University of Washington School of Medicine
Curriculum Renewal

Patient Care Phase Committee
Report to the Steering Committee

Committee Members

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Charge to the Committee

The broad charge to the committee was as follows:

Develop recommendations for models of the required “3rd year” clerkship core including, but not limited to, reconsidering the suite of required courses and addressing the length and timing of clerkships.

Specific responsibilities within this broader charge included:

• Critically assess UW School of Medicine’s curricular programs that currently work well in promoting and advancing core clinical education related to patient care (currently addressed by required clerkships) and those programs that either need improvement or should be terminated, including justification for any such recommendations.

• Recommend new programs and/or approaches that will advance and improve core clinical education related to patient care (currently addressed by required clerkships), including justification for any such recommendations, while acknowledging the needs and demands of the additional areas identified as priorities within the School of Medicine curriculum renewal.

• Work collaboratively with the other curriculum renewal committees and the Steering Committee to ensure that core clinical education related to patient care is an integral, integrated and vital part of the UW School of Medicine curriculum.
How the Committee Performed Its Work

The Patient Care Phase Committee met two times per month for two hours per session between December and March. A third meeting was held during the month of March. Committee members participated in-person or by phone from sites throughout the WWAMI region. Specific topics covered during our meetings included:

- The current required clerkship curriculum: what do we do right and what could we do better?
- Review of current required clerkships including Chronic Care, Emergency Medicine, Family Medicine, General Surgery, Internal Medicine, Obstetrics and Gynecology, Neurology, Pediatrics and Psychiatry (The suite of clerkships was discussed over 3 meetings).
- The student perspective including a round table discussion with graduating fourth and fifth year medical students and review of a student proposal for the required clerkship phase put together by the students on our committee.
- Intersessions
- Longitudinal integrated clerkships
- Review of the required clerkship curriculum at eight other medical schools including Florida State University, Hofstra University, Johns Hopkins University, Ohio State University, Northern Ontario University, University of Michigan, University of Minnesota, University of Pennsylvania

The remaining meetings were devoted to formalizing the committee’s recommendations to the Steering Committee.

Summary of Committee Recommendations

The committee’s major recommendations are as follows:

- Proposed clerkship structure for the Patient Care Phase (described in detail below)
- Create a meaningful continuity clinic experience in the Foundations Phase
- Create three required competency-focused rotations in the Explorations Phase
- Begin the Patient Care Phase in the winter of the second year of training
- Create flexibility in the scheduling of required clerkship training
- Increase training opportunities in longitudinal integrated clerkships
- Create an orientation phase at the start of the Patient Care Phase
- Create a series of intersessions between major clerkship blocks
- Improve standardization of clinical experiences across sites within clerkships
- Improve the clerkship orientation process

Each of these recommendations is discussed in further detail below.
Recommendations Regarding Required Clerkship Structure and Timing in the Patient Care Phase

Through its deliberations over the past four months, the committee identified several organizing principles that served as the basis for the proposed clerkship model described below. The organizing principles included the following:

• **Build a curriculum based on competencies rather than specialties:** At present, the required clerkship curriculum is very specialty-focused. Students are considered to have met the requirements for graduation if they pass through rotations in each of the core specialties (e.g. family medicine, general surgery, internal medicine, neurology). Instead of this approach, we think that it would be more appropriate to focus on whether or not the students achieve certain competencies in their training and, in particular, demonstrate the ability to evaluate and care for specific types of patients in a variety of clinical settings.

• **Increase opportunities for active learning and responsibility in patient care:** A concern that became apparent in our review of the current required clerkship curriculum was the not insignificant number of situations in the current clerkship structure where students either do not assume adequate responsibility for patient care and/or face a very passive learning environment. Our goal was to create a curriculum that would emphasize the opposite situation: student responsibility and active learning opportunities. A competency-based curriculum can help achieve this goal because, in order to demonstrate competency, students must have active responsibility and must be observed carrying out that responsibility.

• **Create room for a robust, engaging Explorations phase:** The committee supports efforts to create opportunities for career exploration, scholarship and residency interviews in the Explorations Phase. While we felt it was important to include the content of the current Neurology and Chronic Care rotations in the curriculum, we felt it was necessary to move this content to the Patient Care Phase to leave time for advanced skills rotations and other options under consideration for the Explorations Phase.

Drawing on these principles, the committee developed a proposed structure for the Patient Care Phase of the revised curriculum. This structure is outlined in Figure 1 and is described in detail in the space that follows. The length of each proposed rotation is specified in parentheses within each block.

This phase of the curriculum should include four 12-week blocks, each containing between 1 and 3 distinct competency-based clerkship rotations. The intended competencies of a given rotation are reflected in the title of the rotation. The entire phase should be introduced with a one or two-week preparatory phase and the 12-week blocks should be separated by one-week intersessions. Preparation for the Patient Care Phase and intersessions are discussed in further detail in a later section of this report.
Figure 1. Proposed Structure for the Patient Care Phase

<table>
<thead>
<tr>
<th>Patient Care Phase</th>
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<tbody>
<tr>
<td>Preparation For The Patient Care Phase (1 or 2 weeks)</td>
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<tr>
<td>Care of the Child and Adolescent (6)</td>
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<td>One Week Intersession</td>
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<tr>
<td>Care of the Surgical Patient (6)</td>
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<tr>
<td>One Week Intersession</td>
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<tr>
<td>Care of Patients With Neurologic Disease (4)</td>
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<tr>
<td>One Week Intersession</td>
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<tr>
<td>Family and Community-Centered Continuity Care (12)</td>
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There are two particular clerkships in this structure that warrant further discussion regarding the intended content of the clerkship:

- **Pain, Rehabilitation and Palliative Care:** This is the rotation formerly referred to as Chronic Care. The focus of the rotation will be the topics referred to in the title of the rotation. In the current version of the Chronic Care rotation, students are assigned to a particular focus such as rehabilitation medicine, geriatric medicine, palliative care or chronic pain. They do not actively participate in all tracks and, instead, only receive didactic instruction in the other topics. We would propose that in the new curriculum, attention be paid to ensuring meaningful clinical exposure to all of the areas specified in the rotation title in order to achieve the required competencies.

- **Family and Community-Centered Continuity Care:** Unlike the other rotations whose foundations exist in rotations within the current curriculum, this 12-week rotation represents an entirely new rotation. The focus would be on outpatient care and, rather than being centered around a single discipline, this rotation would involve a multidisciplinary approach in which students have the opportunity to actively work under the supervision of family medicine and internal medicine practitioners as well as providers in specialty clinics. Because of the importance of psychiatric disease in the general population, outpatient psychiatry should also be explicitly incorporated into this rotation. Additional important competencies such as musculoskeletal medicine could also be worked into this clerkship. One option that could be considered in the design of this clerkship is a patient-centered approach similar to that used in longitudinal integrated clerkships in which the “students go where their patients go.”

The length of the clerkships -- noted in parentheses with each block in Figure 1 – also warrants further discussion. Our committee examined the required clerkship rotations at 8 other medical schools and found a wide variety of clerkship lengths in nearly every
specialty. Our current clerkship lengths are compared with these other programs in Table 1. While there is no evidence that one particular approach is better than another, the variety in clerkship lengths at other institutions does show that many other models are possible.

Table 1. Clerkship Length at UWSOM and Selected Other Institutions

<table>
<thead>
<tr>
<th>Specialty</th>
<th>UW</th>
<th>Penn</th>
<th>Hopkins</th>
<th>Michigan</th>
<th>OSU</th>
<th>Hofstra</th>
<th>FSU</th>
<th>Minnesota</th>
<th>UCSF</th>
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<tbody>
<tr>
<td>IM</td>
<td>12</td>
<td>8</td>
<td>8</td>
<td>12</td>
<td>8</td>
<td>6</td>
<td>8</td>
<td>12</td>
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<tr>
<td>Surgery</td>
<td>6 *</td>
<td>4</td>
<td>8</td>
<td>8</td>
<td>8</td>
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<td>8</td>
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<tr>
<td>Family</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td>6</td>
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<td>6</td>
<td>8</td>
<td>8 ***</td>
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<tr>
<td>Psych</td>
<td>6</td>
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<td>4</td>
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<td>6</td>
<td>8</td>
<td>4 **</td>
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<tr>
<td>Ob-Gyn</td>
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<tr>
<td>Peds</td>
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<td>4.5</td>
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<td>4 **</td>
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<tr>
<td>Neuro</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>6</td>
<td>6</td>
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</tbody>
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* UW requires 6 weeks of General Surgery. Students are also required to complete a 4-week selective in their fourth year of training
** Neurology and Psychiatry are a combined 8-week rotation
*** Family medicine is a combined family and community medicine rotation

Abbreviations: OSU: Ohio State University; FSU: Florida State University

On the surface, the lengths of several current clerkships have been shortened in our proposal and one clerkship would no longer exist as currently formulated.

- Psychiatry is a 6-week rotation in our current curriculum and has a 4-week block in this proposal.
- Internal Medicine is a 12-week block in our current curriculum, while only 6-weeks are devoted to inpatient internal medicine in this proposal.
- There is no dedicated Family Medicine rotation as there is in the current curriculum.

It should be noted that these changes were not made because of any perceived deficiencies in the structure and execution of the current rotations or the perceived value of the knowledge content in these rotations. Instead, the committee felt that student competency in these areas could be attained through a different rotation structure. In fact, when one looks below the surface and views the proposal in greater detail, it becomes apparent that the time dedicated to these specialties is largely preserved and their role even enhanced in the new curriculum. For example, as discussed further below, we propose the development of a meaningful clinical experience during the Foundations Phase based in primary care. Because family medicine and internal medicine would serve as the primary rotation sites for students, this would significantly increase their exposure to these fields beyond the level in our current curriculum. In addition, our proposed 12-week rotation in Family and Community-Centered Continuity Care would rely heavily on these two specialties and provide significantly more time for students to develop competency in these areas.

Incorporation of outpatient psychiatry into the 12-week Continuity Care rotation would increase contact time beyond that allotted in the 4-week block and, more importantly,
provide increased opportunities to learn psychiatry in an outpatient setting beyond those currently available to students.

Finally, the committee felt strongly that the rural clerkship sites throughout the WWAMI region would function extremely well in the proposed model. In addition to providing significant variety and diversity in patient care experiences, these sites may increase training opportunities within a competency-based curriculum. Students may no longer be restricted to working with providers from a particular specialty, who are often under-represented in different parts of the WWAMI region and, instead, may be able work in any clinical setting that allows them to achieve the required competencies.

**Recommendations Regarding Required Clerkship Training in the Foundations and Explorations Phases**

In order to create graduates of the School of Medicine that are competent and knowledgeable in all aspects of patient care and well prepared to continue to their next level of training, the Patient Care Phase must be integrated with both the Foundations and Explorations phases. Completion of the Patient Care Phase is a step along a larger pathway that will allow the students to take advantage of all that follows. Towards that end, we recommend additional required training in other phases of the new curriculum.

**Create a Meaningful Continuity Clinic Experience in the Foundations Phase**

The committee recommends expanding clinical exposure in the Foundations Phase to a significant degree. Rather than focusing on time-limited opportunities such as those currently used for this purpose – preceptorships and RUOP -- the clinical exposure should be in the form of a longitudinal experience, spanning the entire length of the Foundations Phase, in which students work in the same clinic under the mentorship of a core group of preceptors and ideally follow a panel of patients throughout this period.

Such an experience will have several benefits for students and our curriculum. For example, meaningful clinical exposure will likely increase students’ abilities to integrate information and think critically about problems, skills that will help them on the USMLE and in their later clinical work. Equally important, earlier development of clinical skills will allow students to “hit the ground running” in the Patient Care Phase. Rather than having to develop these skills at the start of their required clerkships, they may be in a better position to take on more responsibility earlier in their clerkship. This may, in turn, facilitate shortening clerkships in the third year to allow more time for elective clerkships, advanced inpatient and outpatient experiences, re-visititation of Foundation Phase Material or other adjustments in the Required Clerkship Phase. Finally, the continuity aspect of this experience will help students develop long-term relationships with patients and gain a greater understanding of the bio-psychosocial model of medicine, two things that are difficult to do on shorter rotations.

We recommend that this continuity experience be based on the primary care model with opportunities for students to do their longitudinal experience in family medicine, internal
medicine, or pediatrics. In rural environments, general surgery, obstetrics and gynecology and emergency medicine may also provide primary care experiences. A critical element of this experience is the expectation that this is meaningful clinical exposure in which students are not merely shadowing providers and, instead, have consistent active learning opportunities including patient evaluation, differential diagnosis, formulation and presentation of plans, and follow-up of results of interventions. This will require concentrated efforts to develop clinical skills (interviewing, physical examination) at the beginning of the Foundations Phase and will require considerable thought as to how to integrate this plan with the current ICM and Colleges model. The current college system and approach to ICM is a strength of our current curriculum; we should build upon this structure rather than replace it. To improve student readiness for their required clerkships, particularly if clerkship lengths are shortened, there should be additional emphasis on helping students develop data gathering and communication skills and understand models of care delivery.

We also recommend continuing the RUOP program as this is an important tool for increasing exposure to rural and underserved populations and helps address a critical mission of our medical school. This should be maintained if feasible within the new Foundations Phase structure and possibly broadened to include an urban underserved version of this rotation.

Create Three Required Competency-Focused Rotations in the Exploration Phase

At present, students in the School of Medicine are required to take four rotations in their fourth year of training including a four-week surgery elective, Chronic Care, Neurology and Emergency Medicine. Some of the major problems identified with this approach include the significant logistical difficulties associated with scheduling these rotations and the relative inflexibility they create in the students’ fourth year of education.

The committee proposes that the School of Medicine move away from requiring rotations based in a particular specialty during the Explorations Phase and instead require students to complete three competency-focused rotations (4 weeks per rotation), in which the emphasis is on students developing advanced patient evaluation and management skills. The three proposed rotations include:

- **Advanced Surgical Care**: this rotation would be a surgical sub-internship but could be on a surgical subspecialty service provided the student was expected to function at a higher level of responsibility than in the Patient Care Phase. Students are expected to function more independently and demonstrate more mature evaluation and management skills in preparation for residency. While the majority of these spots would be inpatient rotations, in more rural areas of the WWAMI region, students could likely demonstrate advanced responsibility through sites that entail both inpatient and outpatient work.

- **Advanced Medical Care**: this rotation would require the student to function at a sub-intern level on an inpatient service. Rather than being restricted to a single specialty,
students could satisfy this requirement on internal medicine, pediatrics, family medicine and adult or pediatric intensive care unit services. Similar to the advanced surgical care rotation, students would be expected to function more independently and demonstrate more mature evaluation and management skills in preparation for residency. In more rural areas of the WWAMI region, students could again demonstrate advanced responsibility through sites that entail both inpatient and outpatient work.

- **Emergency Medicine**: the committee felt strongly that emergency medicine should be preserved as a required rotation for all students, as it provides an opportunity for students to develop a vital competency, the ability to evaluate and manage undifferentiated patients with a wide range of complaints. Opportunities to do this can sometimes be found in other settings but it was felt that an emergency medicine rotation is the optimal setting to ensure consistent access to opportunities necessary to develop this important skill.

Figure 2 displays a summary of the recommendations for required clerkship training in the new curriculum.

**Figure 2. Summary of Recommendations for Required Clerkship Training**

<table>
<thead>
<tr>
<th>Foundations Phase: Longitudinal Clinical Experience in PC</th>
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<tbody>
<tr>
<td>Patient Care Phase</td>
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<tr>
<td>Preparation For The Patient Care Phase (1 or 2 weeks)</td>
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<tr>
<td>Care of the Child and Adolescent (6)</td>
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<tr>
<td>Women’s Health (6)</td>
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<tr>
<td>Care of the Surgical Patient (6)</td>
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<tr>
<td>Care of the Hospitalized Adult (6)</td>
</tr>
<tr>
<td>Care of Patients With Neurologic Disease (4)</td>
</tr>
<tr>
<td>Pain, Rehabilitation and Palliative Care (4)</td>
</tr>
<tr>
<td>Care of Patients With Psychiatric Disease (4)</td>
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<tr>
<td>One Week Intersession</td>
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<td>Family and Community-Centered Continuity Care (12)</td>
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<table>
<thead>
<tr>
<th>Explorations Phase: Advanced Skills Rotations (Students Must Do All 3)</th>
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<tbody>
<tr>
<td>Advanced surgical care (4)</td>
</tr>
<tr>
<td>Advanced medical care (4) (IM, Peds, FM, ICU)</td>
</tr>
<tr>
<td>Emergency Medicine (4)</td>
</tr>
</tbody>
</table>

**Other Recommendations Regarding Required Clinical Training**

**Start the Patient Care Phase in the Winter of the Second Year of Training**

The committee is in agreement with the goal articulated in other areas of the curriculum renewal process regarding an earlier start to the Patient Care Phase. We propose
beginning this training in February or March of the second year of training. The clerkship model proposed above would require a minimum of 56 weeks to complete, including time for holiday and other breaks (2 weeks around Christmas and two other one week breaks). This time requirement would mean that the Patient Care Phase would finish by roughly March of the third year of training.

Scheduling the Patient Care Phase in this manner would allow the School of Medicine to address a major problem with our current clerkship model. At present, the required clerkship phase ends in June of the third year, after which students have only 3 months to complete important rotations prior to the due date for residency applications. This is problematic for students who have yet to identify a training specialty, as well as for students who must obtain one of a limited number of sub-internship slots or other elective rotations, including possibly “away” rotations, in order to obtain necessary letters of recommendation or demonstrate improved performance prior to the due date for residency applications. Moving the Patient Care phase earlier would significantly ease these pressures as well as increasing opportunities for a longer, more meaningful Explorations Phase.

Create Flexibility in the Scheduling of Required Clerkship Training
While the required clerkships in the Patient Care Phase are intended to be offered in particular thematically-related blocks (e.g., the pairing of Care of the Child and Adolescent with Women’s Health and the linkage of Neurology, Psychiatry, and Pain, Rehabilitation Medicine, and Palliative Care), the committee supports the notion that some flexibility should be permitted in the curriculum. In particular, for the purposes of career exploration or scholarship, students should be able to move blocks within the suite of Patient Care Phase clerkships to the Explorations Phase and replace them with elective clerkships or research and other scholarly work. Students would need to provide adequate justification for rearranging clerkships in this manner and how such a plan fits with their overall academic plan. The committee did have concerns, however, about the logistical problems that might arise from this and whether rearranging a competency-based curriculum would leave them without the requisite skills to succeed in more advanced areas.

Increase Training Opportunities in Longitudinal Integrated Clerkships
The committee spent considerable time discussing the issue of longitudinal integrated clerkships including a presentation by John McCarthy and Richard Hillman, a review of the WRITE and TRUST programs at the University of Washington, and a review of some of the literature published by programs that employ this model. The committee concluded that this was a valuable model of training and its use should be expanded at our institution. Because this training model might not work well for all students and, in particular, is better suited for students who are interested in a unique, integrated care experience and who are also adept at self-directed learning and taking initiative, it was felt that expansion of current opportunities was more appropriate than wholesale adoption of this clerkship model for the entire Patient Care Phase.
The committee has two recommendations for increasing longitudinal integrated clerkship training in the School of Medicine:

- **Increase the number of WRITE slots available to students.** A current impediment to increasing the number of WRITE positions appears to be the requirement that students complete inpatient training in each of the major disciplines in the first half of their required clerkship training before going to their particular site. There were reports, for example, of students being denied WRITE opportunities this year due to the lack of inpatient training slots at Seattle Children’s Hospital in the first half of the year. We propose that this requirement be relaxed and students have the opportunity to work at WRITE sites in the first or second halves of the year, with inpatient training completed in the other half of the year. Related to this, we would also propose increasing exposure to certain specialties such as Obstetrics/Gynecology and General Surgery at existing WRITE sites.

- **Create urban longitudinal integrated clerkships.** Our current model of integrated clerkships emphasizes rural areas throughout the WWAMI region. The committee thinks that it would be worthwhile to create additional integrated clerkships in urban areas within the region, beginning with sites where track programs presently exist, such as Anchorage, Billings, Boise, Missoula, and Spokane. This would further enhance our ability to address workforce needs in the region and increase opportunities for students to work with urban underserved populations. We envision eventually creating such clerkships in Seattle but think that it would be appropriate to start in smaller urban areas where we currently have extensive rotations or training tracks, as this may facilitate integration among the various training specialties. As experience with this model improves, an effort could be made to expand to Seattle.

As the number of longitudinal integrated clerkship spots increase, particularly in the WWAMI region, care will be needed to ensure that there is appropriate matching of the number of possible slots with the number of interested students and to ensure equitable distribution of such training slots throughout the WWAMI region.

**Create an Orientation Period At the Start of the Patient Care Phase**

The School of Medicine used to offer a program for second year students transitioning to the required clerkship phase of their training called Transition to the Wards. This was eliminated after several years for a variety of reasons including the fact that it fell within the period when students were studying for Step 1 of the USMLE. We propose reestablishing a one to two week orientation period or “Boot Camp” prior to the start of the Patient Care Phase. The content of this training period can be similar to the curriculum from the prior transition course and should include a combination of didactics, small group learning, and simulations, to introduce medical students to the clinical setting and to their role in an inpatient or outpatient multidisciplinary team. This training
period should come after Step 1 of the USMLE and should not truncate the time allotted for Step 1 preparation.

Create a Series of Intersessions Between Major Clerkship Blocks

As described above, our proposal for required clerkship training calls for four 12-week blocks. We recommend that these major training blocks be separated by one-week “intersessions” during which students return to the classroom to both revisit material from the Foundations Phase of the curriculum and be introduced to new curricular material.

Rather than having all students return to Seattle for this training, students starting, completing or transitioning between rotations in the WWAMI region should be offered the opportunity to complete their intersession training at one of the first year WWAMI training sites or other appropriate sites in each state or region. Because some of the first year sites are not centrally located, track sites like Missoula, might provide a suitable alternative since many students are already in those locations.

The committee did not reach firm conclusions regarding the training content for these intersessions but did identify several ideas that we feel are worthy of further consideration:

- Certain material from the current first and second year curriculum would be ideal to cover in an intersession period. Epidemiology, Ethics and many of the topics covered in Medicine Health and Society were three content areas identified as being better appreciated by the students once they have worked in the clinical arena and have dealt with issues covered in these courses on first hand basis. Very basic material within these topics should still be covered in the Foundations Phase, as this material appears on the boards, but much of the content could be moved later in the curriculum.

- There is potential to create several new programs with the potential to improve student integration skills and revisit material from the Foundations Phase in a more clinical context. For example, we considered creating a course called “Use and Interpretation of Diagnostic Testing” in which a case-based approach is used to review important principles of anatomy through analysis of different radiology studies. Similarly, a case-based course could be created focusing on therapeutics, which would provide an opportunity for students to review important principles of pharmacology, including mechanism of drug action, in a more clinical context. Yet another course might take a similar case-based approach to microbiology and provide an opportunity to review important basic science concepts in bacteriology, virology and mycology as well as improve mechanisms and principles of antimicrobial therapy.
Simulation training modules should be a part of the intersessions. Modules could be created with a focus on running codes, delivering bad news, performing procedures and developing skills such as bedside ultrasound.

Time should also be built into the intersession period to allow students to debrief with other students and reflect on their patient care experiences. Among many benefits of such activity, this type of interaction would help address concerns about variability between sites as well as the sense of isolation that students often feel when doing rotations in the WWAMI region.

Recommendations Outside the Charge of Our Committee

During the committee’s discussions several issues came to our attention that were not specifically within our committee’s charge but which we felt warranted attention in any attempt to revise the required clerkship training in the School of Medicine. These issues include the following:

Improve Standardization of Clinical Experiences Across Sites Within Clerkships

One of the striking aspects of our current required clerkship training is the large number of sites at which students rotate. For example, the Family Medicine clerkship employs 33 different sites including 5 in Seattle and 28 in the region, while the Pediatrics clerkship is conducted at 17 sites including three sites slated to begin taking students in the next 2 years. Information obtained as part of our clerkship assessments as well as feedback from our student panel indicated that training experiences vary significantly across sites with important differences in opportunities for active participation in patient care as well as differences in the educational opportunities at each site.

It is the feeling of the committee that effort should be devoted to ensuring more uniform clinical experiences across all sites within a given clerkship. While certain factors such as the mix of obstetrics and gynecology cases at a particular site may be difficult to control and we cannot insist on equal exposure to particular clinical problems in patient encounters, efforts should be made to ensure that students have equal, appropriate levels of responsibility in patient care and, in particular, do not simply shadow private practitioners or house officers as was reported at some sites in some rotations.

As noted earlier in this report, the emphasis should be on active learning at all clinical sites on all rotations and should include the expectation to document in the patient chart on all rotations. The committee heard reports from faculty and students that students were not permitted to document in the medical record on certain rotations and, at some sites, were not even provided access to the medical record. Effort should also be devoted to ensuring equal access to active educational opportunities integrated with the process of care delivery at all sites. With respect to didactics, recorded lectures should be available to students throughout the region and a rich set of computer-based resources would ensure that students have the opportunity to learn the full range of core
topics within a given specialty. This would help address some of the variability in clinical problems seen at different sites that is difficult to avoid.

**Improve the Clerkship Orientation Process**
One factor that became apparent during our research into the student perspective was that students do not necessarily understand how each of the clerkships fits into the broader goals of their training. In particular, a common sentiment expressed by the students was that once it is determined that they will not do a particular specialty as their career, there is a tendency to simply determine what they need to do to pass the clerkship exam and bide their time as they complete the rotation. This sentiment is by no means universal among our students but it appeared to be more common than we thought appropriate.

We propose that greater efforts be made to help students understand the broader context of their training requirements and how each rotation fits into the education. A future surgeon, for example, should understand how psychiatric disease can play a role in the development of or recovery from surgical problems. Such context setting should be done at the start of the Patient Care Phase of the curriculum as well as at the start of each rotation.

In a related matter, it also became apparent to the committee that while our clerkship directors do a good job of orienting students to the start of the overall clerkship, there appears to be variability in the extent to which students are oriented to specific clerkship sites. It is the committee’s opinion that the students would benefit from more uniformity in the site-specific orientation that occurs both in terms of the time spent orienting and the type and amount of information made available to the students.