CLER

REPORT OF FINDINGS 2025:

PATIENT PERSPECTIVE OF THE CLINICAL LEARNING ENVIRONMENT

ACGME
Accreditation Council for Graduate Medical Education

CLER
Clinical Learning Environment Review

DEDICATION

The ACGME thanks the designated institutional officials at its accredited Sponsoring Institutions, as well as the executive leaders of the participating hospitals, medical centers, and ambulatory care sites, for graciously hosting this set of Clinical Learning Environment Review site visits. We appreciate the effort that went into arranging the visits and ensuring open access to residents, fellows, faculty members, and other staff. It was a privilege to spend time in your organizations, and we recognize your dedication to continually improving graduate medical education and patient care.

SUGGESTED CITATION:

Suggested citation: Ritenour, Chad W.M., Kevin B. Weiss, Robin Dibner, Nancy J. Koh, Robin C. Newton, Elizabeth Wedemeyer, Martha S. Wright, and Robin Wagner; on behalf of the CLER Evaluation Committee and the CLER Program. 2025. *CLER Report of Findings 2025: Patient Perspective of the Clinical Learning Environment*. Chicago, IL: Accreditation Council for Graduate Medical Education. doi: 10.35425/ACGME.0015

ISBN: 978-1-945365-51-5

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Acknowledgments

The ACGME acknowledges the many individuals involved in the Clinical Learning Environment Review (CLER) Program and in developing this report, including the CLER Program staff who collectively arranged and conducted the site visits, collated and analyzed the data, and provided editorial input; the members of the CLER Evaluation Committee who reviewed the results and offered their insights as to the impact of the findings; and Dr. Robin Dibner for her role in the initial development and implementation of the CLER patient perspective subprotocol. The ACGME thanks them for their dedication and commitment to improving graduate medical education and patient care.

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Special Note

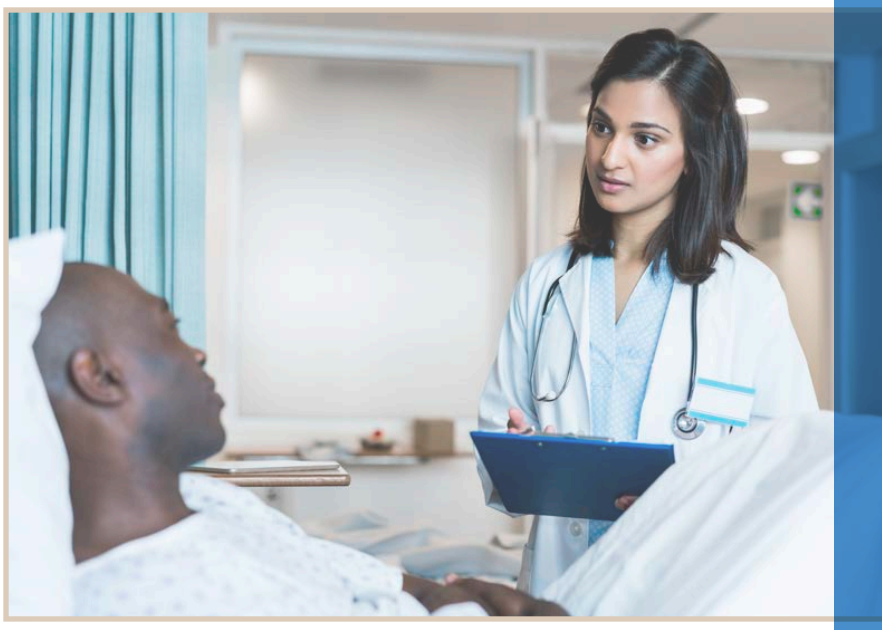
Between 2012 and 2025, the ACGME's Clinical Learning Environment Review (CLER) Program conducted site visits to assess graduate medical education (GME) engagement in important cross-cutting areas of focus such as patient safety and health care quality. The information gathered has revealed numerous opportunities for GME to partner with clinical learning environments (CLEs) to improve both learning and patient care. After four cycles of visits and several special protocols, the CLER Program concluded in late 2025.

Foreword

Chad W.M. Ritenour, MD, Co-Chair 2023-2024, Chair 2025, CLER Evaluation Committee

Since its inception in 2012, the ACGME's CLER Program has provided insights into the clinical settings that support GME and the dual goals of optimizing learning and improving patient care. In previous protocols, CLER site visit teams explored nearly all areas of hospitals in which resident and fellow physicians provide care with one exception: patient rooms. Interviewing patients and their families necessitates special considerations, coordination with hospital leadership, and additional time that is not built into the original design of a CLER site visit. For this subprotocol, the CLER Program crossed the threshold into patient rooms to speak with patients and families under the care of residents and fellows.

Although the body of literature in health care includes many publications on the patient experience, this report is unique in that it captures the perspectives of patients in hospitals that also serve as teaching environments. As this report's findings note, many patients cannot distinguish the roles of learners from roles of other members of the care team. In general, patients trust the care team as a whole to optimize their care and keep them safe. Viewing patient insights within the context of the CLE, as highlighted in this report, reveals many opportunities to improve the patient experience.



Some challenges noted in these findings are common across both teaching and non-teaching hospitals. These challenges are associated with issues such as staffing shortages, aging infrastructure, and rapidly expanding use of new technologies. Other findings identify ways in which teaching environments may add to the complexity of the patient experience.

Importantly, this report's discussion sections authored by the CLER Evaluation Committee note the vital role that GME leaders can play in partnering with CLE leaders to understand the complexities that contribute to a suboptimal patient experience. These leaders can engage residents, fellows, and faculty members in developing, testing, and implementing new approaches to address these challenges. As such, this report, which sheds light on the teaching hospital patient experience, is a valuable resource for both GME leaders and health care executives.

Introduction

Robin Wagner, RN, MHSA, Senior Vice President, Clinical Learning Environment Review, ACGME

Improving health care by enhancing resident and fellow education is the central mission of the ACGME, and the patient experience is fundamental to care. This report, which shares new findings from a special subprotocol that views the CLE through the lens of the patient experience, identifies challenges and opportunities to improve both learning and patient care. For the ACGME, it is the first protocol to collect real-time information from hospitalized patients. This pivotal moment completes the CLER Program's comprehensive assessment of CLEs in the United States.

This report highlights six key findings on the patient experience. Some findings expand on familiar challenges in areas such as:

- Patient involvement in decisions regarding their care;
- Clarity of physician communication; and,
- Perceptions of care coordination.

For example, this new report notes that CLEs vary in the level of patient involvement in decisions regarding their care. These findings are similarly supported in the *CLER National Report of Findings 2025*[1] from the perspective of the care team. Both sets of findings represent an opportunity for CLEs to set expectations that support the care team and include residents and fellows to better partner with patients to optimize understanding, compliance, and outcomes.

These findings also reveal challenges specific to GME including:

- Patient understanding of the roles of residents and fellows on their care team;
- Dissemination of patient experience data; and,
- Education on the concepts of patient- and family-centered care.

These findings note that, in general, residents and fellows were unfamiliar with results of the CLE's patient experience surveys. This finding highlights missed opportunities to improve care and prepare residents and fellows to engage with health care organizations to design adaptable, comprehensive solutions for rapidly changing environments.

For the majority of resident and fellow physicians, learning to interact with patients and their families is a core component of their learning experience. As such, their educational curricula focus on equipping them with communication skills to improve their patient interactions. However, the patient experience involves

much more than the fundamental set of interactions between physician and patient. To prepare for future practice, residents and fellows need to understand how to approach the patient experience as members of a larger interprofessional care team.

The Institute of Medicine identified five core competencies[2] key to the education of all health care professionals, specifically noting that to optimize care, all health professionals need to be educated to:

- Work in interdisciplinary/interprofessional teams;
- Deliver patient-centered care;
- Utilize evidence-based practice;
- Utilize informatics; and,
- Employ quality improvement approaches.

Considering the myriad interactions a patient experiences throughout the course of a hospital stay, this report provides important insights on how the entire CLE shapes those experiences and how GME may contribute to interprofessional systems-based solutions to achieve enhanced care and better outcomes.

Overview of the CLER Program

INTRODUCTION

The ACGME established the CLER Program in 2012[3] to provide GME leaders and executive leaders of hospitals, medical centers, ambulatory care sites, and other clinical settings with formative feedback aimed at improving patient care while optimizing learning in six cross-cutting areas of focus[4]: patient safety, health care quality (including health care disparities), supervision, well-being, professionalism, and a new focus area called Teaming.[a]

By conducting periodic CLER site visits and providing formative feedback to clinical sites that serve as CLEs for resident and fellow physicians, the CLER Program aimed to stimulate conversations and motivate CLEs to build upon their strengths and internally address opportunities for improvement. The ACGME refers to CLEs as living and breathing entities—the embodiment of all the individuals within these settings—that influence and imprint upon these early learners. CLER's formative approach recognized that, although there are shared elements, each site that serves as a CLE for resident and fellow physicians has a unique set of internal and external factors that influence the development and implementation of that CLE's strategic goals aimed at improving patient care.

AN IMPORTANT NOTE FOR THIS REPORT

This report contains aggregate, de-identified data not included in the CLER Program's verbal and written reports to the individual clinical sites. As a result, individual site visit reports may have been more neutral or positive in tone than what appears in the aggregate findings of this report. Therefore, even if the challenges identified in this report were not highlighted in an institution's individual site visit report, the challenges may apply to its CLE.

[a] This is a new focus area, introduced in *CLER Pathways to Excellence Version 2.0*. The concept of teaming recognizes the dynamic and fluid nature of the many individuals of the clinical care team who come together in the course of providing patient care to achieve a common vision and goals. It also recognizes the benefits of purposeful interactions that allow team members to quickly identify and capitalize on their various professional strengths and coordinate care that is both safe and efficient.

Methodology

INTRODUCTION

This report details findings of the first set of CLER site visits designed to understand the patients' perspective of the CLE.[b] Specifically, this special subprotocol explored whether patients:

- Perceive health care is delivered in a respectful environment;
- Know the physicians who are taking care of them;
- Receive care that incorporates the views of culturally heterogeneous patient populations;
- Perceive care provided is patient centered;
- Receive clear and consistent information from the clinical care team about their plan of care;
- Know how and are able to express their concerns regarding care provided by the clinical care team; and,
- Know how and are able to express their concerns regarding the well-being of their physicians and its potential impact on their care.

The CLER Program conducted these visits between October 10, 2023, and March 26, 2025. Findings are based on site visits to the major participating clinical sites (i.e., hospitals and medical centers) for 23 ACGME-accredited Sponsoring Institutions with three or more core residency programs.[5,6] These clinical sites serve as CLEs for the Sponsoring Institutions. In total, the CLER Field Representatives interviewed 1,129 inpatients, including non-English-speaking patients with access to interpreter services.

SELECTION OF CLINICAL LEARNING ENVIRONMENTS

The CLER Program administered the subprotocol to a sample of larger Sponsoring Institutions with ACGME-accredited programs. The subprotocol visit was conducted in parallel with a regular CLER site visit.

The CLER Program used a stratified sampling approach to obtain a sample that is representative of the larger Sponsoring Institution population, with a proportion of each stratum in the sample the same as in the population. For the purpose of this subprotocol, the sample was determined by three strata: geographic region, the number of ACGME-accredited programs, and the number of residents and fellows in ACGME-accredited programs.

Collectively, the 23 Sponsoring Institutions oversee 1,041 ACGME-accredited residency and fellowship programs, with a median of 22 programs per Sponsoring Institution. The number of residents and fellows in

[b] In the context of this report, "patient" can include family members, caregivers, patient legal representatives, and others.

ACGME-accredited programs ranges from 107 to 1,345 learners per Sponsoring Institution (median = 372).[c] The majority (43.5%) of the Sponsoring Institutions were general teaching hospitals, 34.8% were medical schools or health science centers, 4.3% were educational consortiums, and 17.4% were categorized as "other."

Approximately 31% of the CLEs were located in the Southern region of the United States, 26.1% in the Northeast, 26.1% in the Midwest, and 17.4% in the West. The sites ranged in size from 383 to 3,402 acute care beds (median = 799). More than half (59.1%) were non-government, not-for-profit organizations; 36.4% were government, non-federal; and 4.5% were investor-owned, for-profit.

CLER PATIENT PERSPECTIVE SUBPROTOCOL

The CLER patient perspective subprotocol was intended to supplement the observations of the main CLER site visit team. To conduct the subprotocol, two CLER Field Representatives—salaried employees of the ACGME—joined the main CLER site visit team. All visits lasted two to three days depending upon the number of programs and number of residents and fellows at the site.

The patient perspective subprotocol included a structured schedule of events for each visit. The subprotocol visit began with initial meetings with the designated institutional official and executive leadership—both with the main CLER site visit team. The purpose of these initial meetings was to allow the CLER site visit team to become familiar with the basic language and culture of the CLE's current activities in the six CLER Focus Areas.[7] This information helped inform subsequent interviews and observations throughout the CLER visit, including the patient perspective subprotocol portion of the visit. After meeting with executive leadership, the patient perspective subprotocol site visit team separated from the main CLER site visit team to continue with the subprotocol portion of the visit. Detailed descriptions of the methodology of the CLER Program, including the regular CLER site visit process, are available in the full *CLER National Report of Findings 2025*.[1]

Walking rounds on clinical units comprised a significant portion of the patient perspective subprotocol visit. Each CLER Field Representative conducted six sets of walking rounds per clinical site, with each walking round lasting 90 to 120 minutes. The number of clinical units visited per site ranged from 8 to 25, visiting only units where resident and fellow physicians provide care. One resident or fellow from a mix of ACGME-accredited residency programs and fellowships escorted each CLER Field Representative for each walking round.

The goal of the walking rounds was to prioritize brief interviews with patients in their inpatient rooms—aiming for 40 to 50 interviews per site visit. Nurse managers and charge nurses assisted the subprotocol site visit team in identifying patients who met the following criteria: (a) awake, alert, and oriented; (b) could understand and converse in English (or have access to interpreter services); (c) were stable enough and willing to participate in a 5- to-7-minute conversation; and (d) minimum length of stay of 1 day but did not exceed 10 days.

The visits also included a meeting with the CLE's leader responsible for patient experience as well as interviews with residents, fellows, and nurses on clinical units about their interactions with patients.

[c] Source: The ACGME annual data report. The ACGME annual data reports contain the most recent data on the programs, institutions, and physicians in graduate medical education as reported by all medical residency Sponsoring Institutions and ACGME-accredited programs.

All interviews were conducted using a standardized, structured questionnaire with open-ended questions that allowed for richer discussions and in-depth understanding of the experiences and perspectives of patients. Questions were developed under the guidance of patient experience experts, patient advocates, patient representatives, and experts in GME and/or the CLER Focus Areas. After the questionnaires were content validated by expert review, the CLER Program field tested the instruments on five CLER site visits. At the conclusion of each of these visits, the items were refined as part of an iterative design process. With each iteration, the CLER Program reviewed and revised the items as necessary based on feedback from interviewees and interviewers. In the end, the four questionnaires—one each for inpatients, patient experience leader/officers, residents/fellows, and nurses—consisted of 28, 12, 7, and 9 open-ended questions, respectively. The CLER Field Representatives documented all responses qualitatively.

Throughout each visit, the patient perspective subprotocol site visit team conducted huddles to discuss the information they had gathered. Later during the visit, they held a team meeting to synthesize their findings, reach consensus, and document their observations to eventually inform the findings in this report. At the end of the visit, the patient perspective subprotocol site visit team rejoined the main CLER site visit team for the exit meeting with executive leadership.

OTHER SOURCES OF DATA

Several other sources of data were used to augment site visit data, including the ACGME annual data reports[d] and the 2023 American Hospital Association (AHA) Annual Survey Database.[e] The ACGME reports provided information on the Sponsoring Institutions, programs, and physicians in GME, including the number of ACGME-accredited programs, number of residents and fellows matriculated, and university affiliations. The AHA data offered CLE information, including type of ownership (e.g., non-government, not-for-profit versus investor-owned, for-profit) and size, as measured by the number of staffed acute care beds.

DEVELOPMENT OF FINDINGS

Findings were determined in three stages. First, CLER Program staff asked each CLER Field Representative to identify key findings based on their summative experiences and observations through a key informant survey. CLER Program staff systematically analyzed the content of all responses to discern common themes and note salient concepts. The approach to analysis was inductive in that the themes emerged from the content of the responses.

Next, CLER Field Representatives reviewed and commented on the results and offered additional findings by consensus. Based on feedback from the CLER Field Representatives, CLER Program staff revised the summary of results and presented them to the CLER Evaluation Committee.[f] Lastly, both groups reviewed the results and developed a set of commentaries on the importance of the findings and their impact on patient care and physician education and training. The work of the committee and advisory group was achieved by consensus.

[d] The ACGME annual data reports contained the most recent data on the programs, institutions, and physicians in GME as reported by all ACGME-accredited Sponsoring Institutions and Programs. ACGME annual data reports were specifically generated for use by the CLER Program.

[e] The AHA Annual Survey Database includes data from the AHA Annual Survey of Hospitals, the AHA registration database, the US Census Bureau population data, and information from hospital accrediting bodies and other organizations.

[f] The CLER Evaluation Committee was the oversight body for the CLER Program and provided guidance on all aspects of program development.

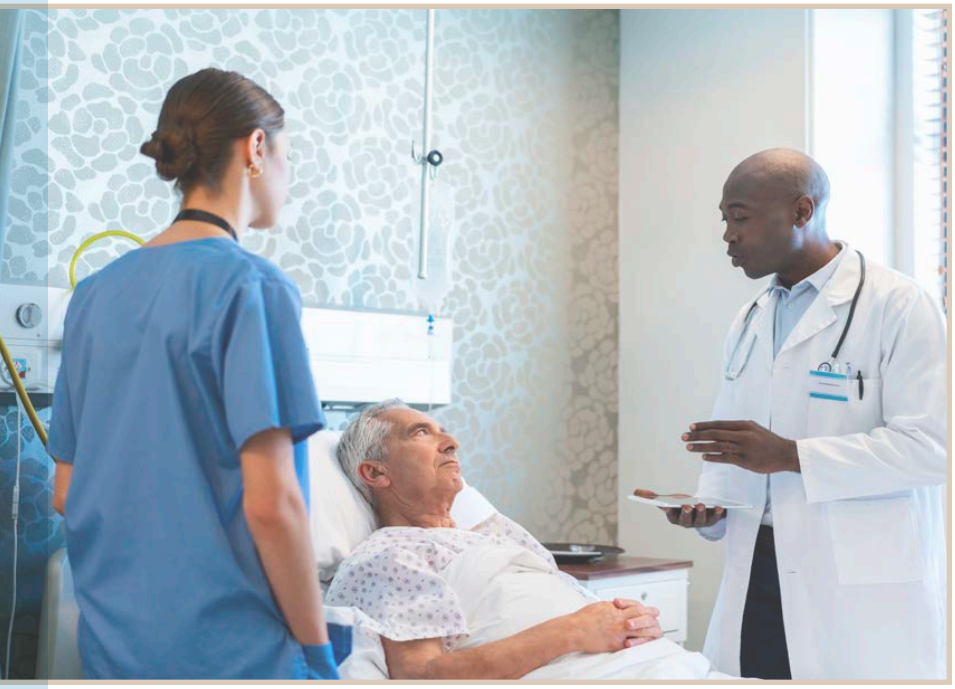
USE OF TERMS TO SUMMARIZE QUALITATIVE RESULTS

For the purposes of this report, a specific set of descriptive terms is used to summarize qualitative data (e.g., responses to open-ended questions during conversations on walking rounds) based on the CLER Field Representatives' assessment of the relative magnitude of responses. The following set of terms is intended to approximate the quantitative terms above: *uncommon or limited*, *occasionally*, *many*, and *generally*.

LIMITATIONS

As with any formative learning process, limitations to the CLER Program warrant consideration in using the information in this report. Perhaps most important, these findings do not suggest cause and effect.

Second, although this aggregated set of findings is designed to be highly representative, it is based on a series of sampled populations and thus may not be generalizable to all CLEs. Although the goal was to achieve a broad degree of representativeness, the sample may or may not reflect the entire population. Considering that the CLER Program engages in formative assessment, this approach to sampling allowed for a broad and in-depth understanding of socially complex systems such as CLEs. The CLEs that were not included in this sample may represent different experiences and consequently could yield different conclusions.



Key Findings

INTRODUCTION

The key findings appear in shaded boxes and are numbered for easy reference within the report; these numbers do not suggest order or importance. Each theme is accompanied by a discussion section, authored by the CLER Evaluation Committee, which highlights the finding's relevance to the GME community and the CLEs in which residents and fellows learn and train.

Finding 1: Few clinical learning environments appeared to have effective systems in place to ensure that patients[a] know the names and roles of the clinical care team members involved in their care.

Across clinical learning environments, many patients were unable to identify the physician in charge of their care and appeared to lack an understanding of the structure of their clinical care team, including roles and responsibilities. Many patients appeared to be unaware if residents and fellows were involved in their care and could not distinguish them from other physicians, learners, and health care professionals on their care team.

Across clinical learning environments, some patients noted that physicians and other health care professionals did not introduce themselves with a clear explanation of their roles on the care team. Some patients also expressed that it would have been helpful if the names and roles of their care team members were repeated throughout the course of care.

Methods (e.g., white boards, patient portals) implemented to assist patients with identifying the physician in charge and other members of the clinical care team had varying success. When these methods were consistently available to patients and updated with current and complete information about the clinical care team, some patients were more likely to identify the physician in charge and other members of the clinical care team. More patients appeared to be aware that residents and fellows were members of the clinical care team when name badges prominently displayed their role as a resident or fellow physician.

Patients receiving care from hospitalist-led teaching services faced an additional challenge to identifying the physician in charge as hospitalist physicians changed frequently during the course of their care.

Patients who knew the name of a physician were often limited to those who had undergone surgery or a procedure. Frequently, patients identified the physician who performed the procedure as the physician in charge even when these physicians were not the physician in charge or served as consultants.

[a] "Patient" can include family members, caregivers, advocates, patient legal representatives, and others.

Discussion

The finding that patients lack understanding of the roles and responsibilities of clinical care team members is not surprising. This is a long-standing challenge, especially in CLEs that host learners across multiple professions (e.g., medicine, nursing, pharmacy), as it may significantly increase the number of people interacting with a patient during their stay. This challenge is exacerbated by a host of additional factors such as staffing challenges, increases in patient volume and acuity, increasing subspecialty of care, evolving care models, and decreasing societal trust in the health care system.

Several years after the COVID-19 pandemic, many CLEs still face significant staffing shortages and increased patient volume resulting in increased use of temporary staff, higher nurse-to-patient ratios, and less time for practitioners to spend with patients. Many clinical sites are also experiencing sustained increases in patient acuity and complexity, necessitating numerous consultants (and associated resident and fellow consultants) to join the patient's clinical care team. Additionally, many of the evolving models of care, such as hospitalist programs and remote care and monitoring, contribute to the growing size of the clinical care team, especially when these models rely on shift work that results in frequent turnover within the team. All of these factors complicate and present possibly confusing and contradictory messages as to who is in charge of a patient's care. To facilitate trust in the care team, patients need to have a basic understanding of who cares for them and the various roles of those involved. This is particularly important for CLEs, as they have the added responsibility of helping patients understand the structure of a teaching environment.

To address this ambiguity, CLEs need to provide patients with tools to help them understand the various roles of members of their clinical care team and to be able to later recall them. Ideally, patients could have a range of tools, from low-fidelity options such as white boards and printed materials to more sophisticated, yet user-friendly options such as online pictures and charts that give them the ability to see connections among various members of the clinical care team. Importantly, to be effective, these tools need to be continually updated and used by all members of the clinical care team.

Patients can benefit from one or two members of the clinical care team they can clearly identify as being in charge of their care so they can partner with them to exchange and synthesize information and engage in decision making. Importantly, CLEs need to develop a mechanism early in the care process so patients know who is overseeing their overall coordination of care, who to reach out to for questions, and who to partner with in decision making. New technologies have enormous potential to aid in this process. CLEs need to recognize, anticipate, and capitalize on new technologies becoming available at an accelerated pace. However, adoption needs to be paced to allow for testing and evaluation to minimize unintended consequences. New technologies need to be rolled out so that patients and members of the clinical care team can understand and embrace them in a manner that benefits all.

Lastly, CLEs need to evaluate and build upon the successes of approaches currently in place and continually develop, test, implement, and evaluate new approaches to optimize communication with patients. The CLE's comprehensive plan for patient communication needs to include standardized training for certain elements of communication, such as introductions. For this element, CLE and GME leaders and leaders of other professions with learners at the clinical site need to partner and decide on a common approach to describing the clinical site as a teaching and learning environment. Subsequently, they need to design and implement education for residents, fellows, other learners, and their mentors such that introductions and descriptions of the CLE are consistently and regularly communicated during all patient interactions.

Building and maintaining a comprehensive strategy to help patients understand who cares for them and the overall structure of their clinical care team is an important investment for CLEs. Doing so has the potential to deliver tremendous returns, as optimizing patient understanding relieves anxiety, improves treatment plan adherence, and builds trust between the patient and the health care system that will better serve both into the future.

Finding 2: Across clinical learning environments, patients' involvement in planning and making decisions about their care varied across services.

Across clinical learning environments, patients indicated that their physicians informed them about their plan of care. With the exception of a few services (e.g., obstetrics, oncology, palliative care), patients did not indicate being presented with treatment options and alternatives or being asked for their input on decisions related to their plan of care during their hospitalization. Occasionally, patients stated that their personal beliefs and preferences (e.g., religious beliefs, cultural preferences, preferred language and provision of interpreter services) were neither elicited nor integrated into the clinical care process.

Few clinical learning environments had explicit expectations that team rounds involve patients. It appeared that patient involvement in team rounds varied across and within clinical learning environments (e.g., by service area, unit, attending physician). When discussions about the plan of care included patients, this most often occurred when team rounds were conducted at the bedside. Not infrequently, patients indicated that rounding occurred early in the morning, impacting their ability to focus and understand information, which in turn made it difficult for them to engage in the discussion.

Among the patients who were aware of residents and fellows assisting their physician in charge, some indicated that the attending physician and residents would round together each day to discuss their plan of care. A limited number of patients mentioned that these rounds included nurses and other members of the clinical care team. Many nurses indicated that daily team rounds with the attending physician did not routinely occur and that the attending physician would round separately. Many nurses also noted that they were not involved in bedside rounds when the patient's plan of care was discussed, and that they learned about the plan by contacting the physician or reading the patient's chart.

Discussion

In many CLEs, competing pressures such as increased numbers of patients, documentation demands, and emphasis on timely discharge can unintentionally impact the clinical care team's prioritization of the discussion of patient health care preferences and potentially threaten patient autonomy. The downstream consequences of this can lead to an erosion of patient trust in their physicians, which can negatively influence treatment plan adherence and suboptimal patient care outcomes.

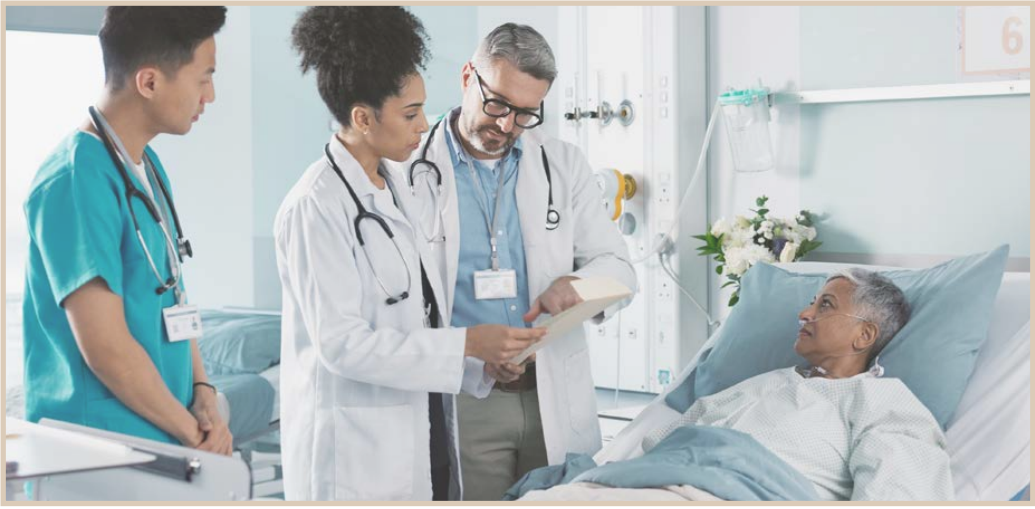
Explaining options for care in a way that is easily understood can facilitate patient-physician discussion; patient agreement to the treatment plan; and, consequently, patient-centered outcomes. CLEs need to set the expectation that treatment options will be discussed and patient preferences will be elicited to enhance

the patient's experience of care. The findings from this subprotocol note that there were clinical services that appear to routinely discuss treatment preferences (e.g., obstetrics, oncology, palliative care). CLEs might benefit from adapting and spreading the successful practices from these clinical services to the entire clinical care team. CLE and GME leaders also need to ensure that faculty members educate and train residents and fellows to pay careful attention to a patient's preferred language, religious beliefs, cultural preferences, and physical and mental capacity to establish and maintain a trusting patient-physician relationship.

Use of strategies such as closed-loop communication, inquiring about the patient's opinions instead of asking if the patient has questions, and using "teach back" to ensure comprehension can promote open conversation. Careful listening when patients question a decision can further contribute to meaningful discussions and sometimes change the care plan. Structured clinical care team rounds (e.g., attending physician, residents, fellows, nurses) at the bedside with patients participating in their care plan and asking questions ensures the patient's perspective is heard by everyone involved in their care and the plan of care is uniformly understood. These skills and practices are crucial if patients are to be involved in planning and making decisions about their care. Thus, it is important that CLEs ensure that residents, fellows, and other new learners develop skills in patient-centered care and apply these practices as part of their education and training.

As mentioned earlier, productivity issues can result in patient-physician time constraints, making discussions on alternative care plans and patient preferences challenging. CLEs would benefit from standardizing development and implementation of support system strategies (e.g., gathering information about patients' religion, cultural practices, living situation) among other clinical care team members to facilitate patient-physician discussions. Involving residents, fellows, and other members of the clinical care team in this way enhances the information obtained to formulate a patient's plan of care.

Lastly, pressures placed on a patient's clinical care team to decrease length of stay can lead to discharge orders being written without giving patients an opportunity to discuss their specific circumstances such as their home environment, support system, access to resources, and potential barriers to recovery. This in turn can lead to patient (and caregiver) anxiety, frustration, and readmission. Although certain members of the clinical care team may be the primary facilitators of a patient's discharge needs, it is important that CLEs ensure that all clinical care team members, including residents and fellows, understand these needs through conversations with the patient and caregiver prior to discharge. Ideally, such conversations would begin upon admission.



Finding 3: While patients indicated that their physician(s) communicated in a way to help them understand the plans for their care, it was not uncommon for patients to ask nurses to clarify or repeat their plans for care.

Many patients indicated that their physician(s) clearly communicated the plans for their care and encouraged them to ask clarifying questions. There were a few patients who also mentioned that there had been times when their physician(s) made them feel uncomfortable about asking questions, noting that their physician(s) seemed rushed, impatient with repeated questioning, or spoke in a way that was perceived to be condescending.

When patients indicated that they asked their nurse to repeat, explain, or confirm what the physician(s) said about the plans for their care, they noted reasons such as having questions after their physician(s) left their room, needing time to process the information received, needing the information repeated given the volume of information received, or feeling overwhelmed by the complexity of the information received. A limited number of patients noted that this was due to the physicians' use of medical jargon or unfamiliar terminology.

There were patients who mentioned that their physicians, nurses, and other members of the clinical care team sometimes provided conflicting or contradictory information about their plan of care. This situation was commonly described by patients who had multiple specialties involved in their care. Patients recognized that these situations represented lapses in communication between clinical care team members.

Discussion

Effective patient-physician communication has been shown to be a critical factor in patients' satisfaction with medical care.[8] Suboptimal communication—either with patients or between clinical care team members—has been noted to be a cause of medical errors, contribute to patient harm, and negatively impact quality and efficiency of care.[9] There are many challenges to effective communication with patients. For physicians, these may include lack of time, inconsistent inclusion of team members and families in rounds, and variable availability and utilization of interpreter services. For patients, the factors may include hesitancy about asking questions of physicians, cognitive overload exacerbated by illness and medications, limited health literacy, and barriers to accessing interpreter services.

Physician communication may be particularly problematic when patients are cared for by multiple specialty teams providing co-management or consultative services. This can be further compounded by the complexity of patients and prevalence of hospitalist services. Patients in the CLE also face the additional challenge of receiving communication from numerous physicians at varying levels of education, training, and experience. One outcome of ineffective patient-physician communication is redundancy of work, such as nurses spending time repeating or explaining information provided by physicians or asking residents and fellows to return to address patient questions or concerns.

There are evidence-based approaches to improving patient-physician communication and physician-care team communication. To optimize physician communication with patients, CLEs need to ensure members of

the clinical care team, including residents and fellows, are learning to use simple tools such as repetition, limiting the volume of information shared at each encounter, and employing "teach back" to ensure patient understanding. This finding also presents an opportunity for CLE and GME leaders to consider how technology can further assist with visual aids, videos, reading materials at the bedside, and remote interpreter services to enhance patient-physician communication. Patients' access to their medical records via portals allows patients and physicians another option for communication. CLEs need to provide patients with education on the effective use of the portal. This is also a chance to engage residents, fellows, and other frontline staff members in CLE efforts to assess and improve use of patient portal technology toward the goal of improving communication and optimizing the patient experience.

One of the most studied approaches to improving patient-physician and physician-care team communication is interprofessional team rounds conducted at the bedside involving patients and families.[10] In the CLE, the presence of larger and more complex teams, including residents, fellows, and learners from other professions, requires thoughtful structuring of these rounds. To do so, CLEs need to ensure increased coordination between interprofessional team members to provide patients with consistent information regarding their care and to prevent patient confusion and loss of trust. This is especially important for residents, fellows, and other new learners, as interprofessional rounds offer a structured setting to learn how to effectively communicate, coordinate care, and make joint decisions with other members of the clinical care team—valuable skills they can draw upon throughout their professional careers.

Finding 4: Across clinical learning environments, there were patients who perceived a lack of coordination among their physicians in planning their care.

Among patients with complex conditions who were receiving care from multiple specialties, some indicated that the physicians did not appear to coordinate their care. There were patients who expressed frustration when different physicians provided conflicting information about their care plan. Patients noted that gaps in coordinating care led to delays in diagnosis and treatment and limited the efficiency and effectiveness of their care.

Discussion

Patient care coordination in the clinical care setting is increasingly challenging due to the complexity of both the health care system and the patients it serves. Clinical sites are dynamic, complex environments where care must rapidly adapt to evolving clinical circumstances. Patients have become medically complex over time,[11] requiring the involvement of multiple consultant specialists. While the expertise of consultants enhances care, it can also introduce more opportunities for miscommunication, delays, and inefficiency. Compounding the issue, physician-to-physician communication may not be in-person or direct. Instead, it often occurs asynchronously through electronic medical records, secure text messaging, or is relayed by nursing staff, creating the potential for gaps in closed-loop communication.

For patients, understanding and navigating such systems can be frustrating. There is often a disconnect between patient expectations and the realities of health care. Patients and families may assume that

all clinicians involved in their treatment are in continuous, direct communication and share a unified understanding of a patient's condition. However, consultants typically provide recommendations specific to their specialty area, and coordination across specialties requires active synthesis by the primary team in the context of patients' goals and preferences. Additionally, for patients with chronic diseases who are accustomed to long-standing relationships with outpatient providers, hospitalization can feel especially disjointed unless a deliberate effort is made to integrate inpatient and outpatient perspectives across the continuum of care.

Inconsistent care coordination can have significant consequences. Medical errors become more likely when information is lost, delayed, or miscommunicated. Patients may experience delays in both care and discharge. Patient trust and confidence in the health care system may erode, ultimately compromising patient adherence and outcomes. Frustration and anger may follow when patients feel confused after receiving conflicting messaging from different physician members of the care team.

It is essential for CLEs to ensure that clinical care team members inform patient expectations through proactive communication. Patients need to be informed about how their care team functions, who is responsible for what, and how communication flows between clinical care team members. Empowering patients and families to ask questions and seek clarification can help bridge communication gaps and foster trust.

Because residents and fellows often serve as frontline physician communicators with patients and families, they are positioned to help patients navigate these complex systems. They are often expected to keep patients informed about the evolving aspects of their care and address concerns as they arise. When coordination falters—such as unclear roles among specialists, delays in communication, or ambiguity in consult recommendations—residents and fellows are among the first to encounter patient and family frustration. Furthermore, they are often members of consulting services themselves, and their ability to engage in timely, respectful, and direct communication with the primary team may help improve quality of care.

CLE and GME leaders have a shared responsibility to support the development of care coordination skills. GME leaders need to ensure that residents and fellows receive formal education and training on interprofessional communication, role clarity, and systems-based practice. It is essential that faculty members actively role model these behaviors so residents and fellows can subsequently apply this education and training in their practices. Additionally, CLE and GME leaders need to collaborate in developing consultation policies that set clear expectations for direct, physician-to-physician communication, particularly between members of consulting and primary teams. Such structural improvements enhance care delivery and foster a culture of accountability, professionalism, and shared responsibility in patient care. Together, CLE and GME leadership can foster a culture in which coordinated, patient-centered care is not only expected but actively taught, practiced, and reinforced across all levels of residency and fellowship.

Finding 5: In general, residents and fellows appeared to be unfamiliar with patient experience data and did not use this information for the purpose of improving patient care.

Across clinical learning environments, patient experience officers indicated that patient experience data are provided to clinical unit leadership and department chairs to disseminate. In most of these instances, it was the responsibility of each clinical unit and department to use this information to improve patient care. Some of the patient experience officers mentioned targeted programs or initiatives aimed at improving patient care based on the results of patient experience data.

Most residents and fellows were unfamiliar with patient experience surveys, the information collected, and how this information could be used to improve patient care. In general, residents and fellows had not participated in a quality improvement project using patient experience data.

Discussion

The hospitals, medical centers, and other clinical settings that serve as CLEs collect data related to the patient experience for the purpose of improving patient care. These data can be used for benchmarking against other institutions, identifying best practices, and driving quality improvement initiatives. Patient experience data can also have a direct economic impact on CLEs through the Centers for Medicare & Medicaid Services' Hospital Value-Based Purchasing Program in which higher scores in patient experience result in higher reimbursement rates to clinical sites.[12]

As this finding highlights, most residents and fellows do not understand the implications of patient experience data, the direct impact of patient experience data on clinical site finances, and the relevance of patient experience data to their daily work. The broad nature of patient experience surveys (e.g., addressing issues ranging from clinical site cleanliness to communication across a range of health care professionals) contributes to the confusion. Additionally, due to the nature of these surveys, there are challenges to attributing care to a specific physician or a specific clinical service involved in a patient's care.

Even in CLEs in which sharing data with physicians is a priority, this information is frequently distributed to service line and department leaders without including GME leaders, further limiting resident and fellow awareness of these data. In addition, CLE initiatives intended to improve patient experience are often oriented to nurses and other health care professionals rather than physicians.

This finding identifies the need for the GME community to improve partnerships with CLE leaders overseeing the patient experience. Working together, CLE and GME leaders need to routinely provide patient experience data to residents and fellows, develop a structure to educate them on the implications and use of the data, provide a framework to help them interpret the data, and make available opportunities for them to problem solve and work collaboratively with other health care professionals to bring about improvements in patient experience and the delivery of patient care. Educating and engaging residents and fellows in efforts to improve the patient experience will enhance their understanding of value-based care, clinical site finances, and the importance of positive patient experiences in enhancing patient retention and attracting new patients.

Finding 6: Across clinical learning environments, a limited number of residents and fellows received formal education on patient- and family-centered care.

In general, residents and fellows appeared to be unfamiliar with the term patient- and family-centered care. If residents and fellows were aware of this term, they mentioned informal education and training when rounding on patients (e.g., attending role modeling) or as part of orientation. Few residents and fellows could recall the details of the education and training. Residents and fellows generally described education on including patients and families in discussions about the plan of care.

Discussion

Patient- and family-centered care (PFCC) is an approach to health care that involves partnering with patients and their families to improve health outcomes and satisfaction by emphasizing care that is respectful of and responsive to individual patient preferences, needs, and values to guide clinical decisions.[13,14] The core concepts of PFCC focus on respect and dignity, information sharing, participation, and interprofessional collaboration.[14] Nearly 25 years ago in the report, *Crossing the Quality Chasm*, the Institute of Medicine identified patient-centeredness as one of the aims for improving health care systems.[15] As emphasized in the report, the tenets of involving patients in their health care decisions, better informing them of treatment options, and improving access to information remain critical in advancing patient care.

Over the years, there has been an increasing awareness that the experience of care as perceived by patients and families is a key factor in improving health care quality and safety.[16,17] Incorporating PFCC into resident and fellow education and training needs to be viewed as foundational to physician practice. Educating and training residents and fellows in PFCC will result in improved communication, teamwork, and shared decision-making skills as well as improvements in care efficiency and the quality and safety of patient care (e.g., decreases in overuse of health care resources, improvements in care efficiency).[18] This in turn will lead to improved patient experience and outcomes (e.g., increased patient satisfaction, better patient adherence to treatment plans), reduced health care costs, and a more positive and supportive environment for patients.[19] Simultaneously, improving the environment for patients will improve the environment for learners.

Integrating PFCC into resident and fellow education and training needs to include, but is not limited to:

- Incorporating PFCC principles and practices into the curriculum through didactic lectures and simulation activities;
- Providing experiential learning opportunities for residents and fellows to practice PFCC skills through direct patient care experiences;
- Pairing residents and fellows with experienced faculty members who model PFCC behaviors and provide guidance; and,
- Regularly soliciting feedback from patients, families, and interprofessional team members to assess resident and fellow performance to identify areas for improvement.

The role and commitment of CLE and GME leaders are essential in creating the infrastructure to develop and support resident and fellow skills in PFCC. CLE and GME leaders need to consider (1) strategies to implement PFCC in the learning environment, such as expanding upon existing patient and family involvement occurring in services and units at the clinical site; (2) integrating didactic education at the bedside for residents, fellows, and other learners; and (3) how to embed PFCC concepts and practice in day-to-day patient care and teaching. Equipping resident and fellow physicians with the necessary skills to provide high-quality PFCC will ultimately lead to a safer and more effective health care system.

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ISBN: 978-1-945365-51-5