

8 PRACTICE TIPS FOR PRECEPTORS

Jeanne Mettner

WHEN MARK EGGEN, MD, DECIDED TO RETIRE FROM PRIVATE PRACTICE AND ACCEPT A PART-TIME POSITION AS AN ASSISTANT PROFESSOR IN THE UNIVERSITY OF MINNESOTA MEDICAL SCHOOL'S DEPARTMENT OF ANESTHESIOLOGY, HE WAS BOTH EXCITED AND INTIMIDATED.

A flexible schedule meant he could enjoy free time not afforded him during his 20 years working at Mercy Hospital in Coon Rapids and Unity Hospital in Fridley. But he felt intimidated and inexperienced taking on the role of preceptor for medical students and residents.

"For 20 years, my practice was taking care of patients. That's it. I didn't do any research. I didn't do any teaching. Then I show up at the university last summer with residents in anesthesiology and medical students on rotation," Eggen explains. "I had this immediate reaction of, 'Whoa. Here I am.' I have this experience practicing anesthesiology, but I have no experience in understanding what the needs are of students and residents." In order to figure out how to be a good preceptor, Eggen shadowed as many seasoned instructors as he could.

Teaching has always been an integral part of what it means to be a physician. "See one, do one, teach one," remains a common maxim in medicine, and the word "doctor" itself comes from the Latin word *docere*, meaning "to teach." From the first year of medical school, students learn that one of their duties will be to help mentor those who come after them. "You are learning how to teach by supervising people one year behind you in the academic learning order," explains James Boulger, PhD, director of the family medicine preceptor program at the University of Minnesota Medical School's Duluth campus. "Second-year medical students teach first years, third years teach second years, senior residents teach junior residents, fellows teach senior residents and attending physicians teach all of them. You gain a lot of teaching experience simply by choosing to become a doctor."

Boulger points out that just because teaching is expected, it doesn't mean that it comes naturally. Although there's not much formal training for physicians who want to be preceptors, there are things you can learn that will make you a better at it. The following advice comes from seasoned preceptors.

1) Know yourself and your student

Ask experienced preceptors, What makes a good preceptor? and the answers they give sound uncannily similar: They must be able to understand where a student is along the trajectory of his or her educational development and then tailor their teaching to help the student reach his or her goal. They must be comfortable in their own skin. And they must be able to admit they don't have all the answers. "Some of the best learning happens in cases where you as a preceptor honestly don't know," says Richard Wehseler, MD, who coordinates rotations at Affiliated Community Medical Center's

clinics in southwestern Minnesota. “A bad preceptor would be one who is not comfortable with that situation—or who is not open to different ideas or approaches a student might discuss.”

2) Be positive

Having a positive attitude is paramount. “A good preceptor is someone who is enthusiastic about having a student with him or her, is engaged and aware of what students need, and is able to ask students exactly what they want to get out of their clinical experience,” says Anne Pereira, MD, assistant dean for clinical education at the University of Minnesota.

Although he’s new to the role, Eggen says he has already learned that liking it is perhaps the most essential aspect of succeeding at teaching. And he’s seen some situations in which a student or resident has been reassigned because the preceptor’s heart wasn’t in the job. “Being a preceptor is hard work, but if you are consistently cranky and no longer enjoying it, it’s best just to realize that it’s someone else’s turn,” he says.

3) Give the student space

Giving the student enough autonomy is important to ensuring that he or she gets the most out of their clinical encounters.

As a self-professed “neophyte preceptor,” Eggen says his greatest challenge is making sure he backs away enough to ensure the student is thinking and working at a level appropriate to his or her experience. He laughs when he recalls the advice he received from a fellow preceptor, who said his job as a preceptor was to “give [students and residents] just enough rope to hang themselves but not so much that they can hang themselves and the patient.” “In a very broad sense, that sums it up,” Eggen says. “I never want bad patient outcomes, certainly, but if I don’t give them enough leeway relative to their experience and comfort, what are they learning?”

4) Set expectations

Ideally, at the beginning of each rotation, preceptors and students take time to establish expectations and learning goals. “It can be very informal, asking them, ‘Are there certain skills you want to hone? Do you want to see as many patients as possible? Are there certain things that, upon leaving this rotation, you would be disappointed not having learned?’” Wehseler says. “And then at the same time, I tell them, ‘Here are the things I want you to know by the end of this rotation. These are the things that are important to know and be comfortable with at this time in your education.’”

Having that discussion gives both student and preceptor a basis for subsequent evaluations and reviews. Eggen says knowing what to expect from trainees at different levels is one of the biggest hurdles for new preceptors to overcome, particularly when they are working with residents. “I’ve been doing this almost a year now, and I still don’t have the experience base yet to be able to say, for example, ‘Thirdyear anesthesiology residents should know X but maybe won’t know Y,’” he says. “Sometimes, I don’t connect as well as I think I should with a resident because I didn’t personally understand the level of knowledge they had coming in. I didn’t challenge them to think at their level.”

5) Have a plan for how you'll share information

In a traditional classroom setting, the learner and teacher interact around the curriculum—be it in a textbook or lecture. For preceptors, the focus is the patient. “Clinical teachers are working and teaching students in their workplaces—where they are caring for patients,” explains Kathleen Brooks, MD, director of the University of Minnesota’s Rural Physician Associate Program, a nine-month, community-based experience for third-year medical students. “That’s much different than having a white board in a classroom setting.”

“There are some real challenges when you are talking about having physicians who are in community practices be your teaching faculty, just in terms of workload and time,” Boulger says. “These are not people waiting for students to enter a lecture hall. These are active clinicians serving strong patient cohorts. We have to make sure they are meeting the needs of their patients while addressing the educational goals of the student.”

Agreeing on a framework for sharing information and learning can make the experience go more smoothly for the preceptor and help the student advance more quickly. One approach, SNAPPS, is a six-step process that students can follow as they review and analyze a patient case. First, the student summarizes the history and findings, then narrows the differential diagnosis to two or three possibilities, analyzes those differential diagnoses, probes (asks questions of) the preceptor, plans management of the medical issue, and selects a case-related issue for further self-directed study. “We introduce the SNAPPS model in year one of medical school, and it’s our expectation that the students will learn to do presentations that way across their training,” explains James Nixon, MD, associate professor of internal medicine and pediatrics and vice chair for education in the department of medicine. To help community-based physicians, Nixon hosts a seminar on SNAPPS, as well as one on the One-Minute Preceptor—a similar model that is preceptor-directed rather than student-directed.

“Having these models has proved to be a time-efficient, quality way to direct the clinical encounter,” Nixon says. “It allows the preceptor to take care of the patient while helping students learn in a more consistent, even standardized way as they move from site to site and rotation to rotation.”

6) Be aware of the hidden curriculum

Students are always watching. Therefore, preceptors need to pay attention not only to what they are saying and teaching but also to what they are doing. “The hidden curriculum is the difference between what we say and overtly teach and what the students learn by observing us,” notes Nixon. “It’s important to role model the professionalism, the appropriate interaction with our patients. Strive to create good habits so your students are absorbing those—rather than bad habits.”

7) Consider feedback from your student

Each time a student completes a rotation, he or she evaluates the experience. They provide feedback on how the rotation was organized and their overall experience, then they evaluate the individual preceptors they worked with. In some cases, feedback is submitted anonymously through an online questionnaire. In others, such as with rural medicine rotations, students and preceptors complete short surveys and then talk in person. This system of checks and balances ensures that clerkship

directors can resolve problems effectively. “In cases where there are ‘outlier’ rotations or sites that did not meet student expectations, it’s important to discuss plans for remediation so that the concerns are addressed,” Pereira says.

“Evaluations also help the preceptor refine their approach,” Nixon says. Ideally, less-than-glowing feedback should serve as a springboard for further preceptor development. “We may, for instance, need to talk with a preceptor because the students are saying he or she is not defining expectations on Day 1 of the rotation,” Nixon says. “That helps us educate the preceptor about why setting goals is important to the learning process.”

8) Find your best style

Nearly a year after taking the job at the university, Eggen has discovered for himself what works and what doesn’t with his preceptor approach. He’s found he prefers the Socratic method of teaching—asking learners questions and then using their answers to stimulate further discussion and critical thinking. “I have learned that being a preceptor is an art more than a science,” he says. “I certainly am still new at this, but I have definitely discovered I can do it. And I’m also having fun.”

Jeanne Mettner is a frequent contributor to Minnesota Medicine.

RESOURCES FOR PRECEPTORS

Most preceptors are too time-pressed to devote hours to learning the ins and outs of the job. But when they do feel they need or want to develop their teaching skills, help is available.

Preceptors working with students at the University of Minnesota Medical School Duluth receive a complimentary subscription to “Teaching Physician,” a web-based resource for community preceptors offered by the Society of Teachers of Family Medicine. “Built into the site are resources for learning how to problem solve, how to provide appropriate feedback, how to identify negative behaviors that might be impairing students’ learning environment—and it provides all this information in a confidential way,” says Emily Onello, MD, assistant professor of family medicine and community health on the Duluth campus. “Physicians can even get CME credit for using it.”

James Nixon, MD, vice chair for education in the University of Minnesota’s department of medicine, offers seminars on SNAPPS and the One-Minute Preceptor, approaches for presenting cases. Other offerings are listed on the Medical Office for Medical Educator Development and Scholarship website (www.meded.umn.edu/meds/).

Kathleen Brooks, MD, director of the University of Minnesota’s Rural Physician Associate Program (RPAP), a nine-month clerkship for third-year medical students, says RPAP preceptors are given a 40-page guidebook that’s updated annually as well as laminated cards with reminders about SNAPPS and the One-Minute Preceptor.

For the past several years, the Minnesota Academy of Family Physicians has worked with RPAP faculty to present an educational session on precepting at its annual Spring Refresher. The goal is “to provide general information that would be helpful to any physician or health care professional who has a teaching role,” says MAFP Executive Vice President Virginia Barzan. Last year’s session focused on “truth-telling when evaluating student learners.” This year’s session, called “How your tablet or smartphone can make you a smarter doctor,” is on using digital resources in simulated precepting encounters.