CAME Voice/Voix

The rise and rise of the Longitudinal Integrated Clerkship - Jill Konkin

The first Longitudinal integrated clerkship (LIC) started more than 40 years ago at the University of Minnesota. The LIC is now part of contemporary Canadian medical education with more than half of our schools running or piloting an LIC. So what is it about this model of medical education that is so compelling?

Students in LICs engage in comprehensive care of patients over time; they develop longitudinal learning relationships with those patients' physicians and; they meet most or all of the core learning objectives for the year in an integrated fashion. (Norris et al., 2009). The core principles of LICs have been described as continuities of patient care, curriculum, and supervision. (Hirsh et al., 2007) Essentially medical students in LICs spend a significant part of a year of their clerkship learning the core disciplines in an integrated fashion rather than through discipline-specific rotation-based clerkships.

There is growing evidence that students in LICs perform at least as well as those in rotation-based clerkships (RBCs) if not better (Hirsh et al. 2012; Myhre et al. 2013; Walters et al. 2012). Research in to LICs is now exploring how and why LICs work and for whom, not least because the characteristics of graduates of LICs seem to be different from those in rotation based clerkships. For instance, LIC students are afforded many more opportunities to grow into a doctor role and to be patient-centred than students in RBCs (Hauer et al., 2012). Patients also see LICs as patient- and learner-centred (Hudson et al., 2012).

Only the Northern Ontario School of Medicine has a mandatory LIC. Other Canadian schools run a mixture of LICs and RBCs. Assessment in LICs is often organized to demonstrate comparability with discipline-based summative assessments for RBCs, something that LIC students experience as very disruptive to their learning (Bates et al., 2012). What learners valued most was the daily formative feedback given at the bedside by their preceptors, who students got to know well over time, which in turn made students a lot more comfortable asking for corrective feedback.

Not only are LICs pedagogically sound, they can foster patient-centredness, counter the documented decline in empathy experienced by students in clinical years, and effectively facilitate the transition of learners from students into junior clinical colleagues. Are we approaching a time when all Canadian schools run an LIC?

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