COMMUNITY FACULTY HANDBOOK
DEPARTMENT OF FAMILY MEDICINE
THIRD-YEAR CLERKSHIP

Department of Family Medicine Website (http://fammed.utmb.edu/)

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</tr>
</tbody>
</table>

We highly recommend the book *Teaching in Your Office: A Guide to Instructing Medical Students*, (2nd ed.) by Patrick C. Alguire, MD; Dawn E. DeWitt, D MSc; Linda E. Pinsky, MD; Gary S. Ferenchick, MD (Eds.) We have a limited number of copies and would be happy to send you one for your office.

Handbook Revised 1/6/2017
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LETTER OF INTRODUCTION

Dear Family Medicine Community Faculty Member,

We are so grateful to all of our community-based and campus faculty who dedicate their time and effort to teaching our medical students during their required 3rd-year clerkship. Our students are enthusiastic in their appreciation of how much each of you contributes to their learning the complexities of ambulatory care in the Family Medicine clinic context.

To better assist you in maintaining and further improving your teaching skills, we are launching updates over a series of months for the "Teaching Guidelines" section of our Community Faculty Handbook that will contain brief, helpful reminders of ways of teaching in the office. Some of these may be new to you, other things you already do. In any case, since each student is different, each faculty’s office and practice unique, we will try to offer the broadest range of proven teaching tips and skills.

Any of you that have the book, Teaching in Your Office by Algire et al will have seen some of the tips and skills we will be suggesting, as this is an excellent reference for this arena. If, like me, you put it up on a shelf and haven’t looked at it for a while, dust it off and see if there is something that can refresh your teaching.

When you next take a student, you will have the opportunity to receive a copy free of charge or if you have taken a student in the last year, we would be happy to send you a copy. Also, for those of you who are new to teaching in the office, or even for some of you veterans, we have a limited number of subscriptions to an online teaching program offered by the Society of Teachers of Family Medicine. This is called The Teaching Physician and offers tips, skills, videos, and other tools to help you become a better teacher. If you wish to obtain access to this helpful database, please notify Layne Dearman (lmdearman@utmb.edu).

We do so appreciate your efforts to train the physicians of tomorrow.

Sincerely,

Barbara L. Thompson, MD
Chairman, UTMB Health
Department of Family Medicine

Victor S. Sierpina, MD
Clerkship Director, UTMB Health
Department of Family Medicine


2The Society of Teachers of Family Medicine: www.teachingphysician.org

utmb.edu The University of Texas Medical Branch | Member, Texas Medical Center
<table>
<thead>
<tr>
<th>Activity</th>
<th>When</th>
<th>Physician Responsibility</th>
<th>Supplementary Materials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orientation</td>
<td>1st day student is with you</td>
<td>Provide orientation to practice, including your expectations of student; work up schedule with student</td>
<td>Read Guidelines for Community Faculty and Students</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Review printout from student’s Clinical Encounters Logbook</td>
<td>Every few days</td>
<td>Check logbook for accuracy and to determine how assignments should be adjusted to meet objectives</td>
<td>Read Clinical Encounter Logbook</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Mid-clerkship Feedback Meeting            | End of Week 2 or beginning of Week 3 | • Schedule specific time for session  
• Review Weeks 1 & 2 with student  
• Provide student with feedback  
• Review the problems students has seen  
• Set goals for remainder of clerkship  
• You and student sign form  
• FAX form to office | See Mid-Clerkship Feedback Form on website  
Review Family Medicine Common Problem List |
|                                           |                               |                                                                                         |                                                               |
| Online Clinical Performance Evaluation    | End of Clerkship              | Completed electronically                                                                   | See Sample Online Clinical Performance Evaluation on website   |
1. Physician is in good standing with the Texas Medical Board with no history of issues.

2. MD is board certified by the American Board of Family Medicine; DO is AOA Board Certified.

3. Physician is full-time and sees between 20-30 patients in an ambulatory setting per day (full-time physicians often take 1/2-day off during the week)

4. Physician sees a broad range of FM-type problems and patients of a broad age range. The purpose is for the student to have good exposure to what Family Medicine is like.

5. Physician is willing to allow students to do history and physicals and to present the cases to them (including differential diagnosis and management plan); physician is willing to allow student to do this with 5-7 patients per half-day.

6. If it is a group practice, there is one FM physician willing to accept responsibility as the primary preceptor. This physician is willing to take the time to teach the student, provide feedback on a daily basis assessing the student’s clinical skills, and complete:
   a. Mid-Clerkship Feedback Form - to discuss your assessment of the student’s progress during weeks 1 and 2. Complete the mid-clerkship rating form and sign. Fax to clerkship office.
   b. Online Clinical Performance Evaluation is completed online at the end of the clerkship. You will receive further instructions by email at the end of the rotation about access.

If the physician agrees to take a UTMB-FM student, then the coordinator will follow up with a confirmation by mail 3-4 weeks prior to the start of the rotation. UTMB requires teachers of medical students to have a faculty appointment with the sponsoring department. Additional information will be requested to begin this process.

Our website contains the current Faculty Handbook for community preceptors and the course syllabus and forms for students. https://ifammed.utmb.edu/predoc_clerkship/Default.aspx
The quality of the clerkship is determined by the quality of our Community Faculty and the quality of the interaction each student has with you as a faculty.

A. Welcome and Introduction
   1. Inform your patients that you are currently supervising a student.
   2. Introduce the student to the office staff; make the student feel welcome. Discuss with the student the title by which he/she is to be addressed.

B. A Good Beginning
   Students will be coming into the clerkship with differing skills, clinical experiences, and expectations. The Community Faculty should:
   - Review the Family Medicine clerkship course goals and objectives
   - Review the evaluation forms

C. Orientation – Guidelines for Student
   Establish the ground rules when the student arrives, including:
   - Student’s role in your practice; your expectations of how the student should “fit in”
   - Hours the student is expected to be in the office; the schedule the student should follow
   - Office dress, appearance (refer to the Clerkship Policies section in this handbook)
   - The weekly and daily schedule (if you are off one afternoon per week, allow the student the same)
   - Procedure if student or is ill or cannot be in the office (refer to the Clerkship Policies section in this handbook)
   - Student responsibilities for hospital rounds, if applicable
   - Student “on-call” responsibilities, if applicable
   - Any other policies of which student should be made aware

D. Orientation - Educational Assessment
   With the student:
   - Review which clerkships and/or educational experiences the student has completed prior to taking the family medicine clerkship
   - Formulate with the student 2-4 specific learning objectives to accomplish during the clerkship

E. Orientation - Office (and Hospital)
   1. Office
      - Show the student the “office space” and the rest of your office
      - Introduce the student to your staff and describe their responsibilities; include how the student should address your office staff
Orient the student to the standard operating procedures, i.e., appointments, medical records and where/how to make entries

Discuss the characteristics of your patient population

Instruct the student in patient protocol

Describe your special interests and skills, i.e., sports medicine, occupational health, OB, geriatrics

Show the student:
  - Where to park
  - Office lab and procedure room
  - Reference materials
  - Where to place their belongings
  - Computer that may be available to student

2. Hospital, if applicable – show the student:

- Where to park
- How to use the paging system
- Medical record organization and where/how to make entries, if allowed
- Location of special areas, i.e., ER, x-ray, nursery, doctors’ lounge, cafeteria

F. Student Involvement with Patients - Allow the student to be involved in the care of at least 100 patients in the office during the rotation

- For the first few days have the student “shadow” you and assist you with patient encounters. Talk with the student about each patient, ask questions, and assess the student’s fund of knowledge.
- As you become more comfortable with the student allow them to interview the patient, perform focused exam, and develop an assessment and plan
- Be sure to observe the student at intervals during the clerkship.
- Ensure the student is conducting appropriate health care assessments and providing correct information to patients.
- Continue to ask questions which challenge the student’s thinking and fund of knowledge throughout the clerkship.
  
  **Be sure to include questions about pharmacology and pathophysiology.**

- Encourage the student to read about all problems on the “Problem List,” as well as other problems encountered.
- Review the Patient Encounter Logbook for accuracy and revise the student’s patient assignments, as necessary

**NOTE:** At **NO TIME** should the student be given direct patient care responsibility without the community faculty being immediately accessible.

G. Provide Feedback to the students:

Spend time each day giving prompt and constructive feedback.

- Evaluate the student’s performance during the clerkship
  
  - Informally on a day-to-day basis give feedback about areas in which the student needs improvement, as well as areas in which the student is doing well.
o Formally, at mid-clerkship (the end of the second week) complete the Mid-clerkship Feedback form and review it with the student

o Formally, at the end of the clerkship, as soon as possible complete the online Clinical Performance Evaluation

H. Complete the electronic Clinical Performance Evaluation within one week of completion of the clerkship. Be sure to include your comments about the student on the online evaluation. (Review with the student in paper form prior to completing online, if possible.)

I. Other Information You May Want to Cover
- Interests and activities of both you and the student
- Family and other important people
- Places to eat near your office
- Other things of interest around town

GUIDELINES FOR THE STUDENT’S ROLE IN THE OFFICE

The student’s role should be as an active participant rather than a passive observer. The student is expected to be an independent learner who will read about patient problems as they present in the office and at other sites; special emphasis should be placed on the symptoms/diagnoses that are in the lists of Acute and Chronic Disease Presentations found in this guide.

The student is expected, under the supervision of the physician, to:

- work up and follow patients assigned by you and function as a provider of health care

- perform an appropriate focused history and physical exam based on the chief complaint, assess health risks, formulate a differential diagnosis, and plan further investigations and/or treatments

- order appropriate tests, write prescriptions and provide patient education, with the physician’s approval

- dictate or write progress notes in the appropriate SOAP format at the completion of the patient’s visit if appropriate at your site

- see the patient for follow-up, if the visit is scheduled while the student is still with the physician

Students are expected to accurately record their level of participation in all patient experiences.

- Full Participation = elicited HX, performed PE, and participated in medical decision-making

- Partial Participation = any one or two of the three mentioned previously

A minimum of 100 patients must be seen in the outpatient setting. Most students will record 135-175 patient encounters. A maximum of three problems or diagnoses that are actively addressed in a patient experience may be recorded for any one encounter. We hope students see between 5-7 patients per half day and work up to full participation for the majority of the patient encounters. Most students need time to process what they are seeing and to look up information on the cases to help prepare for the exam. You may want them to see every other patient or set up another system that you and the student work out. They are student learners and time for reading and researching patient problems is important. We hope they are capable of full participation in most, if not all, cases by Week 2 of the clerkship.
THE COURSE

OVERVIEW OF CLERKSHIP

Duration: 4 weeks

The discipline of Family Medicine encompasses a body of knowledge and an approach to the practice of medicine which are unique. Family Medicine considers the patient in a comprehensive and holistic manner. Health care is encompassed within the context of the individual's environment, including family, vocation, culture, beliefs and community, and provides comprehensive, continuous cost-effective care across the age span.

ADMINISTRATION AND CONTACT INFORMATION

The clerkship is under the direction of the Medical Student Education Committee of the Department of Family Medicine at UTMB. The clerkship administrative staff is primarily responsible for the day-to-day administration of the clerkship.

- Department of Family Medicine, 2.234 Primary Care Pavilion, Galveston, TX  77555-1123
  phone: 409-772-3126  fax: 409-772-4296  http://fammed.utmb.edu

- Victor Sierpina, MD, Director, Medical Student Education; Co-Director, FM Clerkship vssierpi@utmb.edu

- Jennifer Raley, MD, Co-Director, FM Clerkship jraley@utmb.edu

- (Ms.) Layne M. Dearman, B.S., Clerkship Coordinator lmdearma@utmb.edu

The Department of Family Medicine Medical Student Education Committee determines the goals and objectives for the clerkship and makes decisions about other academic matters related to the course. Members include Cassandra Arceneaux, M.D., Kyu Jana, M.D., Julie McKee, M.D., Jennifer Raley, M.D., and Victor Sierpina, M.D.
CLERKSHIP OBJECTIVES

The overall goal of the family medicine clerkship is to provide an outstanding learning experience for all medical students.

THE GOALS OF THE FAMILY MEDICINE CLERKSHIP

- Demonstrate the unequivocal value of primary care as an integral part of any health care system.
- To teach an approach to the evaluation and initial management of acute presentations commonly seen in the office setting.
- To teach an approach to the management of chronic illnesses that are commonly seen in the office setting.
- To teach an approach to conducting a wellness visit for a patient of any age or gender.
- Model and discuss the principles of family medicine care.
- Provide instruction in historical assessment, communication, physical examination, and clinical reasoning skills.
- Discuss the principles of family medicine care.
- Discuss the critical role of family physicians within any health care system.

STUDENT LEARNING OBJECTIVES FOR THE FAMILY MEDICINE CLERKSHIP

At the end of the Family Medicine Clerkship, each student should be able to:

- Gather information, formulate differential diagnoses, and propose plans for the initial evaluation and management of patients with common presentations.
- Evaluate patients having one or more common chronic diseases.
- Develop evidence-based health promotion/disease prevention plans for patients of any age or gender.
- Demonstrate competency in advanced elicitation of history, communication, physical examination, and critical thinking skills.

PRINCIPLES OF FAMILY MEDICINE

The family medicine method of delivering health care was developed in the late 1960s at the inception of the specialty. The specialty embraced continuity and comprehensiveness and placed an emphasis on the patient’s perspective within the context of family and community. These concepts were echoed in the Future of Family Medicine document published in 2004. Most recently, these principles are embodied within the concept of the Patient-centered Medical Home. Medical students should learn this method of care, study our philosophy of practice, and observe our passion for our work.

- The bio-psychosocial model
- Comprehensive care
- Continuity of care
- Contextual care
- Coordination/complexity of care
COMMUNICATION

It is important for students to check email and maintain contact with Family Medicine and the UTMB-Galveston campus. We also encourage you to email us with questions and to let us know how things are going.

If the student encounters any problems or conflicts that interfere with learning, they should discuss them with you. Most problems or concerns at the practice site should be discussed with the physician supervisor. Other problems or concerns can be discussed with the Clerkship Coordinator or the Clerkship Director at UTMB (409) 772-3126.

PROFESSIONALISM

As with any clinical clerkship, students are to accept the dual responsibilities of student and trusted member of the health care team.

Students are expected to abide by the Honor Code and all policies of the School of Medicine and the Family Medicine Clerkship. This includes being on time, being prepared to learn, checking email daily, being informed of all expectations, and the timely completion of all assignments. In the clinical setting, this includes appropriate interaction with patients and staff, appearance, punctuality, reliability, and responsibility.

UTMB Student Honor Pledge
On my honor, as a member of the UTMB community,
I pledge to act with integrity, compassion and respect
in all my academic and professional endeavors.

Professionalism is formally evaluated by the community faculty using the electronic Clinical Performance Evaluation at the end of the clerkship. Failure to receive a satisfactory rating on all aspects of professionalism may result in failure of the clerkship. Instances of unprofessional conduct should be reported to the clerkship office immediately (409) 772-1395.

ABSENCE POLICY

Family Medicine adheres to the UTMB School of Medicine Student Absence Policy.

Students are expected to attend all required activities. An absence is any instance when a student is not physically present at an activity. Absences are considered acceptable only when:

1. Unavoidable and anticipated, as in a residency interview or presentation at a professional meeting. Students are strongly encouraged to schedule interviews during vacation periods to avoid conflict with scheduled courses.

2. Unavoidable and unanticipated, as in personal illness or family tragedy.

In the event of any absence, students must (in advance when anticipated, and as soon as possible when unanticipated):

1. Notify their supervising faculty (e.g. facilitator, clinical attending, or preceptor); and

2. Notify the FM Medical Student Education Program Administrative Staff: Layne M. Dearman lmdearma@utmb.edu and/or Shannon Samuelson sosamuel@utmb.edu. Any absence from the clerkship must be approved by the clerkship administrative staff.
SCHEDULES – DAILY AND WEEKLY

A reasonable workday can begin as early as 7:00 am and may not end until 7:00 pm. Actual hours vary by site and the schedule of the community faculty. Schedules are often variable, with more hours on one day or week and less on another. Students are expected to follow the schedule set up by the supervising clerkship physician.

The student is expected to see patients in the office of the community faculty no less than 4 and preferably 4 ½ days per week during Weeks 1-3 of the Clerkship (excluding holidays.) The ½-day off each week should be the same as the community faculty’s. The student should use this time to complete assignments, to maintain the Clinical Encounter Logbook, to read and study. Personal time off requested by the student should be scheduled during the non-clinical time.

UTMB requires students to have a minimum of one day free of clinical responsibility per week and should not work more than 60 hours per week.

Students are expected to be in clinic during week four of the rotation until the assigned release time, usually 5:00 PM of the final Wednesday. A weekly schedule should be negotiated between the community faculty and the student at the beginning of the rotation.

GRADE TABULATION

<table>
<thead>
<tr>
<th>Component</th>
<th>Weight</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Performance Evaluation - completed by Preceptor(s) online. If more than one form is completed, scores are averaged.</td>
<td>65%</td>
<td>The raw score must be 61% or above in order to pass.</td>
</tr>
<tr>
<td>NBME Subject Exam – Family Medicine</td>
<td>25%</td>
<td>The raw score must be 60 or above in order to pass.</td>
</tr>
<tr>
<td>DAC Case Quiz</td>
<td>10%</td>
<td>Satisfactory completion of all 8 cases and the DAC quiz by 4th Monday of rotation.</td>
</tr>
<tr>
<td>Clinical Encounter Logbook (New Innovations)</td>
<td>NA</td>
<td>NI Patient Logbook should be current for the previous week each Sunday by midnight. Minimum of 100 patient encounters required.</td>
</tr>
<tr>
<td>Other assignments and quizzes</td>
<td>NA</td>
<td></td>
</tr>
</tbody>
</table>

The final grade is obtained by applying the weights as described above to the scores for the component assessments. Final grades are assigned as follows:
- **Honors** - a final grade of 91 or above and no documented concerns related to professionalism
- **High Pass** - a final grade of 87 to 90
- **Pass** - a final grade of 70 to 86

HOUSING

Housing is provided at a few sites. If housing is requested and available, students are given information about contacts for housing via our website.

DRESS

Students are expected to dress professionally during the clerkship. Their white coats should be clean, pressed, and worn at all times when they are involved in patient care. They will be expected to conform to the standards of dress at your site and abide by your expectations.
Patients at all sites should be told that students may be involved in their care. The students should always wear their UTMB name tag and introduce themselves as medical students working with the practice as a part of their medical studies at UTMB.

ADVERSE WEATHER

In the event of severe weather, students should refer to the following websites for the latest weather conditions, when to return to work and/or school, and other pertinent information.

- The UTMB Homepage: http://www.utmb.edu
- The School of Medicine Website: http://www.som.utmb.edu
- Alert Website: www.utmb.edu/alert
- UTMB Emergency Hotline (409) 77-ALERT (772-5378) or toll free (888) 772-5549
COURSE REQUIREMENTS FOR STUDENTS

CLINICAL ENCOUNTER LOGBOOK

Maintaining a logbook is a requirement of the LCME (Liaison Committee on Medical Education, an organization that accredits medical schools.) The purpose is to document whether or not the student is seeing the appropriate range of problems, seeing the appropriate number of patients, and is involved in the patients’ care as required by the Clerkship. Each encounter must include the visit date, setting, a primary problem, secondary and tertiary problems if applicable, and the level of care provided by the student. No patient identifiers are included.

The Community Faculty is encouraged to review the logbook. Ask the student to print a summary report for you. You could include the logbook review at the end of each day or week with the student as part of the wrap-up.

ASSIGNMENTS & QUIZZES

Students will be expected to complete assignments during the ½-days off and on weekends during the clerkship, not during time in the clinic. (You are not expected to review them; this will be done by the department faculty.)

CLINICAL REASONING INSTRUMENT (CRI) ASSIGNMENT

The goal of this tool is to assist medical students in organizing data, synthesizing their ideas, and thinking critically. Weekly during Weeks 2, 3, and 4, students will see a patient and record data from the interview and physical exam into the form. Form, sample, and additional instructions are emailed to Community Faculty members prior to the student’s arrival. The student will return 3 forms to the coordinator at their final exam. (The students have access to the CRI form. It is their responsibility to make sure this assignment is completed.)

ORTHOPEDIC RUBRICS FOR BACK, SHOULDER, AND KNEE EXAM

Please observe the student performing a physical exam for back pain and one for either the shoulder or knee. Your student will have a form for you to complete, provide feedback, and sign. (It is the student’s responsibility to make sure this assignment is completed and turned in.) If you are interested in reviewing any of the videos we provide the students for learning how to do these exams, here is the link: http://designacase.org/clerkshipvideoseries.asp

MID-CLERKSHIP FEEDBACK MEETING

Complete the mid-clerkship rating form (see website) face to face at the end of the 2nd week of the Clerkship. This is a very important time for you to discuss your assessment of the student’s progress during weeks 1 and 2 and to make plans with the student to meet the course objectives, as well as the student’s learning goals, during the final two weeks of the clerkship.

Mid-Clerkship feedback is an important part of the formative evaluation of students during their Family Medicine Clerkship.

- Please take time to complete the mid-clerkship form mindfully and honestly with the students.
- In general, it is better to mark the mid-clerkship form a little lower as appropriate rather than higher to prevent frequent grade appeals by disappointed students.
- Discuss and document how the student can demonstrate improvement.
- Follow up with the student giving verbal feedback on how they are improving or in areas still needing attention which may affect their final evaluation.
This kind of feedback also gives them specific areas to work on during their last two weeks as there is always room for improvement. Note: Prior to the Mid-Clerkship Feedback Conference, the student should print out a current report from their logbook for your review.

**CLINICAL PERFORMANCE EVALUATION**

The clinical performance portion of the grade will be determined from scores on the electronic Clinical Performance Evaluation for the Family Medicine Clerkship. You will complete this electronically on the New Innovations website at the end of the clerkship. A sample of this form is included on our website. You will receive further instructions by email at the end of the rotation about accessing this secure site.

We encourage all students to schedule a final evaluation feedback session with you, similar to the formative mid-clerkship evaluation, on the last Wednesday of the clerkship. If asked, please take the time to review a printed copy of the final Clinical Performance Evaluation form with your student. The form will not be "official" until you enter the information into the online system when the form opens. This process will allow a final face to face feedback opportunity for the students.

**NBME SUBJECT EXAMINATION**

On the last day of the clerkship, students will sit for the NBME Subject Examination in Family Medicine. This examination is administered under NBME guidelines and protocols.

**FAMILY MEDICINE COMMON PROBLEM LIST**

The Family Medicine Common Problems (Lists of Acute and Chronic Disease Presentations) consist of problems commonly seen in family practice – specific examples of each general problem are provided for illustrative purposes. Students are expected to have patient experiences that will include all of these general problems. If the student has not seen specific examples of one or more of the general problems by the time of the Mid-Clerkship Feedback Conference – and you as community faculty feel they are not likely to in the time remaining – they should let the administrative staff know. The following tables are reprinted from the Family Medicine Clerkship Curriculum with permission from the Society of Teachers of Family Medicine.
### Table 3: Core Acute Presentations With Common Diagnosis, Serious Diagnoses, and Topic-specific Objectives

<table>
<thead>
<tr>
<th>Topic*</th>
<th>Common</th>
<th>Serious</th>
<th>Topic-specific Objectives</th>
<th>Additional Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upper respiratory symptoms</td>
<td>Infectious (viral upper respiratory infection, bacterial sinusitis, streptococcal pharyngitis, otitis media, and mononucleosis) and noninfectious cause (allergic rhinitis)</td>
<td>• Recognize that most acute upper respiratory symptoms are caused by viruses and are not treated with antibiotics. • Determine a patient’s pretest probability for streptococcal pharyngitis and make an appropriate treatment decision (eg, empiric treatment, test, or neither treat nor test). (PBLI)</td>
<td>Detect a fracture on standard radiographs and accurately describe displacement, orientation, and location (eg, nondisplaced spiral fracture of the distal fibula).</td>
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<tr>
<td>Joint pain and injury</td>
<td>Ankle sprains and fractures, knee ligament and meniscal injuries, shoulder dislocations and rotator cuff injuries, hip pain, Carpal Tunnel Syndrome, osteoarthritis, and overuse syndromes (eg, Achilles’ tendinitis, patello-femoral pain syndrome, subacromial bursitis, rotator cuff tendinosis)</td>
<td>• Describe the difference between acute and overuse injuries. • Elicit an accurate mechanism of injury. • Perform an appropriate musculoskeletal examination. • Apply the Ottawa decision rules to determine when it is appropriate to order ankle radiographs. (PBLI)</td>
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<tr>
<td>Pregnancy (initial presentation)</td>
<td></td>
<td>• Recognize that many family physicians incorporate prenatal care and deliveries into their practices, and studies support this practice. • Recognize common presentations of pregnancy, including positive home pregnancy test, missed/late period, and abnormal vaginal bleeding. • Appreciate the wide range of responses that women and their families exhibit upon discovering a pregnancy. (PR)</td>
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<tr>
<td>Abdominal pain</td>
<td>Gastro-esophageal reflux disease (GERD), gastritis, gastroenteritis, irritable bowel syndrome, dyspepsia, constipation, and depression. Appendicitis, diverticulitis, cholecystitis, inflammatory bowel disease, ectopic pregnancy, and peptic ulcer disease</td>
<td>• Recognize the need for emergent versus urgent versus non-urgent management for varying etiologies of abdominal pain.</td>
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<tr>
<td>Common skin lesions</td>
<td>Actinic keratosis, seborrheic keratosis, keratoacanthoma, melanoma, squamous cell carcinoma, basal cell carcinoma, warts, and inclusion cysts</td>
<td>• Describe a skin lesion using appropriate medical terminology.</td>
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<tr>
<td>Common skin rashes</td>
<td>Atopic dermatitis, contact dermatitis, scabies, seborrheic dermatitis, and urticaria</td>
<td>• Describe the characteristics of the rash. • Prepare a skin scraping and identify fungal elements.</td>
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<tr>
<td>Abnormal vaginal bleeding</td>
<td></td>
<td>• Elicit an accurate menstrual history. • Recognize when vaginal bleeding is abnormal.</td>
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<tr>
<td>Topic*</td>
<td>Common</td>
<td>Serious</td>
<td>Topic-specific Objectives</td>
<td>Additional Skills</td>
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<tr>
<td>Low back pain</td>
<td>Muscle strain, altered mechanics including obesity, and nerve root compression</td>
<td>Anerysm rupture, acute fracture, infection, spinal cord compromise, and metastatic disease</td>
<td>• Describe indications for plain radiographs in patients with back pain. (PBL1)</td>
<td>Conduct an appropriate musculoskeletal examination that includes inspection, palpation, range of motion, and focused neurologic assessment.</td>
</tr>
<tr>
<td>Cough</td>
<td>Infectious (pneumonia, bronchitis, or other upper respiratory syndromes, and sinusitis) and non-infectious causes (asthma, GERD, and allergic rhinitis)</td>
<td>Lung cancer, pneumonia, and tuberculosis</td>
<td>• Understand how pretest probability and the likelihood of test results altering treatment can be used to guide diagnostic testing. (PBL1) Recognize pneumonia on a chest X ray.</td>
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<tr>
<td>Chest pain</td>
<td>Gastrointestinal (eg, GERD), musculoskeletal (eg, costochondritis), cardiac (eg, angina and myocardial infarction), and pulmonary (eg, pulmonary embolism, pneumothorax)</td>
<td></td>
<td>• Describe how age and comorbidities affect the relative frequency of common etiologies.</td>
<td>Recognize cardiac ischemia and injury on an electrocardiogram (EGD).</td>
</tr>
<tr>
<td>Headache</td>
<td>Tension, migraine, and sinus pressure headaches</td>
<td>Meningitis, subarachnoid hemorrhage, and temporal arteritis</td>
<td>• Determine when imaging is indicated.</td>
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<tr>
<td>Vaginal discharge</td>
<td>Urotritis, bacterial cystitis, pyelonephritis, prostatitis, and vulvovaginal candidiasis</td>
<td></td>
<td>• Discuss the interpretation of wet prep and potassium hydroxide (KOH) specimens.</td>
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<tr>
<td>Dysuria</td>
<td>Urotritis, bacterial cystitis, pyelonephritis, prostatitis, and vulvovaginal candidiasis</td>
<td></td>
<td>• Discuss the interpretation of wet prep and potassium hydroxide (KOH) specimens.</td>
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<tr>
<td>Dizziness</td>
<td>Benign positional vertigo (BPV), labyrinthitis, and orthostatic dizziness</td>
<td>Cerebral vascular disease (CVA), brain tumor, and Ménière's Disease</td>
<td>• Discuss the interpretation of wet prep and potassium hydroxide (KOH) specimens.</td>
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<tr>
<td>Shortness of breath/wheezing</td>
<td>Asthma, chronic obstructive pulmonary disease (COPD), obesity, angina, and congestive heart failure (CHF)</td>
<td>Exacerbations of asthma or COPD, pulmonary embolus, pulmonary edema, pneumothorax, and acute coronary syndrome</td>
<td>Recognize typical radiographic findings of COPD and CHF.</td>
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<tr>
<td>Fever</td>
<td>Viral upper respiratory syndromes, streptococcal pharyngitis, influenza, and otitis media</td>
<td>Meningitis, sepsis, fever in the immune-suppressed patient</td>
<td>• Describe a focused, cost-effective approach to diagnostic testing. (SBP)</td>
<td>Propose prompt follow-up to detect treatable causes of infection that appear after the initial visit. (SBP)</td>
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Table 3: (Continued)

<table>
<thead>
<tr>
<th>Topic*</th>
<th>Common</th>
<th>Serious</th>
<th>Topic-specific Objectives</th>
<th>Additional Skills</th>
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<tbody>
<tr>
<td>Depression: initial presentation</td>
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<td>• Appreciate the many presentations of depression in primary care (e.g., fatigue, pain, vague symptoms, sleep disturbance, and overt depression).</td>
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<td>• Use a validated screening tool for depression (SSPI).</td>
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<td>• Assess suicidal ideation.</td>
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<td>• Recognize when diagnostic testing is indicated to exclude medical conditions that may mimic depression (e.g., hypothyroidism).</td>
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<td>• Recognize the role of substance use in depression and the value of identifying and addressing substance use in depressed patients.</td>
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<td></td>
<td>• Recognize the potential effect of depression on self-care and ability to manage complex comorbidities.</td>
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<td>Male urinary symptoms/precipitate</td>
<td></td>
<td>Select appropriate laboratory tests for a male patient with urinary complaints.</td>
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<tr>
<td>Dementia</td>
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<td>• Perform a screening test for cognitive decline (e.g., the clock drawing test or the Mini-Mental Status Examination).</td>
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<td>• Select appropriate initial diagnostic tests for a patient presenting with memory loss, focusing on tests that identify treatable causes.</td>
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<tr>
<td>Leg swelling</td>
<td>Venous stasis and medication-related edema</td>
<td>Deep versus thrombosis (DVT), obstructive sleep apnea, and CHF</td>
<td>• Recognize the need for urgent versus nonurgent management for varying etiologies of leg swelling, including when a Doppler ultrasound test for DVT is indicated.</td>
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</tbody>
</table>

* Ordered from most to least common based on numbers of ambulatory care visits to primary care offices according to diagnostic groups; United States 2005–2006 (National Health Statistics Reports No.8, August 2008).
† Musculoskeletal examination to include inspection, palpation, range of motion, assessment of commonly injured structures (e.g., ligaments of the ankle and knee, rotator cuff in the shoulder), and assessment of neurovascular integrity.
PBLI—problem-based learning and improvement, PR—professionalism, SBP—system-based practice.
<table>
<thead>
<tr>
<th>Topic*</th>
<th>Topic-specific Objectives</th>
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</table>
| Multiple chronic illnesses (e.g., depression, hypertension, hypothyroidism, type 2 diabetes mellitus) | • Assess status of multiple diseases in a single visit.  
• List important criteria to consider when prioritizing next steps for management of patients with multiple uncontrolled chronic diseases.  
• Document an encounter with a patient who has multiple chronic diseases using a SOAP note and/or chronic disease flow sheet or template. |
| Hypertension | • Take an accurate manual blood pressure.  
• Recognize the signs/symptoms of end-organ disease. |
| Type 2 diabetes mellitus | • Perform a diabetic foot examination.  
• Document an encounter using a diabetes mellitus flow sheet or template. (SBP)  
• Recognize the signs/symptoms associated with hypoglycemia or hyperglycemia. |
| Asthma/chronic obstructive pulmonary disease (COPD) | • Discuss the differences between asthma and COPD, including pathophysiology, clinical findings, and treatments.  
• Elicit environmental factors contributing to the disease process.  
• Recognize an obstructive pattern on pulmonary function tests.  
• Recognize hyperinflation on a chest radiograph.  
• Discuss smoking cessation. |
| Hyperlipidemia | • Determine a patient’s cholesterol goals based on current guidelines and the individual’s risk factors.  
• Interpret lipid laboratory measurements. |
| Anxiety | • Describe how an anxiety disorder can compromise the ability for self care, function in society, and coping effectively with other health problems. |
| Arthritis | • Guide a patient in setting goals for realistic control of pain and maximized function. |
| Chronic back pain | • Obtain a medication use history.  
• Anticipate the risk of narcotic-related adverse outcomes.  
• Guide a patient in setting goals for pain control and function. |
| Coronary artery disease | • Identify risk factors for coronary artery disease.  
• Use an evidence-based tool to calculate a patient’s coronary artery disease risk.  
• Counsel patients on strategies to reduce their cardiovascular risks. |
| Obesity | • Obtain a dietary history.  
• Collaborate with a patient to set a specific and appropriate weight loss goal. |
| Heart failure (HF) | • List underlying causes of HF.  
• Recognize the signs/symptoms of HF.  
• Recognize signs of HF on a chest radiograph. |
| Depression (previously diagnosed) | • Assess suicide risk.  
• Describe the impact of depression on a patient’s ability for self care, function in society, and management of other health problems. |
| Osteoporosis/osteopenia | • Recommend prevention measures. |
| Substance use, dependence, and abuse | • Obtain an accurate substance use history in a manner that enhances the student-patient relationship.  
• Differentiate among substance use, misuse, abuse, and dependence.  
• Discuss the typical presentations for withdrawal from tobacco, alcohol, prescription medications, and common street drugs.  
• Assess a person’s stage of change in substance use/abuse cessation.  
• Communicate respectfully with all patients about their substance abuse. (PR) |

* With the exception of multiple illnesses (unknown) and osteoporosis (estimate), these are ordered from most to least common based on numbers of ambulatory care visits to primary care offices according to diagnostic groups, United States 2005–2006 (National Health Statistics Reports No. 8, August 2008).

PR—professionalism, SBP—systems-based practice
TEACHING GUIDELINES

RECOMMENDED RESOURCE

We highly recommend the book *Teaching in Your Office: A Guide to Instructing Medical Students*, second edition by Patrick C. Alguire, MD; Dawn E. DeWitt, MD MSc; Linda E. Pinsky, MD; Gary S. Ferenchick, MD. We have a limited number of copies and would be happy to send you one for your office.

STUDENTS’ SKILLS TO OBSERVE

(Problem areas to observe and address if needed)

- Failure to drape patient
- Listening to heart and lungs through gown
- Failure to wash hands before examining patient
- Palpates thyroid incorrectly
- Uses ophthalmoscope incorrectly
- Uses otoscope or tongue blade improperly
- Listens to only one or two areas of the lung
- Conducts incomplete abdominal exam
- Palpates and percusses liver and spleen incorrectly
- Improper technique or incomplete cardiovascular exam
- Palpates peripheral pulses incorrectly
- Has no eye contact with the patient
- Allows no personal space for patient; student towers over patient
- Failure to listen to the patient
- Lectures the patient
- Uses medical jargon when talking with the patient
- Performs inadequate review of systems
- Uses rough physical contact with the patient
IDEAS FOR EFFICIENT AND EFFECTIVE TEACHING

Because teaching takes time in an already busy practice, here are some tips from Teaching in Your Office to help you keep up with patient flow while offering the student a worthwhile learning experience:

- **The Focused Half Day**—review the schedule and use it as a table of contents to plan teaching issues
- **Presenting in the Room**—save time, spend more face-time with the patient, involve the patient in education as well as their care and use them to verify information by having the student present the case in the patient room
- **Collaborative Examinations**—the learner and faculty see the patient simultaneous and you observe some aspect of the history or physical examination while role modeling clinical skills
- **Active Observation**—critical elements that make this different than mere shadowing are describing the rationale for the observation, declaring what the learner should observe, reviewing what was observed, and allowing the learner an opportunity to practice
- **Dual Teaching**—providing the patient education with the learner there or having the learner summarize the visit and educational issues while the faculty observes
- **Service-Based Education**—put the student to work as part of the health care team by having them do tasks done by others in the office such as vitals, diabetic foot exams, following up on labs and phone calls, triaging, filling out forms, administering vaccines, doing EKG’s, answering point of care learning issues by looking them up on line
- **Just-in-Time Learning**—have the student look up a learning issue and read about it while you go on to see another patient or two
- **Self-Directed (Independent) Learning**—stimulate reflection and promote reading and study about cases seen by asking the student to identify learning issues, questions, concerns, areas for improvement. You might make an educational prescription and have the student report back to you.

Most likely, you already use some of these methods or a mixture of them. Consider initiating a couple that you haven’t tried out and see how they work.


TEACHING SKILLS AND ORGANIZATIONAL TECHNIQUES FOR OFFICE-BASED TEACHING

**Meaningful Responsibility** for an effective learning experience

- Vary responsibility according to learner’s level of training
- Give learners the opportunity to see patients independently, collect data, and make preliminary decisions
- Allow for “legitimate peripheral participation” — learners also learn from observation of clinician in action.

**Characteristics of Effective Teachers**

- Communicate expectations clearly and explicitly.
- Select appropriate patients for the learner, tailored to student and patient, to maintain clinic flow and efficiency. Difficult patients with psychosocial issues may not be appropriate for novice learners and may generate patient complaints.
• Stimulate interest enthusiastically, by making learning fun, enjoyable, and exciting.
• Interact skillfully with patients. This may also “set the stage” for learners so they can actively observe, describe what occurred, and practice the skill.
• Involve the learner in the teaching process.
  o Ask the learners to identify their own learning needs.
  o Give learners assignments to address learning needs. (self-directed learning)
  o Give educational prescriptions that include task, time frame, and how it should be completed.
  o Model patient-centered clinical problem solving.
• Limit the number of teaching points; do not overwhelm the learner.
• Role model desired behaviors to help shape values, attitudes, behaviors, and ethics of learners.
  o Stress doctor-patient relationship, spend time on psychosocial aspects, give in-depth and specific feedback, build relationships with learners, and create a non-threatening learning environment.
• Provide opportunities to learn and practice clinical skills.

For Learners Who Need Help Organizing the Office Visit
• Use Focused Scripts for acute and chronic conditions (see reference p. 139-140)
• Prime learners for a visit. Provide learners with critical information to help initiate the visit. For example, ask patient to generate differential diagnosis of the chief complaint, and review pertinent history and physical related to the chief complaint
• Frame the visit. Set parameters for the visit, including expectations and time limits, for the learner to accomplish a focused task.
• Use Data collection scheme for learners:
  o What? Elicit patient’s agenda, “What should we talk about today?”
  o Why? Elicit patient’s understanding of the problem, “What do you think is causing this?” Identify likely hypothesis and supporting data, “What is the supporting evidence?”
  o What else? Generate a prioritized and weighted differential diagnosis, “What is the supporting evidence?”
  o What now? Determine next steps: “What history, physical, and tests need to be done? Treatment options? Patient education?


CASE BASED LEARNING

What is Case-based Learning?

Traditionally in case-based learning, a learner presents a case to you after they independently gather patient data. You then create educational opportunities for them that both relate to the case and provide care for the patient. This is usually accomplished by techniques such as role modeling, questioning, modeling problem solving, and encouraging self-directed learning.
The Microskills Model (One-Minute Preceptor):

This model developed utilizes five microskills to address what the learner does and does not know, instruct the learner, and to provide feedback more efficiently. These skills include:

- **Get a commitment**: “What do you think is going on with this patient?”
- **Probe for supporting evidence**: “Why do you think that?”
- **Teach general rules**: “Always do this when you see a similar case.”
- **Reinforce what was done right**: “Here is what you did right, and this is why.”
- **Correct mistakes**: “I will tell you what you can do better.”

The “Aunt Minnie” Model:

An alternative to the traditional case-based learning approach, this is a teaching model based on pattern recognition. i.e. If she talks, walks, and dresses like Aunt Minnie - she probably is Aunt Minnie! In this model, the learner presents only a chief complaint, and a probable diagnosis. This allows the teaching-learning dialogue to focus on problem solving rather than a detailed history and physical. If learners seem to be making incorrect “snap judgments” with this model, you can always convert back to a more thorough evaluation of traditional case-based questioning and detailed history and physical.

Modeling Problem Solving:

This technique is best utilized during encounters with particularly complex patients, and can be thought of as “thinking out loud.” By verbalizing your thoughts when reviewing your differential diagnoses, considering risks and benefits of specific treatments, or providing rationale behind orders, you role model sound critical thinking skills, while also educating patients if done within the patient room. In addition, this approach allows you the opportunity to model the specific skills with which you would expect the learner to present subsequent patients.

The One-Minute Observation:

The one-minute observation is a strategy that allows a preceptor to focus on one specific clinical skill per patient encounter. This approach allows learners to get feedback on one aspect of a physical exam or history taking - without the commitment by the teacher of large blocks of clinical time. The most beneficial benefit to this strategy is the ability of learners to receive immediate first-person feedback.

Learner-Centered Precepting:

- The presentation begins and ends with the learner’s question to the preceptor.
- The learner begins with a question that guides the preceptor’s teaching and after providing all the important patient information needed by the preceptor to understand the case, the learner then reiterates a more specific statement of the question. For example the learner first presents the patient’s identifying data and the patient’s main concern. At this point the learner asks a general question such as “My question is…about the best medication for this patient’s rheumatoid arthritis…”.
- After completing the presentation of the patient including history, physical, most likely diagnosis, and initial plan, the learner formulates a specific targeted question about the knowledge, skills, or logistical information that he or she needs to care for the patient such as “Is drug ‘X’ a good medication for the patient given the lack of response he had to the other medications I listed?”
SNAPPS Model of Learner –Centered Precepting:

The student is expected to take the lead role in moving through these steps. Initially this may require support and coaching from the preceptor.

- **Summarize briefly the history and findings.** *This shouldn’t take more than 50% of total encounter.*
- **Narrow the differential to two or three possibilities**
- **Analyze the differential by comparing and contrasting the possibilities**
- **Probe the preceptor by asking questions about uncertainties, difficulties, or alternative approaches**
- **Plan management for the patient’s medical issues.** *The plan is modifies as needed by the preceptor with an explanation to the learner.*
- **Select a case related issue for self-directed learning.** *Learners should keep track of learning issues by noting them on a n index card or personal digital assistant. The preceptor may wish to do the same in order to facilitate follow-up with the learner.*

**Reflection:**

Reflection moves away from addressing the clinical facts of the case and toward discussions of deeper and often more meaningful content that focuses on the professional development of the learner. Three keys to successful reflection:

1. **Being a good role model;**
2. **Gaining the trust of the learners;**
3. **Having skills to facilitate reflection.**

Some good examples of questions leading to reflection are: “What did you mean by that?”, “You seem concerned about the last patient”, and “So what did this patient teach us”. Reflection explores emotion, interpersonal relationships and topics related to professionalism.

**Pitfalls of Case Based Learning:**

Some common pitfalls occur when the preceptor is:

- **Taking over the case**
- **Asking too many questions**
- **Not allowing sufficient “wait time”** *(interrupting)*
- **Inappropriately giving lectures.** *Give information in small ‘bites’*  
- **Asking questions with “preprogrammed answers”** *(the question suggests the answer.) Make the student think.*
- **Pushing the learner past his or her ability**
- **Not giving feedback**
APPENDIX:

EXAMPLES OF PHARMACOLOGY AND PATHOPHYSIOLOGY QUESTIONS
to ask the student during the rotation:

- What are the different classes of anti-hypertensive medications?
- What are the common side effects seen in each class?

FORMS

The following forms are found on the Family Medicine Online Clerkship website:
https://ifammed.utmb.edu/predoc_clerkship/Default.aspx

- Mid-Clerkship Rating Form
- Clinical Performance Evaluation-Sample

UTMB SOM FACULTY APPOINTMENT PROCESS

UTMB now requires every community preceptor who teaches our students to have a faculty appointment. Once the process is complete, you will receive an appointment to the faculty of the School of Medicine at UTMB as a Clinical Assistant Professor (non-tenure track) from the Department of Family Medicine in recognition of your commitment as a student preceptor. With this academic appointment, we welcome you as a formal partner in helping UTMB educate the next generation of physicians.

To initiate the process for your appointment, please contact Layne Dearman by email lmdearma@utmb.edu or phone 409-772-1395. There are several forms to complete and supporting documentation needed. A completed criminal background check is required prior to beginning this appointment. UTMB HR takes care of this process and there is no cost to you.

We have purchased a subscription for you to an innovative web resource to enhance your teaching skills. It is a production of the Society of Teachers of Family Medicine entitled, Teaching Physician (available at TeachingPhysician.org). The site offers videos, tips, answers to frequently asked questions, and links to in-depth information on clinical teaching topics. We hope this subscription will provide you with quick answers to questions that arise during your daily interaction with learners. You can earn up to 40.5 CME credits FREE by exploring the useful information on this website. Your subscription starts once your appointment process is complete. You will receive additional information at that time.
INFORMATION FOR COMMUNITY PRECEPTORS

UTMB Office of Clinical Education

UTMB Community Teaching Physicians

UTMB is grateful for all of the physicians across the state of Texas who volunteer to teach UTMB medical students. This page is designed to be an information resource for all UTMB community teaching physicians.

UTMB Community-Based Courses

Search for UTMB courses that require community-based teaching physicians.

Benefits of becoming a UTMB Community Teaching Physician

Most medical student preceptors are volunteer preceptors that offer their time to medical schools and their students. This link provides information on the perks that UTMB offers to physicians who teach for the Practice of Medicine 1 Course (POM1), the 3rd year clerkships, and the 4th year Ambulatory/Community Selective (ACS)

Faculty Development Modules

The Office of Clinical Education has developed informational presentations on topics in medical education which we hope community-based teaching physicians will find useful. Even if stated in the modules, CME credit is no longer available for these modules. We invite you to review the modules and provide feedback.

- The Community Physician’s Role in Medical Education
- Providing Feedback and Evaluation
- Applying Teaching and Learning Styles
- Defining Professionalism
- The Role of Medical Education in Career Advancement
- Information about Becoming a Medical Student Preceptor

We welcome your feedback on the above modules

Evaluation - The Community Physician’s Role in Medical Education
- Evaluation – Providing Feedback and Evaluation
- Evaluation – Applying Teaching and Learning Styles
- Evaluation – Defining Professionalism

UTMB Top Doc Award

UTMB Faculty, course coordinators and AHEC coordinators will be asked to nominate Community Teaching Physicians that have excelled in teaching UTMB medical students. This link will tell you more about the annual "Teacher of Distinction" award.

If you are interested in becoming a UTMB School of Medicine preceptor, or need information about the courses which utilize community-based preceptors, please contact Brian Sullivan.

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THE TEACHING PHYSICIAN ARTICLE “PATIENT WITNESSED PRECEPTING”

Excerpted from “For the Office-based Teacher of Family Medicine”
Patient Witnessed Precepting: Faster Precepting That Is Effective and Fun
by Caryl J. Heaton, DO, UMDNJ-New Jersey Medical School
(Fam Med 2009;41(10):696-8)

The traditional process for teaching in a family medicine residency may not be the best choice for teaching students in a private office. Residency teaching has usually encouraged the faculty preceptor to stay in the “precepting office.” The faculty is assigned from one to four residents who come to knock on the door. The faculty physician is “unencumbered” with patient care of their own. Teaching can be brief or in depth, but it takes place, primarily, out of the view of the patient.

I would like to introduce a different model of teaching—Patient Witnessed Precepting (PWP). Teaching medical students can be more effective and more rewarding, at least for me, if the teaching takes place directly in front of the patient. Our three-person office takes a student year round, and my partners still use the traditional model of having the student present in our faculty office before seeing the patient. My process is different. If the student starts to present I say, “Wait a minute, tell me when we get in the room.”

PWP has also been called “exam room staffing” and “teaching in the patient’s presence” (TePP). There have been few objective evaluations on patient witnessed teaching, but the early research suggests a preference by patient and faculty and a split decision as to the degree to which the learners like it. The components of PWP are listed in Table 1.

Setting Expectations
The introduction to PWP occurs on the first day that I work with a student. I explain that I do all teaching in front of the patient. I introduce the student to the patient and ask them to take a history of the chief complaint and do an appropriate physical examination. I tell them that I will double-check all pertinent physical exam findings. I tell them I am happy to double-check their “normals,” and I must be told about all “abnormals;” even if they aren’t sure, I tell them that I may do parts of the physical exam while they are presenting the patient. I ask them to have an announcement and plan ready and that we will discuss this in front of, and with, the patient.

I go to see another patient while they are in the room. They can take their time, but I will interrupt if they take too long. If they finish before me, they can start writing the note. All of our students have access to our electronic health record. I tell them that I am willing to discuss almost anything in front of the patient but that they should tell me privately about any “loaded” history such as substance abuse, dangerous mental health symptoms, or possible abuse. We establish a code to leave the room, if needed. Lastly, I have them act as “scribe” of the encounter for me and writing the note. They only record the things that we discuss together and the physical examination that I perform in the note. I double check and co-sign any note they write. I warn students that the expectation may be to write more, but the note must be a record of only what the licensed physician knows, says, and does.

Student Presentation
The process of teaching with the patient looking on is not so different from teaching done in your office. After greeting the patient I say something like, “You’ve already asked to Jeff, he’s a third-year student getting pretty near to the end of his rotation, and he is going to tell me what he found out.” The student presents the history, and I ask clarifying questions using the one-minute preceptor microskills steps. I may not always get the order in exactly the way it was first described, but I stick to this process pretty faithfully.

There are several advantages in PWP. The student can immediately fill in any gaps in the history. If there are any questions the student forgot to ask, we can turn directly to the patient. The patient learns from the teaching. Questions such as “Do you think this patient will benefit from antibiotics?” or “What options do we have to lower the blood pressure?” lead to a discussion that helps the patient to have a better understanding of their condition. In addition, the patient feels that they are an integral part of the process. The patient is reassured that their story has been accurately told and that you heard every word. The student writes the note. This saves time (maybe a lot) of time at the end of the day. The notes are usually specific and complete but still require me to do some editing.

Focus of the Encounter
The challenge of PWP is to keep your focus on the student when the student is presenting and to appropriately turn it to the patient when the teaching is done. It is easy to take over the encounter if the student has missed an important question. The key is to turn back to the student and resume teaching. I will say:

Table 1 Components of Patient Witnessed Precepting

| 1. Set expectations. |
| 2. Focus and respond to the student presentation. |
| 3. Rephrase and summarize the patient’s |
| statement. |
| 4. Provide feedback and teaching to the student |
| and the patient. |
| 5. Wrap-up and summarize expectations. |

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something like, “OK, now let’s see what Jeff thinks he’s going on,” to get back to the student.

I try to make sure that at some point I turn all my focus to the patient. It is often to make sure that they were following the discussion. I used to worry that if we get into basic science or pharmacology they would be somehow annoyed, but that does seem to dim their enthusiasm for this process at all. I still do the critical parts of the physical exam, and occasionally I perform parts of the exam that the student did not do. Patients appreciate that they have been examined by two physicians.

Summarizing the Plan

PWP does not diminish my standing with patients, if anything, I feel that they are more impressed with the fact that I am a teacher of medical students. A discussion of “Is this good control?” helps the patient put the state of their chronic medical condition into perspective. The follow-up question “What does she need to do to get her diabetes under excellent control?” can become a robust group discussion with the patient taking an active role. At times I give both the patient and the student an assignment based on the visit. I have even known to give myself in assignment, to model lifelong learning.

Even patients with difficult or confusing problems can be included in

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Table 2

**Documentation**

“Medical students (University of Medicine) will see patients in this office and write a note in the medical chart that documents my direct activity with the patient. They will document only the components of the visit that are discussed and evaluated by myself. I review all medical documentation, and my signature attests that I was present.”

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PWP. I will occasionally describe my thinking about my toughest patients to the student in that patient’s presence. It reaffirms to the patient that I have considered multiple possibilities and that I have done appropriate testing. To this point I have never had a student who came up with a clear answer that had stumped me, but that day may come, and it may be right in front of the patient. I am prepared for it, because these students are pretty bright.

If you have a student function as a scribe for your notes, you should have documentation in your office that attests to the process. (See Table 2) This attestation should be signed and documented by every physician in the practice that uses PWP. Your organization’s legal department (if you have one) may also want to have a look at this.

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