4	1	8	4
Obstetrics/Gynecology	6	4	12	4
Pediatrics	6	4	12	8
Psychiatry	6	3	14	4
Surgery (PACMed)	8	4	12	12 2

Please let me know if you have any additional questions. We are very excited that this data will be part of the 2011 Curriculum Directory, and that the data will be based on the annual LCME Questionnaire data, so we’ll know that the courses are clerkships, and that 100 percent of the schools will have responded!



APPENDIX F: Interprofessional Education Competencies

UVA IPEI Core Competencies and Associated Learning Objectives

Interprofessional Core Competencies	Learning Objectives
<p><u>Communication</u> Occurs when two or more persons from different professions interact to enhance the exchange of meaningful information.</p>	<p>After completing this experience, students will be better able to:</p> <ol style="list-style-type: none"> 1. Be responsive to and interactive with members of other professions in a manner that fosters collaboration 2. Effectively exchange knowledge and ideas with other professions. 3. Ensure that information exchanged is being heard and understood correctly through active listening and reflection 4. Use information systems and technology to exchange relevant information among the professionals
<p><u>Professionalism</u> A shared values perspective and set of ethical principles that affirms joint responsibilities for ensuring good health and safe, effective health care for all</p>	<ol style="list-style-type: none"> 1. Establish and focus common goals across professions for patient/family/community centered care. 2. Display interest, trust, and mutual respect across the professions 3. Exchange information about own and other professions’ culture, values, roles and scope of practice 4. Develop, promote, and exercise non-judgmental integrity, honesty, social responsibility and ethical behavior in all professional activities
<p><u>Shared problem solving</u> Working together across the professions to address a situation requiring collective knowledge and skills to develop optimal approaches/solutions.</p>	<ol style="list-style-type: none"> 1. Determine whom to involve depending on the needs of the patient/client 2. Share discipline specific knowledge with the team 3. Integrate collective knowledge to develop alternative solutions 4. Identify which team member will take the appropriate leadership/facilitator role in specific contexts
<p><u>Shared decision making</u> Collectively agreed plan of action involving two or more professions resting on the best evidence of risks and benefits for each available option</p>	<ol style="list-style-type: none"> 1. Negotiate actions with other health professionals based on an understanding of scope of practice and other practice constraints 2. Implement joint decisions taking into account all options and evidence provided, discussed and evaluated for risks and benefits 3. Define individual responsibility for implementing joint decision and follow-up. 4. Share responsibility for team decisions, culture, and values.
<p><u>Conflict resolution</u> A process used to address disagreements and arrive at a mutually agreeable outcome through the use of mediation, diplomacy, and negotiation across the professions</p>	<ol style="list-style-type: none"> 1. Understand issues that may contribute to the development of conflict and ensure conflicts are addressed before they become counterproductive 2. Re-evaluate own position in light of new information from others 3. Identify strategies for addressing disagreements, and approaching situations in which conflict is likely to occur. 4. Ensure that complexity, uncertainty and other stressful situations do not negatively affect relationships or the care of patients/clients.

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