AAIM Perspectives

Aiming for Equity in Clerkship Grading: Recommendations for Reducing the Effects of Structural and Individual Bias

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INTRODUCTION

In recent years, we have witnessed how the content and structure of clerkship education changes in response to societal and patient needs.1,2 Examples of such adaptations include pedagogical redesign,3 early immersion in patient care,4 competency-based medical education,5,6 and longitudinal integrated clerkships.7,8 More recently, many learners and educators have turned their attention to structural racism in medicine9,10 and the parallels between disparities in health care and disparities in access to education and opportunity within medicine. Educational equity is now recognized as a core principle of undergraduate medical education.11-13 Many learners from racial and ethnic groups underrepresented (URG) in medicine9,10 and the parallels between disparities in health care and disparities in access to education and opportunity within medicine. Educational equity is now recognized as a core principle of undergraduate medical education.11-13 Many learners from racial and ethnic groups underrepresented (URG) in medicine face inequities in the clerkship learning environment that lead to social isolation, job dissatisfaction,14,27-29 and eventual attrition of URG learners and faculty. These negative outcomes are particularly concerning because diversity among learners, health care workforce, and teams is important for health equity,17-19 enhances the learning environment, promotes culturally responsive care, improves access to care for underserved communities, and can improve health outcomes.20-23

A thorough analysis of disparities in medical school is critical to creating a learning environment that is equitable, particularly in the clerkship year when assessment of student performance can have long-term ramifications on a career trajectory.24-26 URG learners face multiple pressures and inequities that affect their lived experiences and assessments in the clerkship setting,14,27-29 including heightened scrutiny from physicians and patients, stereotype threat when facing faculty and resident assessors,14 “covering” (concealing or reducing the prominence of a trait),30 differential expectations in the classroom,31 and imposter syndrome.14 Although many of these phenomena occur in interpersonal relationships, structural barriers are also woven into clerkship assessment, evaluation, and grading. Clerkship students are observed, assessed, evaluated and, at many institutions, graded. They receive formative feedback meant to foster their growth and summative evaluations to determine their performance based on clerkship objectives and rubrics. Grades or narrative summaries serve to communicate their level of achievement or competence to internal and external stakeholders. In most Liaison Committee

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intrapersonal domain, consider how individuals influence assessment.32,33 Yet there is evidence of inequity in these assessments and the grading process.26,33,34

In this perspective, we summarize evidence-based recommendations to address inequities focusing on the clerkship grading process. We aim to guide clerkship directors through an exploration and potential redesign of current assessment and grading systems using an equity lens. Although we focus on strategies that internal medicine clerkship leaders can use, we believe these strategies can be applied to other specialty clerkships seeking to create a more equitable grading process.

APPLICATION OF THE SOCIAL-ECOLOGICAL MODEL

We organize our recommendations using the social-ecological model (SEM),35 a theory-based framework that describes the complex interplay among the individual, interpersonal, institutional, and societal factors that influence behavior and effect change (Figure). Commonly used in the public health sphere,35,36 SEM informs policy, outreach, and prevention strategies. This model is increasingly being used to identify gaps and improve medical education, such as identifying possible factors contributing to inequities in assessment26 and maximizing growth in the learning environment.37 We propose the model as an organizing framework for recommendations to promote an equitable grading process in clerkships (Table).25,27,31,38-43

Individual/Intrapersonal

As we review student assessment in the individual/intrapersonal domain, consider how individuals—students, assessors (supervising faculty and residents), and clerkship leaders responsible for generating summative information—affect each other and how interpersonal relationships can affect change. Individual/intrapersonal factors that influence assessment include personal attitudes, biases, and experience with bias. Strategies to modify individual/interpersonal factors include enhancing confidence, developing skills, expanding knowledge, modifying attitudes, and promoting assessment methods that minimize bias. Individual strategies can be directed toward both supervisors and students.

Faculty and resident supervisor development. Medical schools, including clerkships, should prioritize teaching faculty and residents the skills and strategies needed to mitigate bias when they assess students. Ongoing development of supervisors should occur in both the inpatient and outpatient settings. All faculty and resident supervisors should be required to participate in ongoing education (workshops or modules) through the department or school, around concepts that could include:

- The history and pervasiveness of bias in medicine, including examination of the current learning environment44,45
- The effects of personal and structural bias on assessment of learners24-26,44
- Best practices in observation and assessment of students in the workplace (workplace-based assessments)46
- Best practices in mitigating the effects of sex and racial bias on assessment, including information on how to write specific, behaviorally based narrative assessments that include students’ strengths and areas for improvement24

Education on differences in language used based on sex and race is critical. This language should focus on descriptors for knowledge, skills, and attitudes, rather than personality descriptors (pleasant, quiet).38 Sex-bias tool calculators for narratives are available on the internet.39 A behaviorally based narrative such as “She was a treat to have on the medicine service” can be changed to “Her presentations were thorough, she was responsive to the patients, and her interactions with staff were professional.” A sample awareness of inequities in language example is “As is common in his culture, he was quiet and studious.” This statement can be changed to “During rounds, when prompted, his responses to direct questions about patient care reflected that he had done extensive reading about his patients.”
Many medical schools provide local online and in-person workshops addressing these topics, and free resources are widely available.\textsuperscript{47,48} Examples include the Alliance for Academic Internal Medicine (AAIM) website,\textsuperscript{49} which provides links and guides for faculty development, assessment, and information on diversity, equity, and inclusion initiatives, as well as the online Implicit Association Test to help raise awareness of biases.\textsuperscript{40}

Assessment tools. Careful selection of assessment methods, ideally prioritizing those based on observations in the workplace, is critical, and must be paired with ongoing institutionally supported faculty and resident development on how to utilize these tools.

Clerkships should utilize criterion-referenced and competency-based assessment forms with defined rubrics that include specific behaviors reflective of a certain level of achievement for clinical performance measures. Well-defined anchors indicating a certain level of achievement can help reduce misinterpretation or subjectivity.\textsuperscript{50} Examples of assessment rubrics are found in Appendix A and Appendix B (available online). Standardized checklists can also be used in select situations, including during review of notes, directly observed patient encounters, objective structured clinical examinations (OSCE), or oral presentations. The Association of American Medical Colleges offers a guide for developers of core entrustable professional activities that can be used as a guide to create clerkship assessment rubrics.\textsuperscript{51}

Clerkships should increase the number of clinical care-based observations of students.\textsuperscript{26,46} This increase might include workplace-based assessments, for example, observing a student communicating with a patient or with an interprofessional team member; reviews of students’ patient care notes or oral presentations; and OSCEs. Increasing the total number of observations might mitigate potential bias from a single supervisor or assessment tool.

Clerkships should identify ways to decrease bias in assessment tools and processes and be consistent with the use of race/ethnicity for clinical reasoning cases or OSCEs.\textsuperscript{52,53} The inconsistent and inaccurate use of race for assessment cases can reinforce stereotypes and suggest that phenotypes, rather than the socioeconomic, structural, or biologic factors, are pertinent for

\textbf{Figure} The Social-Ecological Model (SEM), a framework that describes the complex interplay between individual, interpersonal, institutional, and societal factors that can influence behavior and effect change.
### Table: Using the Socioecological Model to Organize Clerkship-Level Recommendations to Promote an Equitable Grading Process

<table>
<thead>
<tr>
<th>Socioecological Level</th>
<th>Recommendation</th>
<th>Action</th>
<th>Details/Resources</th>
</tr>
</thead>
</table>
| Individual/Intrapersonal | Supervisor development | Teach faculty and resident supervisors about best practices in writing narrative assessments. Require all faculty and resident supervisors to participate in ongoing bias education in the following:  
- History and pervasiveness of bias  
- Effects of bias on assessment  
- Workplace-based assessments  
- Best practices in bias mitigation | Resource with descriptors by personal attribute vs competency: [38](https://link.springer.com/article/10.1007/s11606-019-04889-9/tables/4)  
Gender bias calculator tool: [39](https://www.tomforth.co.uk/genderbias)  
Resources on UIM learners’ cognitive burdens in the learning environment: [27], [31]  
https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2703945  
https://journals.sagepub.com/doi/pdf/10.1177/0022146518821388  
Resource on identifying one’s own implicit attitudes and beliefs: [40]  
https://implicit.harvard.edu/implicit/education.html |
| Assessment tools | Utilize criterion-referenced and competency-based assessment forms with defined rubrics that include specific behaviors | Example of observed clinical encounter form rubric: Appendix A  
Example of note review rubric: Appendix B |
| Interpersonal | Applying a pro-equity lens to assessment of competencies | Avoid overemphasis on knowledge-based standardized examinations  
Observe and assess patient advocacy or structural competency skills, student initiative, team collaboration, and self-improvement with significant weighting as essential skills | Example of a Structural Competency domain: The student can identify social and structural determinants that impact their patients’ health and actions that promote optimal health outcomes  
Example of Patient Advocacy Competency grading rubric: Appendix C |
| Organizational/institutional | Access to learning | Ensure that all learners have equitable access to learning resources and study materials | Provide computer and stable WiFi access  
Resources for examination preparation, question banks |
| Grading process | Implement criterion-referenced and competency-based grading rather than normative grading | Example of equity in assessment checklist: [42]  
Resource on clerkship grading committees: [41]  
https://link.springer.com/content/pdf/10.1007/s11606-019-04879-x.pdf |

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certain pathologies. In addition, when race or ethnicity is used only when a patient is non-white, it implies that white is the norm. Failing to minimize bias in assessment tools can further marginalize URG students and add to cognitive overload, which may, in turn, impact performance. Extend bias mitigating strategies to standardized patient assessors, such as intentional recruitment of standardized patients from diverse backgrounds, bias and pro-equity training, and implementation of rubrics.

**Student education.** Empowering students to understand their potential vulnerabilities in the clerkship learning environment and providing strategies that they can employ to overcome these and advocate for themselves is important. This type of education can be led by the school given the cross-clerkship nature of these skills. Online resources are also readily available.

Increase student awareness around cognitive bias such as stereotype threat, which is the concept when a student worries about confirming a negative stereotype of one’s racial or gender population to the point that this thought negatively impacts their performance. Reinforce the growth mindset (embracing challenges as opportunities to learn and grow).

**Interpersonal**

When we consider the second domain of SEM, we examine interpersonal factors that can provide support or create barriers to equity. We define them as interactions and relationships between people such as educational alliances, mentoring, social networks, and peer cohorts. We also consider the relationships that students build with their patients. Interpersonal strategies relate to increasing professional support, improving relationships, and the clinical learning environment.

**Apply a pro-equity lens to assessment.** Clerkships should avoid overemphasizing knowledge-based standardized examination scores to encourage students to focus on patient care learning, including developing the clinical knowledge and skills needed for optimal patient care delivery.
Clerkships should assess “patient care” skills that traditionally are neither assessed nor weighted significantly in the determination of the final clerkship grade. These activities and skills should be considered an essential clinical experience or important attribute for patient care and should contribute to a student’s final grade or summary. Skills that could be observed and assessed include patient advocacy (eg, addressing patient social determinants of health), student initiative, team collaboration, and self-improvement.\(^24,59\)

Formally observing and assessing these skills signals to students the value of this competency in their professional development. An example of a patient advocacy domain and assessment rubric is in Appendix C (available online).

**Institution/Organization**

The factors that perpetuate inequities in clerkship grading that we consider to be in the institution/organization domain relate to large-scale issues such as the explicit and implicit norms of the learning environment, hidden curriculum, policies, and guidelines. Strategies relate to transparency, partnership with institutional stakeholders, and institutional oversight to ensure equity and mitigate bias and structural racism in the curriculum, learning environment, and assessment.

**Access to learning resources.** It is critical to ensure that all learners have equitable access to learning resources and study materials for clerkship examination preparation (eg, resources for standardized test preparation).\(^25,26\)

**Clerkship oversight of grading process.** Clerkships should implement criterion-referenced and competency-based grading, rather than normative grading.\(^24,26\) Normative grading compares one student’s performance with the average performance of his or her peers, for example, using a predetermined number or percentage of students who can be assigned a certain grade. The clinical performance assessments that supervisors complete at the end of the rotation, which often form the majority of a student’s grade, are susceptible to individual supervisor biases. The use of a normative approach to grading students may magnify the challenges with potential bias in individual evaluations. In contrast, criterion-referenced and competency-based grading provides transparency about the behaviors needed to reach a predetermined level of achievement.

Clerkships should provide guidance on how to use individual supervisor comments to generate a final detailed narrative summary that is free of bias.\(^24\) Each summary should be reviewed specifically to ensure that biased language (eg, gendered language) is not used.

Clerkships should limit the weight that standardized examination scores, such as National Board of Medical Examiners (NBME) subject examination scores, have in determining a student’s grade.\(^24\) Differences between population group outcomes in standardized examinations likely reflect the impact of structural racism and unequal educational opportunities on URG students.\(^24,26\) Limiting the weight of examination scores on final grades might also enable students to focus on other important patient skills that they need to develop.

Clerkship leaders should recommend against standardized test score cut-off for honors grades.\(^62\) Analysis of differences in clerkship performance based on URG status suggests that attributes linked to performance on high-stakes multiple-choice examinations may be responsible for differences in clerkship performance assessment.\(^24,25\) Small differences in clerkship director ratings are amplified by institutional grading policies and institutionally defined eligibility criteria to the Alpha Omega Alpha honor society, which leads to lower attainment of honors grades and selection for Alpha Omega Alpha membership for URG students when compared with non-URG students.\(^24,26\) This amplification cascade can affect URG student residency training and career options and choice.

Schools should institute the use of a grading committee with diverse membership (eg, race, sex, experience) when determining grades or final level of achievement to mitigate the possible effects of the individual bias of those responsible for assigning grades and to perform holistic review.\(^24,41,63\) Provide faculty development to ensure committee members apply grading criteria in a standardized way.

**Educational continuous quality improvement (clerkship programmatic evaluation).** Clerkships should review data to identify areas of potential bias impacting students’ learning experiences and thus, assessments.\(^24,25\) This review can occur during curriculum phase/segment review and review of data analyzing equivalency of sites, and is aligned with the LCME accreditation standard requiring schools to evaluate their program’s effectiveness. This review might include an annual review of data provided by central administration of the following clerkship variables that relate to equity, including sex and URG status in distribution of clerkship grades and NBME subject examination scores; mistreatment reported by students on clerkship evaluations or school reports; and student clerkship satisfaction in areas related to race, ethnicity, and sex.

If new standardized assessments are developed, leaders should analyze by race/ethnicity/sex variables to ensure that similar biases do not exist within the new tools. Tracking these variables can identify factors in the clinical learning environment that can impact student performance, and supervisor assessment of students.
Schools should establish a senior leadership committee to oversee the annual review of clerkships, with a lens on diversity, equity, and inclusion in curricular opportunities, learning climate, and assessment. Central administration can assist clerkship directors in monitoring these variables by providing mechanisms, for example, anonymous web-based student surveys and focus groups, to annually elicit student input about diversity, equity, inclusion, and bias in the clerkship, which can impact assessments.

Institutional leaders should ensure that pro-equity training is implemented across disciplines (eg, nursing, advanced practitioners, social work, case management) and ensure that policies, processes, and the environment enhance a culture of respect and inclusion.

Community and Policy
While the community and policy domains are out of the scope of this paper, we acknowledge that it is imperative that larger medical education communities such as AAIM, and national organizations such as NBME, LCME, and the Accreditation Council for Graduate Medical Education, examine and re-envision their role in improving equity in clerkship grading through policy changes.

CONCLUSION
The heightened national awareness of race- and ethnicity-based health and learner inequities has led medical schools and organizations such as AAIM to critically examine the structural factors and pervasive bias that perpetuate inequities in assessment in the learning environment. Critical to this effort is the deliberate examination of institutional processes, educational practices, and systems that negatively and disproportionately affect URG students. In this perspective, we describe a pro-equity framework for minimizing bias in clerkship assessment and grading. We structure this framework using the socioeconomic model and base our recommendations on the inequities in narrative language in evaluation and insidious effects of bias in clerkship assessments and grading described in the medical literature.

We believe that clerkship leaders are ideally positioned to critically examine their assessment system, implement novel strategies, and innovate the learning environment using a pro-equity lens. It is critical that clerkship leadership develop and utilize an assessment system built on the fundamental principle that all learners deserve the opportunity to attain their full potential—the concept of educational equity.

ACKNOWLEDGMENTS
The authors would like to thank Clerkship Directors in Internal Medicine Council members, and Emerald Wong for her editorial assistance.

References
62. Schilling DC. Using the clerkship shelf exam score as a qualification for an overall clerkship grade of honors: a valid practice or unfair to students? Acad Med 2019;94(3):328–32.

SUPPLEMENTARY DATA
Supplementary data to this article can be found online at https://doi.org/10.1016/j.amjmed.2021.06.001.
## APPENDIX A.
**OBSERVED PATIENT ENCOUNTER (OPE) SCORING (20 MIN WITH PATIENT; 25-MIN DEBRIEF)**

<table>
<thead>
<tr>
<th>Category</th>
<th>Sub Category</th>
<th>Answers (Points)</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data Gathering (EPA 1)</strong></td>
<td><strong>Observed with patient</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>History</strong></td>
<td>Pertinent positives (3)</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Pertinent negatives (3)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Complete &amp; accurate in organized fashion (3)</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Physical examination</strong></td>
<td>Pertinent components (2)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Appropriate skill (2)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Correct findings (2)</td>
<td></td>
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<tr>
<td></td>
<td><strong>Doctor-patient communication</strong></td>
<td>0 — Lack of rapport, little empathy, failure to act on verbal or nonverbal cues</td>
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<tr>
<td></td>
<td></td>
<td>1 —</td>
<td></td>
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<td></td>
<td></td>
<td>2 —</td>
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<td></td>
<td></td>
<td>3 — Good rapport with patient. Empathic. Recognizes and responds to verbal or nonverbal cues</td>
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<td>4 —</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>5 —</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>6 — Good rapport with patient. Empathic. Recognizes and responds to verbal or nonverbal cues</td>
<td></td>
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<tr>
<td></td>
<td><strong>Differential Diagnosis</strong></td>
<td>Identified pivotal pts(1)</td>
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</tr>
<tr>
<td></td>
<td><strong>Most likely leading diagnoses</strong></td>
<td>Appropriate can’t miss/alternate diagnosis (2)</td>
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<tr>
<td></td>
<td><strong>Evaluation</strong></td>
<td>Appropriate test for ruling in disease (1)</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Management</strong></td>
<td>Appropriate test to rule out disease (1)</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Appropriate rationale for decision to order a test (1)</td>
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<tr>
<td></td>
<td><strong>Patient Education</strong></td>
<td>Basics of management (3)</td>
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<tr>
<td></td>
<td><strong>Observed in debrief session</strong></td>
<td>Clear explanation in patient appropriate language</td>
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<td></td>
<td><strong>Overall performance</strong></td>
<td>Assessment of understanding</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Anticipatory guidance (2)</td>
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<tr>
<td>Totals</td>
<td></td>
<td><strong>Out of 3</strong></td>
<td></td>
</tr>
<tr>
<td>Grade (Honors Manager 32-36\High Pass Interpreter 24-31 \Pass Reporter 18-23 \Fail&lt;18)</td>
<td><strong>Out of 36</strong></td>
<td></td>
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</table>

APPENDIX B. GRADING RUBRIC FOR A COMPREHENSIVE NOTE WRITE-UP

Chief Complaint: 0, 1, 2 points

0: none
1: present R
2: includes patient’s main complaint, in patient’s words, and no additional information/patient information/other non-pertinent wording I

Opening sentence: 0, 3, 5 points

0: none
3: present but lacks appropriate important information, or includes information that is not important to the differential R
5: includes appropriate history and not distractors I

HPI: 0-15 points I

2: Organized
2: Thorough
4: Includes pertinent positive ROS
4: Includes pertinent negative ROS
3: Includes pertinent past history/family history/social history

Past Medical History: 0, 1, 2 points R

0: none
1: disorganized, incomplete, paragraph format
2: organized, thorough, bulleted format (includes surgical history, ob/gyn history if appropriate, vaccinations/developmental history if a child)

Medications: 0, 1, 2 R

0: nothing written (if no medications, must state so)
1: medications listed but uses abbreviations, trade names
2: medications listed, no abbreviations, generic names

Allergies: 0, 1, 2 points R

0: nothing listed (if no allergies, must indicate such)
1: allergies listed but not reactions
2: allergies and reactions listed, or no allergies listed as “no known drug allergies”

Social History: 0, 1 point (point system does NOT reflect a lack of importance to this!!! Please include alcohol, tobacco, drug use, living situation, social support) R

Family History: 0, 1 point (point system does NOT reflect lack of importance) R

ROS: 0, 1 point R

0: none or lists only a few, not organized, includes PE or other findings, repeats information already described in HPI
1: thorough, excludes information written in HPI with “as in HPI” references, does not include any PE findings in ROS

Physical Examination: 0, 5, 10 points

0: none
5: incomplete, unorganized R
10: includes vitals, organized in appropriate order, thorough, mentions pertinent findings and pertinent negatives findings I

Summary Statement: 0, 5, 10 points

0: none
5: present but unorganized, does not include pertinent information or includes information that is not pertinent or incorrect I
10: organized, includes pertinent HPI, PE and data leading to differential diagnosis M

Problem list, Assessment/Plan with differential: total of 50 points

Problem list: 0, 2, 5 points

0: none listed
2: present but incomplete I
5: organized, thorough, complete; includes cc; in order of acuity M

Differential diagnosis: 0, 10, 20 points

0: none R
10: less than 3 items on differential I
20: at least 3 items on the differential, includes the cc as a problem for clinical reasoning M

Clinical reasoning: 0, 5, 10, 15, 20 points

0: none
5: minimal reasoning, does not list most likely diagnosis or must not miss diagnosis R
10: more thorough, but not organized into “differential, workup, treatment”
15: thorough and organized, works through differential, describes why and why not diagnoses should be considered, includes most likely diagnosis (and describes this), includes must not miss diagnoses when appropriate; organized into “differential, work up, treatment plan” format

20: differential and clinical reasoning “wows”; reasoning is advanced; M

**Overall organization and prioritization: 0-4 points**

Organized, extraneous information removed, edited information from auto-population

**Interpreter = 38-80**

**Manager = 81-100**

**Reviewer: __________________________**

**Total points & Grade: __________________**

Rusiecki J, Pincavage AT. University of Chicago Internal Medicine Clerkship, 2019.

Adapted with permission from: Bynum D, Colford C, McNeely D. Writer’s workshop: teaching preclinical medical students the art of the patient "write-up". MedEdPORTAL. 2014;10:9805.

HPI = ; PE = ; ROS = .
APPENDIX C.
EXAMPLE OF AN ASSESSMENT ITEM FOR THE DOMAIN OF “PATIENT ADVOCACY”

From the University of California School of Medicine, San Francisco (UCSF) Internal Medicine Clerkship, 2021.

Supplementary Reference