2021 CDIM Spring Survey of Internal Medicine Clerkship and Subinternship Directors: Summary Results (June 2021)

2021 CDIM Spring Survey of Internal Medicine Clerkship and Subinternship Directors

Table of Contents

Survey Fielding History, Methods, and Data Sources ***3***

Notes on Statistical Methodology **4**

Interpretation of Results **5**

Representativeness of the Survey Responses ***6***

Section I. Student Advising for Internal Medicine Residency Applications ***10***

Section II. Alliance for Academic Internal Medicine (AAIM) Guidance for the 2020 - 2021 Virtual Residency Interviewing Season; and Internal Medicine Clerkship Planning ***19***

Section III. AAIM Guidelines for Department of Medicine (DOM) Standardized Letters of Evaluation (SLOE) ***22***

Section IV. Clerkship and Sub-Internship Director and Medical School / Institutional Characteristics ***27***

Q32 The CDIM Council wants to ensure that your needs as a medical education leader are addressed. ***30***

Survey Fielding History, Methods, and Data Sources

Action	Date
Email prenotification to **253 individuals** designated as "CDIM Clerkship Director" or "CDIM Physician-Educator" with an employment title of "Co-/Associate/Assistant Clerkship Director" or "Sub-Internship Director" whose fully-accredited Liaison Committee on Medical Education (LCME) U.S./U.S. territory-based medical school or associated teaching hospital site held Alliance for Academic Internal Medicine (AAIM) membership as of March 2021	15-Mar-21
Survey launch to **253** possible respondents; **140** unique medical schools; **59** associated teaching hospital sites	23-Mar-21
First email reminder to nonrespondents	5-Apr-21
Second email reminder	15-Apr-21
Third email reminder	26-Apr-21
Population adjusted to **186 individuals** after accounting for invalid contacts and opt-outs and to represent **140 LCME-accredited medical schools** as the unit of analysis	10-May-21
Survey closure: 103 complete responses representing **94** medical schools: **55.4% individual** response rate (103/186); **67.1% (94/140) institutional** response rate	**10-May-21**
Human Subjects Research Determination This study and its protocol (Number: 21-AAIM-118) were submitted to Pearl IRB (registered with the U.S. Department of Health and Human Services Office for Human Research Protections as IRB00007772) for exemption determination in accordance with FDA 21 CFR 56.104 and DHHS 45 CFR 46.104 regulations, and were deemed exempt according to FDA 21 CFR 56.104 and 45CFR46.104(b)(2): (2) Tests, Surveys, Interviews on 03/01/2021.	
Survey platform: *Qualtrics Surveys;* summary data analysis conducted in *Stata SE 16.1.*	

Notes on Statistical Methodology

The data gathered in this survey were intended to represent the perspectives of medical education faculty-leaders who advise students at their institution about internal medicine residency applications. Because it is possible that multiple individuals at a single institution serve in this role, the original survey population included CDIM members who are core clerkship directors, co-/associate/assistant clerkship directors, or sub-internship directors. To ensure that perspectives from the 140 fully-accredited Liaison Committee on Medical Education (LCME) medical schools with CDIM membership at the time of survey fielding were represented, the population was extended to include individuals situated at 59 affiliated teaching hospital sites with Alliance for Academic Internal Medicine (AAIM) membership. Upon survey closure, medical schools and their affiliated sites were collapsed to determine the amount of representation between survey respondents and non-respondents relative to the 140 medical schools. Thus, although the "individual" response rate was 55.4% (103/186 possible respondents), the "institutional" response rate was 67.1% (94/140 possible responding schools). It is noted that two respondents reported "no" to the first screening question of the survey ("Do you advise students at your institution about internal medicine residency applications?") and thus were skipped to the third section of the survey.

The subsection "Representativeness of the Responses" compares survey respondents and non-respondents as well as responding and non-responding institutions to key variables that define the survey population. Generally, there were no statistical associations between respondents/non-respondents or between responding/non-responding institutions at $p \leq 0.05$. All test results were two-sided with the exception of comparisons based on "institutional classification" (a simple proxy for medical school size based on AAIM institutional membership criteria), which were one-sided due to a limited number of institutions having one than one possible respondent. The 103 individual respondents represented 94 distinct institutions (mean of 1.1 respondents per institution. The final table in the subsection compares responding and non-responding institutions by number of survey-eligible individuals on their AAIM membership rosters (another proxy for size) and demonstrates that there was no association between each group based on median roster size at $p \leq 0.05$.

Interpretation of Results

Item non-response (unanswered/skipped survey questions) is reported in table footnotes as the actual number of respondents to a question out of the total number of possible respondents to it. Where applicable, table footnotes provide further clarification about denominators.

Denominators for multiple-choice, select-all-that-apply questions are based on the number of respondents who selected one or more items for those questions. Total number of responses will exceed the number of respondents to those questions and total percent of responses will exceed "100." See, for example, Question 13.

Statistical Notations
SD=Standard Deviation; Min and Max: the minimum and maximum values reported for continuous variables.

Interquartile Range: The range of values between the first and third quartiles for a "continuous" variable (e.g., number of medical students); reported when there is excess variability in data points due to large and small "outliers."

P-value: a metric used to reflect the likelihood that a difference between two or more groups is due to random chance or due to a statistical association, for testing hypotheses. For example, whether the difference in number of survey respondents and non-respondents by gender is likely due to random chance (see "Representativeness of the Survey Responses").

Representativeness of the Survey Responses

Survey Respondents and Nonrespondents by Institution/Medical School Type (Public or Private)*			
	Responded to Survey?		
	Yes	No	Total
Public	58	49	107
Column percent	*56.3*	*59.0*	*57.5*
Private	45	34	79
Column percent	*43.7*	*41.0*	*42.5*
Total	**103**	**83**	**186**
Column percent	***100.0***	***100.0***	***100.0***

Notes
Bivariate test (Pearson Chi-Square with 1 degree of freedom): 0.1397; p-value: 0.709.
Fisher's Exact Test (two-sided): p-value: 0.766.

*Source: National Center for Education Statistics - Integrated Postsecondary Education Data System. *2019-20 IPEDS Universe of Institutions (Institutional Characteristics)*. Available at https://nces.ed.gov/ipeds/datacenter/DataFiles.aspx?goToReportId=7.

Responding and Nonresponding Institutions/Medical Schools by Type (Public or Private) *			
	Responded to Survey?		
	Yes	No	Total
Public	54	29	83
Column percent	*57.5*	*63.0*	*59.3*
Private	40	17	57
Column percent	*42.6*	*37.0*	*40.7*
Total	**94**	**46**	**140**
Column percent	***100.0***	***100.0***	***100.0***

Notes
Bivariate test (Pearson Chi-Square with 1 degree of freedom): 0.4008; p-value: 0.527.
Fisher's Exact Test (two-sided): p-value: 0.585.

*Source: National Center for Education Statistics - Integrated Postsecondary Education Data System. *2019-20 IPEDS Universe of Institutions (Institutional Characteristics)*. Available at https://nces.ed.gov/ipeds/datacenter/DataFiles.aspx?goToReportId=7.

Survey Respondents and Nonrespondents by U.S. Census Bureau Region*				
	Responded to Survey?			
	Yes	No	Total	*P-Value***
Northeast	26	17	43	0.487
Column percent	*25.2*	*20.5*	*23.1*	
Midwest	27	21	48	0.999
Column percent	*26.2*	*25.3*	*25.8*	
South	39	32	71	0.999
Column percent	*37.9*	*38.6*	*38.2*	
West***	11	13	24	0.279
Column percent	*10.7*	*15.7*	*12.9*	
Total	**103**	**83**	**186**	
Column percent	***100.0***	***100.0***	***100.0***	

*U.S. Census Bureau. *Census Regions and Divisions of the United States.* Available at https://www2.census.gov/geo/pdfs/maps-data/maps/reference/us_regdiv.pdf.
**Bivariate test (Fisher's Exact; two-sided).
***To ensure data confidentiality due to small cell sizes, includes three medical schools from an unincorporated territory; to ensure accurate results, test for association does not include those three schools, however.

Responding and Nonresponding Institutions/Medical Schools by U.S. Census Bureau Region*				
	Responded to Survey?			
	Yes	No	Total	*P-Value***
Northeast	23	9	32	0.669
Column percent	*24.5*	*19.6*	*22.9*	
Midwest	23	13	36	0.682
Column percent	*24.5*	*28.3*	*25.7*	
South	38	15	53	0.459
Column percent	*40.4*	*32.6*	*37.9*	
West***	10	9	19	0.117
Column percent	*10.6*	*19.6*	*13.6*	
Total	**94**	**46**	**140**	
Column percent	***100.0***	***100.0***	***100.0***	

*U.S. Census Bureau. *Census Regions and Divisions of the United States.* Available at https://www2.census.gov/geo/pdfs/maps-data/maps/reference/us_regdiv.pdf.
**Bivariate test (Fisher's Exact; two-sided).
***To ensure data confidentiality due to small cell sizes, includes three medical schools from an unincorporated territory; to ensure accurate results, test for association does not include those three schools, however.

Survey Respondents and Nonrespondents by Institutional Classification (From AAIM Membership Database)				
	Responded to Survey?			
	Yes	No	Total	*P-Value**
Medical School Large: 100 or more students	50	25	75	0.064
Column Percent	*48.5*	*30.1*	*40.3*	
Medical School Medium: 65- 99 students	25	31	56	0.487
Column Percent	*24.3*	*37.4*	*30.1*	
Medical School Small: Less than 65 students	25	26	51	0.107
Column Percent	*24.3*	*31.3*	*27.4*	
Medical School: No Internal Medicine Residency	3	1	4	0.396
Column Percent	*2.9*	*1.2*	*2.2*	
Total	**103**	**83**	**186**	
Column Percent	***100.0***	***100.0***	***100.0***	
*Bivariate test (Fisher's Exact; one-sided) due to multiple possible respondents per institution.				

Responding and Nonresponding Institutions/Medical Schools by Institutional Classification (From AAIM Membership Database)				
	Responded to Survey?			
	Yes	No	Total	*P-Value**
Medical School Large: 100 or more students	45	7	52	0.064
Column Percent	*47.9*	*15.2*	*37.1*	
Medical School Medium: 65- 99 students	23	19	42	0.487
Column Percent	*24.5*	*41.3*	*30.0*	
Medical School Small: Less than 65 students	23	20	43	0.107
Column Percent	*24.5*	*43.5*	*30.7*	
Medical School: No Internal Medicine Residency	3	0	3	0.396
Column Percent	*3.2*	--	*2.1*	
Total	**94**	**46**	**140**	
Column Percent	***100.0***	***100.0***	***100.0***	
*Bivariate test (Fisher's Exact; one-sided) due to multiple possible respondents per institution.				

Survey Respondents and Nonrespondents by Self-Reported Gender (From AAIM Membership Database)			
	Responded to Survey?		
	Yes	No	Total
Female	59	39	98
Column percent	*57.3*	*47.0*	*52.7*
Male	44	44	88
Column percent	*42.7*	*53.0*	*47.3*
Total	**103**	**83**	**186**
Column percent	***100.0***	***100.0***	***100.0***

Notes
Bivariate test (Pearson Chi-Square with 1 degree of freedom): 1.9537; p-value: 0.162.
Fisher's Exact Test (two-sided): p-value: 0.106.

Responding and Nonresponding Institutions/Medical Schools by Self-Reported Gender (From AAIM Membership Database)			
	Responded to Survey?		
	Yes	No	Total
Female	49	21	70
Column percent	*52.1*	*45.7*	*50.0*
Male	45	25	70
Column percent	*47.9*	*54.4*	*50.0*
Total	**94**	**46**	**140**
Column percent	***100.0***	***100.0***	***100.0***

Notes
Bivariate test (Pearson Chi-Square with 1 degree of freedom): 0.5180; p-value: 0.472.
Fisher's Exact Test (two-sided): p-value: 0.590.

Responding and Nonresponding Institutions/Medical Schools by Number of Clerkship (or Co-/Associate/Assistant) Directors and Sub-Internship Directors per Institution (From AAIM Membership Database)							
Responded to Survey?	**Number of Responses**	**Mean**	**SD**	**Median***	**Min**	**Max**	**IQR**
Yes	94	1.4	0.6	1	1	4	1
No	46	1.2	0.4	1	1	2	0
Total	**140**	**1.3**	**0.5**	**1**	**1**	**4**	**1**

Notes
*Nonparametric equality-of-medians test (Continuity corrected): p=0.080.

END OF SECTION

Section I. Student Advising for Internal Medicine Residency Applications

Q5 Do you advise students at your institution about internal medicine residency applications?		
	Number of Responses	**Percent**
No	2	1.9
Yes	101	98.1
Total	**103**	**100.0**

Q6 On average, for how many of the following did you advise a typical "middle-third-of-the-class" student at your institution?							
...Number of PROGRAMS to APPLY to?							
	Number of Responses	**Mean**	**SD**	**Median**	**Min**	**Max**	**IQR**
PRIOR to the 2020-2021 application cycle (pre-COVID-19)	101	19.9	7.3	20	0	50	10
DURING the 2020-2021 application cycle (COVID-19)	101	23.6	9.0	20	0	50	13
...Number of INTERVIEWS to ACCEPT?							
	Number of Responses	**Mean**	**SD**	**Median**	**Min**	**Max**	**IQR**
PRIOR to the 2020-2021 application cycle (pre-COVID-19)	101	11.6	3.4	12	0	20	5
DURING the 2020-2021 application cycle (COVID-19)	101	14.0	5.3	14	0	35	5
Notes For 101 of 101 respondents who reported "Yes" in Q5.							

Q8 Please answer for the pandemic application cycle (2020-2021), compared to PRIOR cycles (pre-COVID-19). How did the following change during the 2020-2021 residency application cycle?				
	Decreased	**About the same**	**Increased**	**Total**
Total number of students you advised	4	75	22	**101**
Row Percent	*4.0*	*74.3*	*21.8*	***100.0***
Number of students who asked you for informal advice	2	48	51	**101**
Row Percent	*2.0*	*47.5*	*50.5*	***100.0***
Your time spent advising students	0	37	64	**101**
Row Percent	*--*	*36.6*	*63.4*	***100.0***
Number of students who asked you to contact a residency program or advocate on their behalf	5	48	31	**84**
Row Percent	*6.0*	*57.1*	*36.9*	***100.0***
Number of requests you received from individuals (e.g., other than students) to advocate for a student	9	55	15	**79**
Row Percent	*11.4*	*69.6*	*19.0*	***100.0***
Number of residency programs you contacted on behalf of student(s)	5	52	25	**82**
Row Percent	*6.1*	*63.4*	*30.5*	***100.0***

Notes
For 101 of 101 respondents who reported "Yes" in Q5.
*Excludes 17 respondents who reported "Not applicable."
**Excludes 22 respondents who reported "Not applicable."
***Excludes 19 respondents who reported "Not applicable."

Q9 How prepared were you for your advisor's role during the 2020-2021 residency application cycle when interviews were conducted virtually?		
	Number of Responses	**Percent**
Very unprepared	5	5.0
Unprepared	17	16.8
Neutral	26	25.7
Prepared	40	39.6
Very prepared	13	12.9
Total	**101**	**100.0**
Note: For 101 of 101 respondents who reported "Yes" in Q5.		

Q10 Answer to the best of your ability: Compared with pre-COVID-19 application cycles, how likely were your current advisees to…					
	Less likely	**Neither less likely nor more likely**	**More likely**	**Do not know / Unsure**	**Total**
receive invitations for out-of-state interviews?	21	32	22	26	**101**
Row Percent	*20.8*	*31.7*	*21.8*	*25.7*	***100.0***
match at your institution's residency program?	10	52	29	10	**101**
Row Percent	*9.9*	*51.5*	*28.7*	*9.9*	***100.0***
match at regional residency programs?	2	57	28	14	**101**
Row Percent	*2.0*	*56.4*	*27.7*	*13.9*	***100.0***
Note: For 101 of 101 respondents who reported "Yes" in Q5.					

Q11 Generally speaking, how well could your current advisees assess a residency program(s) during the virtual interview day?		
	Number of Responses	**Percent**
Not at all well	12	11.9
Somewhat well	60	59.4
Very well	9	8.9
Other (please explain):	7	6.9
Do not know / Unsure	13	12.9
Total	**101**	**100.0**
Note: For 101 of 101 respondents who reported "Yes" in Q5.		

Q11: Text for "Other"
advised for many to contact our graduates at the programs where they interviewed to get additional info relied heavily on program website
Challenges in truly getting "a feel" for a program
It varied. For our local programs it was pretty good. Students had a very difficult time assessing programs in cities they were not familiar with.
many of the responses above may be driven by changes in the student's attitude or priorities- so receiving invitations for out-of-state interviews may have gone up or down because more or less were likely to apply to out of state programs
Mixed. Applicants reported reasonable understanding of the program. They often reported a sense of the people they would be working with but at the same time would frequently "dismiss" any sense of their "fit" with the other people in the program as "possible just due to zoom." Students were much less willing to trust their impression of how well they would find a "home" at the location for concerns of not matching. Overall sense of location, etc was also more difficult.
They did their best but it's hard to compare virtual interviews to regular interviews as I suspect these same students might have slightly different opinions of the programs if they had in person interview days.
they felt the interviews were short and that the residents may have felt pressure to "say the right things" during the "informal" resident meet and greets (as compared to the "night before dinner gatherings" they had heard of from their senior classmates)
Total: 7

Q12 If onsite interviews are an option, do you think that the residency recruitment process should remain entirely virtual next year?		
	Number of Responses	**Percent**
No	54	53.5
Yes	31	30.7
Hybrid model*	13	12.9
Other (please explain):	3	3.0
Total	**101**	**100.0**
Notes For 101 of 101 respondents who reported "Yes" in Q5. *This response option was coded from 13 open-ended comments originally reported for "Other."		

Q12: Text for "Other"
either all virtual or all in person, to "level the playing field" so to speak. I fear that in person interviewees will have an advantage over those interviewed virtually.
should be either in person or virtual. Should not be hybrid
Unsure. There needs to be a universal understanding amongst programs about this process; especially if there is a "hybrid model" proposed. Students should not be penalized if they choose virtual over live interviews regardless of the reason (financial, etc).
Total: 3

Q13 If unrestricted travel is allowed next year, what aspect(s) of virtual interviewing would you like to retain for the 2021-2022 residency interview season?		
	Number of Responses	**Percent**
Option for virtual interviews with faculty (some or all)	65	64.4
Option for virtual interviews with residents	45	44.6
Option for a full virtual interview cycle	58	57.4
Other (please explain):	12	11.9
Do not know / Unsure	3	3.0
None of the above	5	5.0
Total	**188**	**186.1**
Note: For 101 of 101 respondents who reported "Yes" in Q5. Multiple responses allowed: total number of responses will exceed number of respondents to question and total percentage will exceed 100.		

Q13: Text for "Other"
Full virtual interviews with second-look days to meet and see the program and house staff.
I don't see how we'd fairly have some but not all be either all in-person or all virtual.
I think the decision should be made by AAIM about virtual vs in person without virtual option. A hybrid would place undue burden on students, who may feel pressured to do FTF interview to increase their chances of matching.
I would imagine some faculty would like to retain the flexibility of interviewing virtually. What's most useful for the students is to see the camaraderie among the residents, so if in-person is what's opted for, I'd favor in-person interaction with residents.
I would worry about developing a 2 class system: those who interviewed in person vs those who interviewed virtually. If an effective way to limit the bias could be established, I would be in favor of optional virtual interviews as the convenience and cost are factors.
My students reported that the aspect most unsatisfactory were the virtual meetings with residents - online forum did not allow the casual atmosphere to have conversation and connect with them. The formal faculty interviews went very well virtually and should be retained. There could be an option for "follow up visit" to see the campus/clinical sites and meet with residents for "favorite/top programs" under high consideration.
Option to do interview virtual, but come to campus in person for a tour
See prior comment: "There needs to be a universal understanding amongst programs about this process; especially if there is a "hybrid model" proposed. Students should not be penalized if they choose virtual over live interviews regardless of the reason (financial, etc)."
should not be hybrid- should be binary- either in person or virtual only
Virtual for prelim residents. Virtual for residents beyond a certain distance away. Interview days should be all virtual or all in-person. It wouldn't be fair for a virtual student to interview on a day with in-person students.
Virtual informational sessions.
Virtual interviews for prelim/TY positions, but not categorical
Total: 12

Q14 What challenges did your students experience due to virtual residency interviews? Answer to the best of your ability.
- didn't really get to "experience" programs - missed out on seeing the city they may be living in next year
- Not getting a full sense of camaraderie that exists in a residency program. - Unable to differentiate between programs that are very close to each other on paper. - Unable to get a sense of allocation and community if interviewing for programs that are out of state.
* difficulty assessing the "culture" and feel of a program and city * the increased scrutiny that the online interview can bring (attending to background, lighting, internet connection, etc)
A little less able to gauge the facilities comparatively and get a sense of the cities.
ability to really gauge atmosphere of a program, facilities, location
Anxiety about not having the opportunity to physically see the program or city. Overall, however, my students very much enjoyed virtual interviews
being able to convey their full personality. inability to get "a feel for the working environment" aesthetics.
Biggest issue was getting good feeling on a location and program. Internet and website can only do so much. Many more students played it safe and stayed at their home institution.
Can't know a program's culture. They rely heavily on "heresy" which are not accurate most of the time. Time zone difference is difficult. Technical difficulties experiences by faculty and applicants alike.
concerns about not seeing the physical program site and the area around the hospital/institution Feeling that they needed to do more interviews - accepting all interviews, rather than feeling that they had done "enough" .
Determining the “feel” of a program and city/locale
Fear was the most notable. Concerns that advising data on match was not applicable to them (admittedly there was no data) and concerns of how much was zoom related vs actual sense of the program. The other challenge was "zoom fatigue."
From what I heard; most were slight technical issues.
getting a better sense of the culture because the time spent with the residents was limited and virtual
getting a feel for the program and for the residents visiting a place that maybe further away many expressed concerns matching to a program that they never visited
Getting a sense of the place without seeing city or touring hospitals. Getting a real sense of the residents and how they get along.
Getting a true sense of a program and how they were a good fit for the program. Some had challenges with connecting with the interviewers.
Getting to know the physical space and the city. Having the opportunity to take in non-scripted interactions between faculty, residents, administrative staff.
Getting to know the program
Had they never visited a residency program in person, they would be unfamiliar with the program, the hospital sponsoring the program, and the city/town in which the program was located. If they matched at a place with which they were unfamiliar, they might decide, once they arrived and lived there for a while, that it was not the place they wanted to spend several years. This inability to travel to a place, see what it's like, and speak face-to-face with faculty and other residents is the chief disadvantage of virtual interviewing.
Hard to gauge culture of program; the residencies all seemed to look great online, but on the ground, experiences were lacking of course in the virtual setting.
hard for them to get a feel for culture and the nature of residents virtually
I believe it was harder to get a complete picture of the places where they interviewed and find out if they were a good fit for a given program.

Q14 What challenges did your students experience due to virtual residency interviews? Answer to the best of your ability.
I only advise a small number of students and did not get any feedback from them either way
I think their biggest challenge was the uncertainty of the process, but overall, I think it was much smoother than anticipated.
Identifying the culture of a program. Ensuring adequate time with residents
In previous question, I mentioned that majority of students felt connection to the residents was most affected by virtual format and they believe in person social conversation is best to truly get a sense of their satisfaction with the program and if they would like working with them. Very few experienced technical problems and thought the formal faculty interviews went well. They would like the ability to visit the campus to see the hospitals and city.
Inability to assess things such as residency culture and camaraderie among the residents.
Inability to fully assess how collegial and supportive a program is; what the training "environment" is really like.
it seemed to me that even some of our stronger students were not offered interviews at programs I would have expected them to be invited to interview at because most students, on the whole, were applying to more programs and declining fewer interview offers.
It was a stressful year. The pandemic was personal for many students and program directors. In many ways the virtual interview cycle served students well. There is benefitted to visiting the city/institution to get a better feel for the environment. Not experiencing this is likely the biggest challenge. Suggest asking students after their internship year if they would have matched their current program as high on their match list if they experienced the environment during their interview day. A flawed question but I hope you understand what I mean.
It was difficult to get a feel of the "culture" of the program during virtual interview days.
It was more difficult to obtain a feel for the program. Although nonverbal cues can be read through video, it is easier to do so in-person. Students also felt that obtaining the true feelings that residents have about their program was more of a challenge to read virtually.
lack of city exposure lack of shared experience with other applicants
less interviews were offered did not get as clear of a sense of a program by students whomever happened to be in your smaller breakout rooms for the night before had a disproportionately greater impact upon a student's perception of the group characteristic. If you were in a real room, you could wander over to another group of docs and see if that was a fit for example.
Limited ability to meet with residents, see facilities, experience the town/city. Fewer interview invites due to "higher tier" students hoarding interviews.
Lots of interview competition. Inability to assess "intangibles". Lack of access to current residents. Inability to assess hospital and patient care settings.
Most of the students had less issues than programs or faculty based on what I have heard. I do think we had a couple students not match their initial choice programs because the virtual interview process limited their ability to communicate or interact with both verbal and non-verbal communication. These are also students who would have benefitted from "away" rotations which would have helped them "show-off" their talents under direct observation.
Not able to walk the halls and see the clinical campuses in person. Occasional internet connectivity issues.
Not being able to fully assess the culture of the program.
Not all had reliable tech options at home, we provided space for them. Zoom fatigue is real, and these are long days. Hard to fully get a sense of culture without going to visit a program. Those informal conversations are lost in this format and those can be very important.

Q14 What challenges did your students experience due to virtual residency interviews? Answer to the best of your ability.
Not being able to have separate sessions with residents (like the dinner the night before the interview)
Not being able to visit a program and "get a feel" for programs or cities/regions was a limitation.
Not being able to visit the campus or the town to get a feel for whether they would like to live there.
Not getting as many interviews for mid-tier students. Top tier did too many. Getting a perspective on what a program is like.
Poorly able to get to know programs well
Primary challenge is having a sense of the physical space, as well as group gatherings, especially with residents, that are more difficult to achieve on-line. The efficiency and increase in equity benefits may outweigh the downsides with virtual interviewing.
Really seeing all the facets of a program - institutions, culture, etc.
securing at least 10 interviews if considered "middle of the road" (tended to get fewer invites) fatigue from interviewing at so many sites Trying to decide which interviews to turn down (out of the many invites)
Some students didn't get interviews because other students hoarded them.
Some technological glitches, but otherwise just seeing less of the program's personality and camaraderie between residents. Some of my higher-performing students said that they thought the more competitive residency programs weren't trying to recruit them, just kind of going through the motions as they knew they'd fill with top candidates, so they didn't get to know those programs very well.
Sometimes hard for them to really get a sense of what made a program unique. Many programs seemed the same
Students did not get as many interviews and interviews they did receive were for programs that, in a non-COVID year, I would not have expected. It seemed that programs were offering to different types of students this year as opposed to prior years.
Students did not have opportunities to see the program hospitals, ask additional questions to residents on site, learn about each program city. The big plus though, is the savings, as they did not have to pay for travel/lodging during the interview season.
Students missed seeing the general area and the hospital system where they may be committed to live for a few years.
Students missed seeing the physical campus of the hospital and surrounding city. They also had limited opportunities to meet a range of residents and faculty, sole input was from the few they had scheduled virtual interviews with.
Students' uncertainty as they expressed to me related to not knowing how programs will assess them given grading policies changed for rotations impacted by COVID. Students felt like they got a good sense of the programs after the virtual interviews, but the process of doing it virtually did cause some anxiety and sense of uncertainty.
The biggest challenge for students was getting a sense of the program's culture. Interacting with residents, especially via social events, has long been key to the residency application process. No matter the online venue, this was difficult for students.
The biggest challenge was getting a proper feel for the culture of the program and how the student would fit in with the house staff there.
The biggest challenge was that the resident did not get a feel for the program. It was hard for them to gauge how happy residents were at the program or if they would be a good fit at the program. Some hard not visited the city before and this presented additional challenges and concerns.
The unknown of how many programs to apply to
The feedback from students was generally positive, feeling the virtual experience went much better than expected--but we had low expectations for the process. They felt that programs that put in a good effort to show the program and the location through videos and virtual tours were generally viewed better than those programs that did not put in this effort. Anecdotally it seems that our students matched further down on their rank list this year than in years past.
The main difficulty was the inability to physically acquaint with the locale and clinical environment of individual programs.

Q14 What challenges did your students experience due to virtual residency interviews? Answer to the best of your ability.
The students did not receive as many interviews. Few students had a good number of interviews and some students had ~2. It was very stressful for these students. In addition, some programs did a better job of creating a welcoming environment in light of the virtual interviews. A few students said Jefferson's program did well to welcome students and get them engaged with current residents.
They felt it was harder to assess the programs.
They had a really good experience at most programs and felt that the programs really had their acts together. BUT the hardest thing was for them to get a reliable "gut" feeling about the programs--with this they really, really struggled. They also had a hard time figuring out whether they'd want to train in the location where the program was since they weren't visiting those cities or locations. One of our students actually flew to [REDACTED] (post-immunization!) just to visit the city because she really loved [REDACTED] on her virtual interview day but wasn't sure about [REDACTED. They also didn't get a feeling for the "culture" of the programs they were interested in or the hospital "feel" since they couldn't walk in and interact with the place or the people and weren't sure how much to trust the Zoom presentations.
They had no way to truly get to know the current residents. They missed out on all informal conversations
They wanted to see more resident interactions to ascertain culture of a program.
They were able to interview more places without having to take extra time off. It can be difficult, as some places did not give much time for interaction with residents. So, I think they missed out on interaction with residents overall.
Top candidates snapped up more interview slots than before, leaving fewer for medium to lower candidates. Our program experienced and unprecedented number of unmatched students.
Two big problems: 1. Students had a difficult time getting a general sense of the program, or they got a good sense but just didn't trust their "gut" because they were worried, they may be missing something 2. The biggest issue with this year had to do with post interview communication (and sometimes pre-interview communication). Students feel they need to reach out to programs to let them know they are interested, and everyone feels compelled to send "letters of intent" about ranking. I STRONGLY feel that we need to stop all post-interview communication about rank decisions. It only helps the program, not the students and it is causing significant anxiety and stress for our applicants. Medical schools should stop advising students to send letters of intent, and nationally we should just come out and make a rule against this type of communication.
Unable to get a sense of resident culture from zoom. Usually this is the #1 factor, or at least a top factor that students select programs on.
Unable to see physical facilities and explore the city, lack of informal unstructured time to talk with residents
Unable to spend enough time talking with residents and unable to get a feel for the program
unknown - did not discuss this with them
Total: 75
Note: For 75 of 101 respondents who reported "Yes" in Q5.

END OF SECTION I

Section II. Alliance for Academic Internal Medicine (AAIM) Guidance for the 2020 - 2021 Virtual Residency Interviewing Season; and Internal Medicine Clerkship Planning

Q16 During the 2020-2021 application cycle (COVID-19), did you use the *AAIM Interview Prep Guidance for Medical Student Advisors*?		
	Number of Responses	**Percent**
No, but I was aware of the Guidance during the 2020-2021 application cycle	24	23.3
No, and I was not aware of the Guidance during the 2020-2021 application cycle	45	43.7
Yes	34	33.0
Total	**103**	**100.0**

Q17 Please share any additional comments that you might have about the *AAIM Interview Prep Guidance for Medical Student Advisors*.
Can't remember all of the material from the AAIM guide now. One piece of advice I would have, (and if this is already present then ignore) if significant administrative/leadership changes are expected then how what tools does the student have to quantify the severity of changes and how it would impact their resident or how it would not.
i have been advising for 25 years
I scanned the document, but I should have spent more time reviewing it, and I should have used it more when advising students.
It was a useful document
More advertising of the Prep Guidance.
Much of what is in there was distributed elsewhere in bits and pieces
Our school was actively helping our students and I did practice interviews with students offered by the school and used the school's tips and forms.
Total: 8
Note: For eight of 24 respondents who reported "No, but I was aware of the Guidance during the 2020-2021 application cycle" in Q16.

Q17 Please share any additional comments that you might have about the *AAIM Interview Prep Guidance for Medical Student Advisors*.
Continue webinars to help bridge the gap between UME and GME - we need to continue trying to get on the same page!
I also shared it with my advisees
I appreciated having guidance from the AAIM community given the involvement of both PDs and CDs.
I felt it was practical.
I read it to make sure I was up to date--it was generally helpful.
I really appreciated that AAIM made an effort to provide advisors with this guidance in real time.
Info was useful. I shared with colleagues advising students entering other residency tracks as well.
It is generally helpful. I always look to AAIM for help!
It was helpful as a general overview.
It was helpful to demonstrate that PD's via AAIM were actually having input into the recommendations for virtual interviews.
Nothing specific. I think this helped me to answer some of their questions.
Prep guide was helpful. Appreciate brevity of guide.
Thank you for providing this resource
Used these resources in conjunction with other resources such as those provided through the AAMC
very helpful
very helpful
Very helpful - would make sure it is well advertised as a resource.
Total: 17
Note: For 17 of 34 respondents who reported "Yes" in Q16.

Q19 For the academic year 2021-2022, how many weeks of the internal medicine clerkship do you plan to allocate to inpatient clinical experiences?		
Ordinals	**Number of Responses**	**Percent**
Four	13	13.7
Five	4	4.2
Six	24	25.3
Seven	7	7.4
Eight	45	47.4
Ten	2	2.1
Total	**95**	**100.0**
Note: An additional three respondents reported "Do not know / Unsure" and an additional four respondents reported "Not applicable." One non-respondent.		

Q19 For the academic year 2021-2022, how many weeks of the internal medicine clerkship do you plan to allocate to inpatient clinical experiences?						
Number of Responses	**Mean**	**SD**	**Median**	**Min**	**Max**	**IQR**
95	6.8	1.5	7	4	10	2
Notes An additional three respondents reported "Do not know / Unsure" and an additional four respondents reported "Not applicable." One non-respondent.						

END OF SECTION II

Section III. AAIM Guidelines for Department of Medicine (DOM) Standardized Letters of Evaluation (SLOE)

Q21 Did your department of medicine implement the new *AAIM Guidelines for DOM Standardized Letters of Evaluation (SLOE) Template* during the 2020-2021 (COVID-19) application cycle?		
	Number of Responses	**Percent**
No	31	30.4
Yes: partially	37	36.3
Yes: fully	27	26.5
I was not aware of this template during the 2020-2021 application cycle	4	3.9
Other (please explain):	3	2.9
Total	**102**	**100.0**
Note: One non-respondent.		

Q21 Text for "Other"
I do not know
I am not involved in this process so do not know.
we have been providing percentages for decades
Total: 3

Q22 Why did your DOM not implement (or if applicable, not fully implement) the *DOM Standardized Letters of Evaluation Template* this year?
1. Concerns that this recommendation came out too late for the number of students that needed letters and changing with all of the other stressors, changes, etc was felt to be too much by department. 2. Conflicting pressures given SLOE was ''suggested'' rather than require/expected by APDIM/program directors' similar to in EM. Examples: information regarding ranking when school indicates students are not ranked; and perceived inability to use narrative data other than what is in the MSPE (for which is reviewed by student and may be appealed by student for adjustments) - conflicted by pressure to ensure to improve GQ scores. 3. Concern for data availability, reliability, and consistency (from different training locations) that would be used to complete the SLOE comparably for all students more than exam 4. Confusing application of RIME in the SLOE. What can clerkship ships student consistently achieve in the RIME framework and will the scale result in varied application between institutions? (need to list number of students given each category to anchor.)
Chair of Medicine not aware of the guidelines
Don't know
I am not the person who generates these letters.
I feel that our Department letter is better than the SLOE and feedback from Program Directors in our region is consistently positive--that we consistently provide the most useful data about our students going into IM that's in the student file. As the [REDACTED] of a large preliminary medicine program that got a lot of EM applicants to it, I long ago noticed a disturbing tendency for letter writers never to put their students below the top 1/3 or top 10%--and I don't believe every student entering EM is a top 1/3 student (knowing our students that go into here at our school are across the spectrum from bottom 1/3 to middle to top.). I think this is just another way we inflate grades. Our letter is much more specific, providing hard data about mean competency scores in each competency for the student's class along with the student's mean scores as well as the quartile the student performed in for IM and quartile performed in Shelf. We also use the code word based upon all this data as well, knowing the student, how they will perform in residency. Anyway, I know lots of good work has gone into SLOE and I truly appreciate the effort to provide more substantive data to the IM PDs, but I feel we have been doing this for over a decade already and therefore won't switch to the SLOE.
I had already written most of my LORs by the time this template came out and did not want to alter the template for the remaining students. We will use a version of this for the upcoming application cycle.
I suggested implementing this structure, but our Department Chair is solely responsible for the letters without my input.
In the context of the pandemic, there was too much other stuff going on at the time to make changes
It asked for us to comment on material that we did not have in our evaluations and may not have in the evaluations for ~2 years given the cycle. We may have to convene a committee to decide exact numbers of students in each grouping as many students a bunched. In addition, we were already in the Departmental letter writing process when it was advertised and given the pandemic, we were not going to redo work. I think the estimation of SubI grade breakdown is not fully reflective of the current year as it would contain data from other years (whereas the clerkship grade breakdown is a direct reflection of that cohort).
My guess is that we only move to this form at the direction of our dean or ACGME/ABIM.
No time to revamp our processes in the midst of a pandemic, we are internal medicine after all so we were all overworked in the hospital or covering clinic for those pulled in to attend in the hospital, etc.
Not involved with the DOM process locally
Our clerkship is pass fail and the AI is honors/high pass/pass. We did not feel comfortable ranking the students based on the recommendations in the SLOE (i.e what is the actual meaning of a student's "professionalism" ranking- if they were in the middle third, how would programs view this and does being in the middle third in professionalism have any real meaning?)
Our letter already had most of the critical elements.
Our letters of evaluation are already similar enough to the template, so that strict adoption of the template does not seem necessary.
our medical school does not believe in ranking students and our clerkship is P/F which makes ranking students very difficult

Q22 Why did your DOM not implement (or if applicable, not fully implement) the *DOM Standardized Letters of Evaluation Template* this year?
Pass/Fail clerkships- can't put students into tiers Concerns regarding equity and impact on putting students into lowest tier on their career trajectory, while using faulty assessment data points. Assessment tools not sufficient to put students into tiers
The program director felt it would be too much work.
The template did not fit well with our current evaluation system. Our old method of describing components of the clerkship grade, then giving students scores and overall rank in clerkship seemed more objective.
This was never discussed
we do not rank our students at our school and this letter wants rankings
We do not rank students at my school, and we have students rotating across multiple sites. It is difficult to compare across sites and stratify them/rank them which has been the most problematic portion of the SLOE for us to digest
we don't keep data that is that granular to robustly divide the class into percentages.
We don't rank students
We felt that SLOE didn't serve our students better than our current Chair Letter format.
we have standardized practice across the hospitals and as a site director I haven't been able to do otherwise. Will try to this year.
Total: 26
Note: For 26 of 31 respondents who reported "No" in Q21.

Q22 Why did your DOM not implement (or if applicable, not fully implement) the *DOM Standardized Letters of Evaluation Template* this year?
Because we felt it was impossible to fairly parse students into tiers for certain domains (eg professionalism) with the data we had and doing so would only harm students. At our school, even the "lower 1/3" scores for professionalism are still VERY professional students
Can't rank or assign textiles for our students on communication, team skills due to lack of granular assessments across the clerkship (we are mandated to use a universal grading form used by all 3rd year clerkships)
Complete data points not available. Some of the information we collected on the students was present, but not in the format to make the template useful. This will be fully implemented this cycle.
Could not rank students on individual domains (e.g. communication)
Credit/no credit grading system and disparate Covid impact on different students
Data is available to answer most of the questions suggested on the SLOE template but not for all of them. Therefore, I don't think the chair (who writes these letters) could have implemented the whole thing. Global assessment is possible. But comparative assessments on knowledge, teamwork, and communication is not easily discernible to the chairman. Clerkship directors use MSPE comments to reflect upon those qualities based on the evaluations received.
Did not like the attempt to rank the students or use the RIME scale as we did not have enough data.
Existing template was very close already
It was difficult to rank students into the each of the SLOE-recommended tiers based on our current evaluation and internal ranking systems.
Need more clear data on grades and distributions. We also have a hybrid of graded and P/F students which makes things more difficult to explain.
I do not agree with the full template. Overall, I felt less free to describe the student and his/her qualities. It felt too formulaic. While it does allow some organization for the letter, I do not agree with the ranking system applied and will not include this next year. I believe that we are still hesitant to be truly transparent as to the areas that students may still be working on in terms of their clinical knowledge or skills because PDs will see these as red flags and not consider them for an interview or acceptance.

Q22 Why did your DOM not implement (or if applicable, not fully implement) the *DOM Standardized Letters of Evaluation Template* this year?
I used most of the template. My biggest issue with the template its original form is that it asks you to rank our students by quartile- this presumes that are students are all on a bell curve which they are not. It's truly impossible for me to rank my students #1-#60. We should be sharing with programs the skills our students have, where they shine and if we think they will be successful at any program (most of my students fall into this category). I think we can also share what students will not only be successful but will likely truly be leaders or add something very unique to the program (a handful of our most competitive students). Finally we should share what students we think could require some extra support or might have more of a transition period from med school to residency. These categories don't break down into quartiles, so I changed the rating portion of my letter.
Included everything component except an “internal ranking score”; and did not report individual IM NBME scores from the clerkship. I have serious ethical and philosophical reservations about providing these. When I met with each student, I informed them that I would be omitting these recommended components—nearly all students were in agreement and appreciative of not reporting thusly. Incidentally, I also included in the letter statements acknowledging these guidelines and why we were not providing this information. I’m curious to know if the committee that developed these recommendations, solicited the input of prospective applicants during the development process. - Chayan Chakraborti, Vice Chair, Tulane SOM
Our current letter format is close to the SLOE format. Also, the rating system at the end was/is difficult for us to execute.
parts of it like elective grades are not applicable to our workflow as managed separately and we do not have access to that information followed other aspects very closely though
SLOE designed and implemented by our committee has all of the key components of the AAIM template with additional information outlined.
still appeared in mostly letter format but followed the requirements
There is some standardization but not fully implemented.
Used a modified version to adjust for what data we had available at time of letter submission deadline (e.g., student performance tier data, 4th year sub-I evaluations).
We adapted most of it except for 2 items (Qualification for IM and Global Assessment which both ask to divide students in terciles) because our evaluation process does not allow me to retroactively divide the students in terciles with the degree of accuracy or precision that would be need.
We are competency based and cannot rank our students into groups as recommended. Also, we don’t think the shelf score should be listed given concerns about racial bias in standardized tests.
We are moving toward full use in 2021
We did not compute grades using the RIME model, so I didn't think that I could fairly appraise that component Some clinical rotations were cut short from COVID, so the ranking would be unbalanced. Mostly, I was really unsure if I was doing it right (was I including too much student information? not enough? was I doing the best thing for the student)?
We did not feel that bucketing our students in the top third, middle third, and bottom third was consistent with our school's policy of not grading/ranking students.
We did not have the formal assessment structure to rank students into tiers for domains of communication, professional, clinical skills, and clinical reasoning so instead we included representative comments from their evaluations for each.
We didn't have all of the requested info--e.g. we didn't solicit evaluations that distinguished between various skills
we do not rank students and therefore had some challenges responding to some of the questions. used the general template to guide our letters this year.
We used most of the template but made a few tweaks at our Chairs request.
We felt there was a great deal of not pertinent
We partially did, we felt some of the information on the template was duplicative or redundant and or not needed, so we adopted our own to make it a bit more concise.
While I was not directly responsible for this, I was told our department chair did was not comfortable with designating students in the bottom third. Also, we don't collect all of the metrics that were asked for
Total: 31
Note: For 31 of 37 respondents who reported "Yes: partially" in Q21.

Q23 Which of the following would promote your school's ability to implement (or to fully implement, if applicable) the new *AAIM Guidelines for DOM Standardized Letters of Evaluation (SLOE) Template* in the future?		
	Number of Responses	**Percent**
Better tools to assess communication in a standardized way	34	53.1
Better tools to assess professionalism in a standardized way	32	50.0
Better tools to assess clinical skills in a standardized way	37	57.8
Better tools to assess clinical reasoning in a standardized way	35	54.7
Incorporation of Entrustable Professional Activities into your assessment	19	29.7
Greater focus on Sub-I performance than clerkship performance	17	26.6
Less emphasis on tiers when rating student performance	24	37.5
Support from medical school leadership to implement all components	24	37.5
Communication from residency programs on preferred DOM letter template	25	39.1
Later submission to allow for more time to collect assessment data	15	23.4
Other (please specify):	5	7.8
Do not know / Unsure	4	6.3
None of the above	3	4.7
Total	**274**	**428.1**
Note: For 64 of 64 respondents who reported "Yes: partially" or "Yes: fully" in Q21. Multiple responses allowed: total number of responses will exceed number of respondents to question and total percentage will exceed 100.		

Q23: Text for "Other"
Already used for this cycle
I think what we do is better
Need either better tools to assess discrete domains or less focus on stratifying by domains.
The awareness that in moving to P/F Step 1, we are trying not to reduce applicants down to a number, let's not substitute one number for another
Time and resources for clerkship director and faculty development.
Total: 5

END OF SECTION III

Section IV. Clerkship and Sub-Internship Director and Medical School / Institutional Characteristics

Q25 What is your *primary* educational leadership role at your institution?		
	Number of Responses	**Percent**
Clerkship Director	77	74.8
Clerkship Co-Director	7	6.8
Associate Clerkship Director	3	2.9
Sub-Internship/Acting Internship Director	7	6.8
Sub-Internship/Acting Internship Associate Director	1	1.0
Vice Chair (or Associate Vice Chair) for Education	3	2.9
Other (please specify):	5	4.9
Total	**103**	**100.0**

Q25 Text for "Other"
both clerkship and AI director
Clerkship Director and VCE
clerkship site director
Director of Student Education for department supervising all of our third- and fourth-year courses, with primary role in charge of senior year and serving as Sub-internship Director
Director of undergraduate education, Medicine
Total: 5

Q26 Do you have a secondary educational leadership role at your institution?		
	Number of Responses	**Percent**
No	42	40.8
Yes	61	59.2
Total	**103**	**100.0**

Q27 What is your *secondary* educational leadership role at your institution?		
	Number of Responses	**Percent**
Clerkship Director	3	5.0
Associate Clerkship Director	1	1.7
Sub-Internship/Acting Internship Director	17	28.3
Sub-Internship/Acting Internship Co-Director	2	3.3
Sub-Internship/Acting Internship Associate Director	1	1.7
Vice Chair (or Associate Vice Chair) for Education	6	10.0
Other (please specify):	30	50.0
Total	**60**	**100.0**
Note: For 60 of 61 respondents who reported "Yes" in Q26. One non-respondent.		

Q27 Text for "Other"
APD
assistant dean
Associate Chair for Education
Associate director of the [REDACTED]
Associate Program Director
Associate Program Director
Associate Program Director for Med-Peds residency
Associate Program Director, IM Residency
Chair of Committee on Medical Education
Core faculty residency program
Course director for another course; division chief for IM
Course director for IM electives
Curriculum Committee
curriculum development for clinical skills course
departmental UME director
director of medical student education at hospital
Director of Phase 3 Curriculum, Dept of Medicine
Director of Student education
Director of the Clinical Curriculum, Sub-Internship Director
director of UME in our hospital DOM
Director of Year 3 Curriculum
Fellowship Program Director
GME Site Director
Medical Director Clinical Simulation Center
Pathway Advisor

Q27 Text for "Other"
residency program leadership
Resident Research Director
Small Group Learning Communities Associate Director
Student Clinic Director
Vice Chair for Student, Resident & Faculty Development
Total: 31

Q28 For how many years have you been in your *primary* educational role?						
Number of Responses	**Mean**	**SD**	**Median**	**Min**	**Max**	**IQR**
101	7.4	6.6	6	0.5	40	7
Note: Two non-respondents. SD: standard deviation; IQR: interquartile range.						

Q29 What is your academic rank?		
	Number of Responses	**Percent**
Instructor	1	1.0
Assistant Professor	36	35.6
Associate Professor	46	45.5
Professor	18	17.8
Total	**101**	**100.0**
Note: Two non-respondents.		

Q30 For the current academic year (2020-2021), how many students are there in each class at your medical school?						
Number of Responses	**Mean**	**SD**	**Median**	**Min**	**Max**	**IQR**
103	151.5	58.0	150	42	365	70

END OF SECTION IV

Q32 The CDIM Council wants to ensure that your needs as a medical education leader are addressed.

Q32 The CDIM Council wants to ensure that your needs as a medical education leader are addressed. Please provide one area that you are struggling with and/or would like the CDIM Council to review as an opportunity to better support leaders in your position. If you completed the 2020 CDIM Annual Survey of Core Clerkship Directors and answered this question, you may provide any other comments that you wish to share with the Council.
1.Objectively assessing students. Physicians and faculty ar ever so busy and inundated with requests from all sides and I wonder how much time is being spent and carefully evaluating a student and comparing them with their peers and judging where do they belong in their class - lower 3rd middle 3rd or higher 3rd.
1. Stronger position statement/guidelines on the minimum amount of protected time that should be dedicated to the Clerkship Director role, so that it can be used to negotiate with my institution for an appropriate amount of dedicated time. 2. Work with Department Chairs across all institutions (both allopathic & osteopathic) to ensure universal use of the standardized letter of evaluation, and with Student Affairs/UME staff to try to achieve a more uniform quality of MSPE's. 3. Work with PD's across all residency programs to adhere to a more standard interview invitation policy (i.e., do not offer more interviews than spots available; offer only in the evening so students aren't distracted from clinical learning, start offering interviews no earlier than a particular day each year, etc.). And advocate for caps on the number of programs an applicant can apply to &/or interview at.
Adequate salary support for clerkship directors/subI directors. Support for core faculty and different sites. Our program does the bare minimum. It seems wrong.
Advising takes a significant portion of time, as does writing DOM letters. At my institution it has always been the medicine clerkship director who does this. It would be so helpful if CDIM came out with some guidelines on FTE support that should be allocated for advising and writing DOM letters. I think this would help a lot of us advocate for more support at our institution.
A more standardized clinical assessment system across medical schools would be helpful if we keep competency and ultimate goals in mind. Does it make sense for each school to use a different evaluation system if we are all trying to assess them for the same skills and then using those findings to rank them for residency? EPA's as a construct may be standardized but also being adapted in different ways using different behavioral anchors and ratings. While use of the same assessment tool will certainly not eliminate problems with reliability and validity in clinical assessments, it will be a step in the right direction.
Appropriate assessment of sub-interns, especially since it seems there is an expectation for all to get honors but not all students are at that level.
As CDIM is aware, burnout is a problem in the CD role. Funding for our roles is insufficient and advocacy with the Chairs of Medicine to get more consistent, higher level funding for bought out time to allow us more space to interact with students meaningfully (which I would theorize would lessen burnout) would be key in changing the trend of clerkship director burnout.
Can we create a standard way to compare "beginning of the academic year" students to end of the academic year students who are clearly more skilled due to on job the training? Does comparison of z scores for each cohort work?
CDIM should take a stand on clerkship grades. Should they be pass/fail, should they be tiered, if tiered what % of each grade should they be? There is no reason that we should not have uniformity as a society. It creates chaos to have different schools in such differing grade scenarios and I am sure is very difficult for residency programs to follow.
Collaboration with other institutions on medical education scholarship.
Continue documenting and advocating for system changes which may help to support our roles.
Did not know there was a document to provide guidance for residency advising. Will try to obtain that document to help prepare for the next cycle. Would be great if we had some orientation regarding VSAS/away rotation counseling for students.

Q32 The CDIM Council wants to ensure that your needs as a medical education leader are addressed. Please provide one area that you are struggling with and/or would like the CDIM Council to review as an opportunity to better support leaders in your position. If you completed the 2020 CDIM Annual Survey of Core Clerkship Directors and answered this question, you may provide any other comments that you wish to share with the Council.
Educational recognition and incentives for teachers. How do we reward and recognize our student teaching?
EPAs are a major area of concern and challenge at our institution. The students and our Medicine faculty are exceedingly unhappy and dissatisfied with the EPAs and find that they are encroaching upon the clerkship learning experience instead of adding to the learning. What data are there to provide better transparency and support the continuation of EPAs and how do other institutions ascertain better buy-in from faculty and students to facilitate their completion without all the stress and challenges?
Evaluation of students when they are on service with faculty for a week or less at a time
Grading - the need to stratify students for residency program directors, while balancing their wellness, anxiety, and ability to learn for the sake of learning!
Guidance on how to work at a small institution balancing education vs. other responsibilities.
Help with scholarship and career advancement
how to manage SLOE when our school went to P/F during pandemic
I have issues with the standardized letter of recommendation and do not agree with implementation until basic issues are solved. The SLOE is designed to help program directors and yet program directors do not use a similar template during the fellowship application process. My role as a student advisor is to help the student, the same as the program director when the resident applies to fellowship programs. I do understand the process and want to help the program directors as well. A true educational handoff with the intention of helping each learner would be best. This is a long-term goal. I do not believe the CDIM should continue to advocate for its use. The clerkship directors work with a large number of students for a short period of time. To accurately assess students, it takes more time. Program directors should be focusing more on the MSPE/Dean's letter which collates information across the years (3 to 5 years). These more formal letters that are supported by teams of people - often with editors - in the medical school should also include their performance on each clerkship, including medicine.
I have not had a coordinator for most of the COVID year. The one I initially had had been in role for less than two months before the work environment went virtual. She looked for another job and was gone. We've not been able to hire anyone else. I do feel our administration does not appreciate the value of clerkship directors and they are paid at an entry clerical level--often using what time they have here to springboard to another company. Just a tiny rant there bc I should not be entering TEAM calendar events, trying to figure out how to send out assessments, etc.
I wish there was more on how to successfully implement faculty development things at the meetings. I would also like to hear more from experienced (highly regarded) faculty about some of their "tricks of the trade"--for example, how they manage to teach on the fly in busy clinic settings or on the wards, as well innovative methods they're using to supplement their teaching in a way that keeps learners consistently engaged. I think it would also be good to continue having workshops and plenaries on ways to get our learners to order less scans and tests and think more critically about what is going on with patients--ie, fostering time outs for clinical reasoning, etc.
I would like more communication between CD and PD re: the SLOE. I would love to have someone review my SLOE and provide guidance. I also think it would be great to reach out to students who recently went through the cycle for their experiences/suggestions.
I would like to see CDIM work on ways to make assessment of medical students more effective and some give degree of standardization.
I'm concerned about the need for better assessment tools given the growing influence of clinical grades when Step 1 goes pass/fail, particularly if students are focused more on Shelf and Step 2 prep than clinical duties.
Implementation of workplace-based assessments (e.g. EPAs)
Improving assessment of students - more tools and improving standardization of faculty evaluations
Improving consistency of faculty assessments of students.

Q32 The CDIM Council wants to ensure that your needs as a medical education leader are addressed. Please provide one area that you are struggling with and/or would like the CDIM Council to review as an opportunity to better support leaders in your position. If you completed the 2020 CDIM Annual Survey of Core Clerkship Directors and answered this question, you may provide any other comments that you wish to share with the Council.
Improving direct observation of students.
In what ways do clerkships at other schools provide feedback to students? What forms are used, how often is feedback given/expected?
It would be great to know more about individual programs' criteria/values/timeline of interview invites/attitudes toward away rotation. Who has step score cutoffs? How important is research to your institution? Do you send out every invite on the same day or send a few at a time? When do you start reviewing/inviting? How do you think about away rotations?
More opportunities for discussion with residency directors about their expectations for SLOE and helping to advocate for a more consistent transparent process across residency programs for notifying students of their interview status so they are not in the dark throughout the process.
More sharing of conference materials
move to P/F
One area would be to better define FTE's for CD and associate CD's along with recommendations for funding those positions particularly in the era of solely RVU-based compensation. Another would be working on and EVU platform with generalizable application.
Our medical school is expanding and currently pushing to expand more. At the same time, our residency program is shrinking. This is decreasing the number of clinical sites available to students and increasing the number of students on each team. I am attempting to partner with private groups in the community; however, they demand payment for working with our students. While we have some resources, they are not limitless. I really do not know how to maintain a high level of experiential educational opportunities for the students in this environment.
Recommended FTE support for clerkship directors.
See previous answers regarding my reservations with some of the DOM letter guidelines
Shelf exam preparation for students. Integration of virtual teaching modules Better tools to support assessment for IM specific skills
Standardization of support for performance of clerkship director and acting internship director roles.
Thanks for all you do to advocate for us!
thanks for all your support!
The COM does not allocate enough protected FTE in order to do this job well. We are allocated 0.3 FTE and my duties far exceed that in clerkship (closer to 0.5 FTE). It would be optimal to have a strong endorsement from AAIM that CD be protected for the time that is devoted to students. This would allow recruitment of assistant CD, site directors, developing clinical competency committees, and protecting educators within the department. This is particularly important in institutions where RVUs and clinical productivity are highly valued and no mechanism for EVUs exist.
The never-ending struggle to come up with a more objective grading system for the clerkship.
The ongoing pressure to stratify students in an effort to make the application process easier for residencies continues to create an uncomfortable environment where there is pressure to “rank” and “judge” the current performance of the student rather than assess them on their growth as an individual. Everyone is going to come into a clerkship at varying levels of competency in the various domains and to hold that against them to inform the grade (and potentially their residency application) does not seem to be very student-centered. I do feel that it is really coming from the residency level. The new SLOE that not only asks us to put a student in a tiered bucket but also tries to further push us by making us report how many students we put in each bucket exemplifies this even further.
This was a tough year, an isolating year. I liked the collaborative Zoom sessions that we had early on in the pandemic. I thought it was a great way to get connected and share ideas. I think many of us have a core group of people that we connect with, but these were nice to see other ideas and did an okay job of replacing the in-person national meeting. I can't wait until we can all safely meet again in-person.

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We are one medical school with three distinct campuses, each campus located in separate cities. Due to this situation, we have trouble maintaining comparability of clerkships. For a while, during the pandemic, we Zoomed our lectures from one location, which enhanced the comparability of clerkship instruction. However, once the "lockdown" eased, we returned to our "old ways" and, to some extent, went back to our "separate ways." Maintaining comparability of clerkship instruction and student experience remains a challenge.
We could use help with incorporating anti-racism principles into our curriculum
We should revise the SLOE many CDs don't want to adopt
With recent increases in our medical school class size, we are under constant pressure to find ways to increase the number of students in our IM clerkships, to find new and 'creative' ways to place students, such as working with hospitalists or specialists instead of traditional ward teams. I think that most of these suggestions are either impracticable or will lead to inferior educational experiences. It would be better to work on developing new clerkship sites at good community hospitals rather than trying to squeeze more and more out of the major teaching hospitals.
Would like to know what kinds of formal assignments students must complete on their clerkships and how these assignments are assessed and how they factor into the student's grade.
would like to see clinical evaluation forms from other institutions to better "best practices" for student clinical evaluations. Our institution requires a common evaluation form for all clerkships. Also, would appreciate information / guides on faculty development for use of the form.
Total 55

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