Residents teaching Students

Department of Family Medicine & Community Health

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Driven to Discover™
All residents are teachers

At some point, all FM residents—especially 2\textsuperscript{nd} and 3\textsuperscript{rd} years-- teach medical students in clinic and / or in hospital.
Even though all residents are teachers...

...Residents don’t always receive adequate instruction in how to effectively teach or give feedback.
1. Describe the **challenges** and **rewards** of teaching students in clinic?

2. Review the Course Objectives of the 2 required courses most commonly taught in our clinics:
   - Essentials of Clinical Medicine (ECM)
   - Family Medicine Clerkship (FMC)

3. Present a model of **Clinical Precepting**

4. Suggest **2 strategies** to increase effectiveness

5. Respond to Any **Questions / Comments**
What challenges have you experienced with teaching students in clinic?

- Too many competing demands
- Some students too inexperienced
- No time for teaching
- Some patients don’t like to see students
- Students slow me down
- Some students not interested
- No training in how to teach
What are the rewards of teaching students in clinic?

• Impacting a student’s education
• Less professional burnout [over time]
• Increased Job Satisfaction
• Enhanced personal clinical knowledge base
• Increase in board scores!
• Meeting the ACGME General Competencies
• Recruitment
• Many patients admire / appreciate it
Essentials of Clinical Medicine (ECM):

- All Year 1 or 2 Medical Students (165 / yr.)
- Each student spends one ½ day in clinic over 8-10 weeks
- Offered in Family Medicine or Medicine or Pediatrics
- Students have just learned basic H&P skills
ECM goals:

• Practice performing a Focused History
• Practice performing a Focused Exam
• Complete course requirements, such as accompany a patient from clinic entry through entire visit through exiting clinic
  – Students do not have EMR access
ECM Observations

- One of student’s first experiences in clinic
- Students need clear instruction / direction
- MS1/2s take much longer than MS3/4s!
Family Medicine Clerkship (FMC)

- ALL Year 3 & 4 Medical students (except RPAP) – [180 per year]
- 4-week required clerkship in Family Medicine
- UCAM: up to 12 per year – 12 weeks in FM
- MetroPAP: 2 students x 9 months, Broadway
- 3-4 days per week in clinic
- 1st Mon & all Weds spent in small group at U or in independent learning
- Final Friday exam at U of M
FMC Goals:

- Students are the First MD-equivalent to Encounter the patient at least 50% of the time
- Student functions as a ‘sub-intern’:
  - Takes relevant History
  - Performs relevant Physical (but not elements that need physician confirmation nor elements that will distress a patient – e.g. child ear exam, adult genital exam)
Student functions as a ‘sub-intern’:

- Student summarizes H&P findings and presents a working ‘Assessment’ and management ‘Plan’
- Both physician and student return to finish visit with patient
- Student adapts to clinic environment and functions effectively in a time efficient manner
FMC Emphasizes:

- Management of Common Outpatient Problems
- DM, HTN, Osteoporosis…
- Health Care Maintenance / Prevention
- Immunizations, Lipids…
- Small group workshops on:
  - Above: plus Asthma, Musculoskeletal exam, Process of Care, EBM
Students’ Clinical Skills

- Medical School wants to ensure that all graduates complete important skills:
  - students carry a list of required skills

- Those skills to be encountered in FMC include:
  - PAP smear
  - Telephone Medicine
  - WCC, CPE and others
FMC Evaluation

- A single faculty evaluator is linked with each student in clinic: in some clinics always the same faculty; in some - not

- This faculty person is responsible for any issues that occur with that student and will be the student’s evaluator
FMC Evaluation, continued

- Students should spend 14 full days in clinic / 4 weeks
- Students are allowed to miss 2 full days per 4 weeks for legitimate reasons: beyond that needs discussion
- Clinic evaluations account for 50% of course grade
- Usual grades: 25% ‘H’; 55% ‘E’; 20% ‘S’ < 5% ‘I’
Some Caveats:

• Some patients don’t want to see a student
• Arrange for other activities

• There can be quite a difference in content knowledge and performance between an Early MS3 and a late MS4

• ~50% of MN students are not entering Primary Care but all must take FMC
The Microskills Model
[aka The 1-Minute Preceptor]

- A 5 step process of clinical teaching
- Often used in Faculty – Resident precepting
- Readily applicable to Clinical Precepting
- Originated in the business literature

The Microskills Model—Five Steps

1. Get a commitment
2. Probe for Supporting Evidence
3. Teach General Rules
4. Reinforce what was done right
5. Correct Mistakes
Step 1: Get a Commitment

- After presenting the facts of a case to you, the learner may stop and wait for your response.

- Instead of telling them the answer, ask them to state what he or she thinks about the issues presented by the data.
Step 1. Get a Commitment, continued

• **Examples**—
  – What do you think is going on with the patient?
  – How can you tie all of this together?
  – What do you think we need to accomplish during today’s clinic visit?
  – What do you think we need to do next?
Step 2. Probe for Supporting Evidence

- After committing him or herself on the presenting problem, the learner may look to you to either confirm or refute the opinion.

- Before doing that, ask the learner for evidence that he or she feels supports the opinion.
An alternative approach is to ask the presenter to expand the differential diagnosis of the patient’s presenting complaint, physical findings, or data.
Step 2. Probe for Supporting Evidence, continued

- **Examples:**
  - I am interested in how you came to that diagnosis.
  - What were the major findings that led to your conclusion?
  - What other things did you consider regarding the patient’s abdominal pain?
  - What else might be causing the elevated LFT’s?
  - Do any further questions come to mind?
Step 2. Probe for Supporting Evidence, continued

**Avoid the following:**
- List all of the possible causes of LLQ abdominal pain.
- I don’t believe this is consistent with acute pancreatitis. Don’t you have any other ideas?
- What was their last creatinine?
- What if, rather than being a white Minnesotan, this patient instead had just immigrated from Somalia? (read my mind questions)
Step 3. Teach General Rules

- At the time of Precepting or at a later time
- You have ascertained from what the learner revealed that there is a knowledge gap (and that you can fill it!).
- Provide general rules or concepts targeted to the learner’s level.
Step 3. Teach General Rules, continued

• **Example:**
  – Patients with strong symptoms such as dysuria, frequency and urgency, without vaginal symptoms are so likely to have a UTI that they should be treated even if they have a normal UA.

• **Avoid** statements like:
  – I always use Cipro
  – The last time I saw this condition...
Step 4. Reinforce what was done right

- The learner may or may not realize that their plan of action was effective and will have a positive impact.

- Focus on the specific deed and the effect it had.
Step 4. Reinforce what was done right, continued

• Example:
  – You considered the cost of the medication and the schedule of dosing in your selection of an antibiotic and checked on the patient’s Medication Allergies. That was really excellent.

• Avoid statements like:
  – Good job!
Step 5. Correct Mistakes

- In the case where the learner’s work has demonstrated mistakes, this needs to be discussed as soon as possible.
  -- What went wrong and why
  -- How to avoid or correct the error in the future
- Best to share feedback directly with learner
Step 5. Correct Mistakes, continued

• Example
  – You may be right to attribute this patient’s confusion to the UTI. However, given the history of a recent fall in a patient on Warfarin, a head CT really should be done to rule out bleed or subdural hematoma.

• Avoid statements like:
  – Why didn’t you mention the need for a head CT?!
  – I wouldn’t want to go to you as my dermatologist!
In summary, the 5 Steps

1. Get a commitment
2. Probe for Supporting Evidence
3. Teach General Rules
4. Reinforce what was done right
5. Correct Mistakes
Two Useful Strategies

• ‘Priming’ the student

• Teaching in the Presence of the Patient [TIPP]
Priming:

• Orienting the Learner to Patient and Tasks immediately before entering patient room

• A mini-orientation with each new provider each new clinic half-day –including clarifying Year of medical student
Priming, continued

- Define the tasks the learner should complete, including the time frame.
- Indicate how & when preceptor will reconnect with student (I’ll come in the room in 10 minutes..)
- Review patient history and any patient-specific details
- Describe the ‘product’ resulting from this contact: such as oral presentation / chart note...

Adapted from Heidenreich et al, Pediatrics 2000
Teaching In the Patient’s Presence (TIPP)
TIPP is:

• Have the student present in the exam room with the patient listening

• Doctor and student can then continue history taking, confirm exam findings and move on to management plan with patient
TIPP: Advantages

- Increases time efficiency
- Patients can see you are talking about THEM!
- May reassure patients that student is accurately reporting information and findings
- Increases contact time between Preceptor and Patient
- Often reduces need for preceptor to repeat history-taking
TIPP: Challenges

- Patient interruptions
- Some students do not like
- Some physicians do not like!
- Some information better shared outside room
- Presentations may be less prepared / fluent
- Sometimes ‘damage control’ needed for student comments
TIPP: Practical Strategies

• **Prime** *before* entering room
• Preceptor maintains *control*
  – Roles & rules
  – Keeping time
• Maintain *focus*
  – Primary: patient care
  – Secondary: student learning
• Maintain *respect*
  – Patient
  – Learner
What we just reviewed:

1. The rewards and challenges of teaching students in clinic
2. The Course Objectives of the two required courses most commonly taught in our residency clinics:
   - Essentials of Clinical Medicine
   - Family Medicine Clerkship
3. One model of Clinical Precepting
4. 2 Strategies to improve teaching
Conclusion

• Thank you! And...Happy Precepting!

• Questions?:
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