The longitudinal integrated clerkship; a student insight

Longitudinal integrated clerkships (LICs)

LICs were developed with the intent of allowing medical students to follow patients over extended periods of time, typically 6 to 12 monthsLICs originated at Harvard Medical School in 2004 and reportedly improve student satisfaction and preparedness for patient interactions (1). One of the 3 tenets of LICs is continuity of care, which benefits both students and patients (2). Medical schools globally have used various models to implement their LIC programmes (3).

Our LIC approach

The [Institutions] (Institution acronym) LIC was an 8-month pilot in 2019/20 involving one-third of the first clinical year's cohort, running alongside the traditional block curriculum. It followed a well-received smaller 12-student pilot in 2017. LIC students received mentorship and longitudinal feedback from volunteer tutors (GPs, surgeons and physicians). The ninety students attending placements with these tutors were automatically enrolled but could opt-out. Students had an introductory lecture detailing the approach of the pilot and were advised to select a patient with complex medical conditions to follow. If students struggled to identify a patient, their assigned tutor could recruit on their behalf. Once written consent was obtained, students attended their patients' healthcare interactions.

LIC tutors were enthusiastic and passionate about the pilot as the model highlights some of the most satisfying parts of being a doctor: building relationships with patients and treating them through their illnesses. Tutors were keen to explore how students can experience increased continuity with patients and learn more about how illness impacts on patients' lives. One of the most challenging factors was recruiting a suitable patient, and some students required considerable support with this. It was rewarding for tutors to have continuity with their students through the pilot and appreciate the benefits that they achieved.

This Insights paper describes the LIC experience of the lead author.

Challenging beginnings

I identified my LIC patient during a GP appointment. With no opportunity to recruit them during the consultation, I telephoned the patient to explain the programme and gain their consent. This was initially tricky, as the patient was reluctant, feeling the process may be intrusive. However, with some perseverance and additional clarification, they consented. Scheduling to be at the patient's clinics was challenging due to timetabling conflicts. Additional travel times and costs to attend some healthcare sites caused further problems.

Box 1: My LIC pathway

The LIC benefits

LICs allow students to learn about their patients' conditions and experience their management in different settings. I saw the journey of a patient through primary and secondary care, increasing my understanding of illness, the role of healthcare, while helping my knowledge retention. Working within my professional boundaries as a student, I was forced to make some decisions and take ownership of interactions with my patient. This helped me challenge myself and develop new skills. Such benefits have been reported from the LIC approach (4).

I witnessed the interplay of psychosocial factors that affect patients' healthcare beliefs and decision-making. I observed my patient holistically and saw first-hand how chronic conditions impacted on their health, finances, family dynamics and quality of life. My patient opened up to me regarding the toll their health was taking on their children, who sometimes acted as informal carers. I fostered a natural and lasting relationship with my patient, built on trust and respect and I was a source of support during appointments. Studies highlight that patients benefit from LICs, as they appreciate the increased interaction they have with students (2,3).

Attending placements in the traditional block structure ensured my access to a range of clinical interactions, though patient contact was short-lived. The LIC enabled me to experience how one patient can have a breadth of conditions affecting different organ systems while still learning about

typical and atypical presentations of illnesses on block attachments. Exposure to both models created an effective balance as I gained from the benefits of patient-centred care and continuity without losing out on seeing a variety of patients and conditions,. I identified attitudes and approaches that helped make the LIC positive and memorable, and by embracing the process, I maximised my experience. These tips (Box 2) may help students engage effectively and develop additional skills that will serve them through training and beyond.

Box 2: Top 5 tips for maximising your LIC

I learnt a lot about myself during this process, aided by my reflections and the opportunities to provide feedback on my experience. Despite the challenges, I had access to incredible teaching moments that may not have been reproduceable in a block curriculum. The LIC allowed me to experience continuity of care, moving it from the abstract, to understanding what it means to a real person. I honed my communication skills, and patient-centeredness while gaining insight to the impact of psychosocial factors on patients' decision-making. These are skills that are identified in the General Medical Councils Outcomes for graduates (5) that medical schools often struggle to achieve. Looking back, the benefits I achieved far outweighed the challenges experienced. The [Institution] LIC though still in its infancy, is showing great promise.

References

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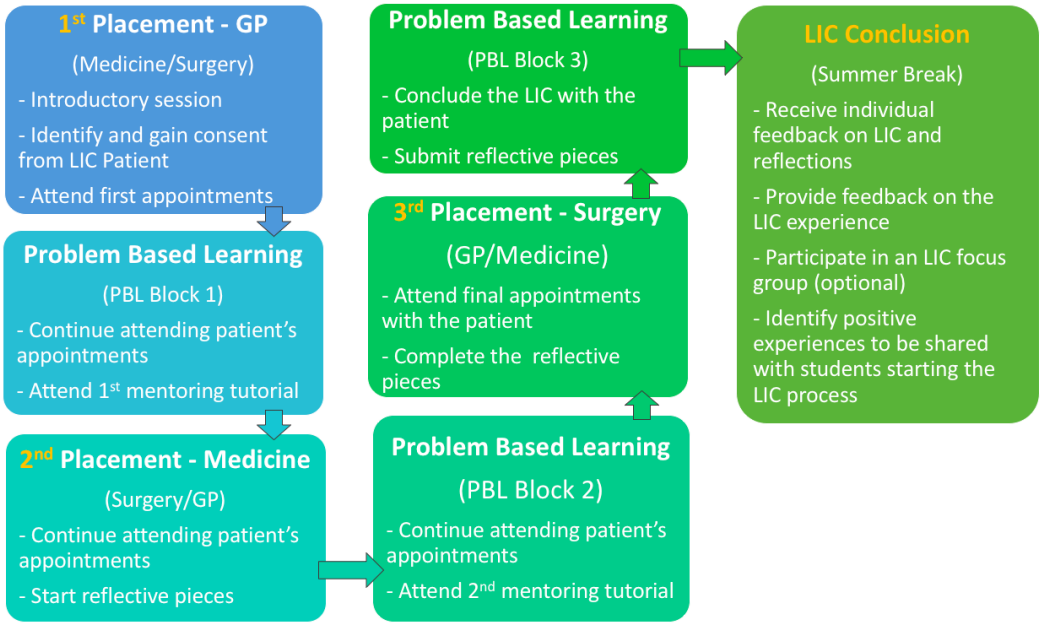
Box 1: My LIC pathway



Box 2: Top 5 tips for maximising your LIC