

291

Washington State University
MAJOR CURRICULAR CHANGE FORM -- COURSE
 (Submit original signed form and ten copies to the Registrar's Office, zip 1035.)

Future Effective Date: 08/15/2012 ☐ New course ☐ Temporary course ☐ Drop service course
 (effective date cannot be retroactive) ☐ There is a course fee associated with this course (see instructions)

- ☐ Variable credit _____ ☒ Repeat credit (cumulative maximum 2 hours)
- ☐ Increase credit (former credit _____) ☐ Lecture-lab ratio (former ratio _____)
- ☐ Number (former number _____) ☐ Prefix (former prefix _____)
- ☐ Crosslisting (between WSU departments) ☒ Cooperative listing (UI prefix and number MedS 505)
 (Must have both departmental signatures)
- taught by: WSU ☐ UI ☐ jointly taught ☒
- ☐ Conjoint listing (400/500) ☒ S, F grading
- ☐ Request to meet Writing in the Major [M] requirement (Must have All-University Writing Committee Approval)
- ☐ Request to meet GER in _____ (Must have GenEd Committee Approval) ☐ Fulfills GER lab (L) requirement
- ☐ Professional course (Pharmacy & Vet Med only) ☒ Graduate credit (professional programs only)
- ☒ Other (please list request) Professional Course (WWAMI Medical Education)

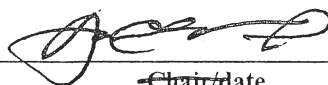
MedS 505 Medical Preceptorship
 course prefix course no. title

1			4	WWAMI Students Only	
credit	lecture hrs	lab hrs	studio hrs		prerequisite
	per week	per week	per week		

* Description (20 words or less) Medical Students work in local clinics, physician's offices, Emergency Rooms, Hospitals; 4 hours minimum per week

Instructor: Local Physicians Phone number: _____ Email: _____
 Contact: Maureen Evermann Phone number: 335-2602 Email: evermann@wsu.edu
 Campus Zip Code: 3510

- Please attach rationale for your request, a current and complete syllabus, and explain how this impacts other units in Pullman and other branches (if applicable).
- Secure all required signatures and provide 10 copies to the Registrar's Office.

 11/2/11  11/4/11 _____
 Chair/date Dean/date General Education Com/date
Director, WWAMI VPHS

Chair (if crosslisted/interdisciplinary)* Dean (if crosslisted/interdisciplinary)* Graduate Studies Com/date

 All-University Writing Com/date Academic Affairs Com/date Senate/date

*If the proposed change impacts or involves collaboration with other units, use the additional signature lines provided for each impacted unit and college.

Memorandum:

Date: November 1, 2011

Re: Major Curricular Change MedS 505, Preceptorship

Catalog Course Description: First-year medical students gain experience and insight into medical practice situations; students are stationed in physician offices at WWAMI sites. Cooperative course taught jointly by UI and WSU (MEDS 505) (Fall and Spring) 1 cr

(To be added) Students may take course for repeat credit (up to 2 cr)

Rationale: The medical students gain knowledge and experience working side by side with a local physician 1 day per week for a minimum 4 hours per week. They have always had the option of changing physician in the second semester for experience in a different field of medicine. The course content does not change, but medical situations constantly change. The University of Washington School of Medicine (who directs WWAMI curriculum) has now approved a second credit to recognize the student's additional course hours.

To: WWAMI Physician Preceptors

From: Andrew Turner, Ph.D., Director & Course Co-chair
Linda Fearn, M.D., Course Co-chair

**Re: MedS 505 Medical Preceptorship:
Preceptor Manual & Information for 1st Year WWAMI Student Placements**

Thank you for being a part of our WWAMI Medical Education Program, through the giving of your time and knowledge as a preceptor for our first year WSU/UI WWAMI students in their **MedS 505 Medical Preceptorship** course. Each semester the students rate their precepting experience as one of the highlights of their medical education, grounding them in the clinical applications of their studies through the hours that they spend with you in your practice settings. The precepting experience is a vital and essential part of our medical education program.

This brief **Preceptors Manual** provides information that relates to the clinical training and educational objectives of the first year, as they have been spelled out in the Introduction to Clinical Medicine Course (ICM). ICM is a year-long course, with a focus on initial patient interview, assessment, and examination skills. It has direct bearing on the medical student's ability to participate effectively in the precepting experiences that you provide for them. As you can see from the enclosed information, there is also an emphasis on professionalism, clinical reasoning, and oral presentation skills. We are enclosing the following information to assist you in monitoring and providing feedback to your student as you go through this semester or academic year of weekly clinical precepting:

1. A copy of the UWSOM Physician's Oath (as a guideline for shaping their professionalism through their career)
2. Articles from UWSOM and Family Medicine on teaching professionalism through preceptor relationships, giving feedback, and precepting models
3. The Teaching Goals for ICM - 1st Year
4. The Introduction to Clinical Medicine (ICM) Student Feedback Form
5. The Oral Case Presentation Guidelines for ICM - 1st Year
6. A copy of the UWSOM Evaluation Form for the Precepting Experience (completed at the end of the semester experience)
7. A copy of the students' evaluation form of their precepting experience (also completed at the end of the semester)
8. A copy of proof of medical student liability from UWSOM

We hope that these documents will be useful to you in addressing the developmental learning needs of our first year WWAMI students. **It is our expectation that all of our WWAMI students will make time to review this Manual and its contents with you as their preceptor, early in the precepting relationship.**

The **final grade & evaluation form** will be sent to you to be completed at the end of the training semester. Your specific comments and check marks are essential to accurate feedback and evaluation of each student. Many times, early deficiencies in knowledge, skill, professionalism, or personal conduct can be addressed midyear if we receive honest evaluations of student performance in a timely manner. It is always our intention to improve and correct student deficiencies, and we rely heavily on course instructors and preceptors to let us know when areas need addressing. **We would also encourage you to use the ICM feedback forms enclosed in this manual to assist you in giving specific feedback to your student at timely intervals during your precepting relationship.**

In addition to the precepting experience of the first year of medical school here at the UI/WSU WWAMI program, **we invite and encourage you to participate in our end-of-year, annual *Preceptor Appreciation Night & White Coat Ceremony*, which is currently scheduled for Friday, April 20th, 2012, 7-9pm, in Pullman.** Please mark your calendars for this important date and allow us to honor both you and your student at this event (formal invitations will follow next spring).

Our WWAMI preceptors are also eligible to apply for affiliate clinical faculty at the UW School of Medicine, with sponsorship through the WSU/UI WWAMI site. Affiliation as clinical faculty members allows preceptors access to UWSOM health science library facilities, both in person and on-line, as well as departmental affiliation for professional development and interaction when visiting the Seattle medical campus. **If you are interested in pursuing affiliate clinical faculty status (it is a lengthy process similar to medical staff privilege applications) please fill out the form in the back of this manual and return it to us at the WWAMI office here in Moscow or Pullman.**

Again, **thank you for your participation** in this important training experience, and for being part of the WSU/UI WWAMI faculty and family. **Please contact us (aturner@uidaho.edu or lfearn@turbonet.com) with any questions/concerns,** or if we can be of any assistance in strengthening this precepting experience.

Physician's Oath

The administration of the Hippocratic Oath or Physician's Oath at graduation time has become a tradition in the western medical world and recognizes our debt to our ancestors for pointing the way to ethical and moral behavior in the midst of the multitude of scientific activities of the medical profession. The Oath is thought to have originated in the fourth century B.C. and has come down to us in several translations. Today's version, the so-called Geneva version of the World Medical Association, has been altered to bring its words and ideas into consonance with today's trends and to free it from unnecessarily irritating or inciting phraseology. Based on input from recent students and approval of the Medical School Executive Committee in the spring of 2000, an additional alteration was made in the oath taken by students at the School's Hooding Ceremony. It serves to remind us once again of the high standards of performance and behavior to which each of you aspires and with which each of you is challenged as you receive your degree and enter upon your professional career as a physician.

AT THE time of being admitted as a member of the medical profession,

1. I SOLEMNLY pledge myself to consecrate my life to the service of humanity.
2. I WILL give to my teachers the respect and gratitude which is their due;
3. I WILL practice my profession with conscience and dignity;
4. THE HEALTH of my patient will be my first consideration;
5. I WILL respect the secrets, which are confided in me;
6. I WILL maintain by all the means in my power, the honor and the noble traditions of the medical profession;
7. MY COLLEAGUES will be my sisters and brothers;
8. I WILL respect and value the lives of all persons;
9. I WILL not discriminate against any person in medical decisions;
10. I WILL maintain the utmost respect for human life; even under threat, I will not use my medical knowledge contrary to the laws of humanity.

I MAKE these promises solemnly, freely, and upon my honor.

Questions to consider:

1. What does this mean to me as a physician-in-training?
2. What do I think my patients will think it means in terms of my professional conduct and/or delivery of care?
3. What are the potential ethical dilemmas, if any, embodied in this oath that I will want to consider during my medical education?

For the Office-based Teacher of Family Medicine

William Huang, MD
Feature Editor

Editor's Note: This month's column begins a two-part series on the office-based teaching and assessment of professionalism. In Part I, George D. Harris, MD, MS, of the Department of Community and Family Medicine at the University of Missouri-Kansas City defines key aspects of medical professionalism and discusses how the office-based teacher can role model professionalism in today's challenging health care environment.

I welcome your comments about this feature, which is also published on the STFM Web site at www.stfm.org. I also encourage all predoctoral directors to make copies of this feature and distribute it to their preceptors (with the appropriate *Family Medicine* citation). Send your submissions to williamh@bcm.tmc.edu. William Huang, MD, Baylor College of Medicine, Department of Family and Community Medicine, 3701 Kirby, Suite 600, Houston, TX 77098-3915. 713-798-6271. Fax: 713-798-7789. Submissions should be no longer than 3–4 double-spaced pages. References can be used but are not required. Count each table or figure as one page of text.

Professionalism: Part I—Introduction and Being a Role Model

George D. Harris, MD, MS

This two-part article will discuss important aspects of professionalism that office-based teachers should consider when working with learners: role modeling, teaching, and assessing the learner's professionalism. Part I gives an introduction to medical professionalism and discusses how the office-based teacher can role model many aspects of professionalism.

Introduction

An important aspect of clinical education is learning and demonstrating appropriate professional behavior.¹ The professional development of a physician begins in medical school, where students learn about the patient-physician re-

lationship, an important aspect of medical practice that sets it apart from others.² Medical educators can assist in the development of professionalism by not only helping learners acquire knowledge and skills and maintain their proficiency but also by explicitly teaching learners how to demonstrate professionalism in patient interactions and their other responsibilities. This process should include the promotion and development of attitudes, values, and commitments necessary to be a physician.³

Webster's dictionary defines professionalism as "the conduct, aims, or qualities that characterize or mark a profession or professional person."⁴ An expanded definition for physicians includes the ability to cultivate a relationship with patients, to listen to them, and to commit to their needs as well as to your profession.

Each profession encompasses a specialized body of knowledge and skills. In addition to its particular knowledge and skills, the medical profession distinguishes itself from other jobs or trades by a high code of behavior that insists on responsibility and public service.⁵ The Hippocratic Oath describes our calling and our mission to help those in need of care and reduce their pain and suffering. Without the Oath as a guide, physicians are merely skilled workers. Practicing what is described in the Oath results in physicians being professionals.^{6,7} The keys to following the Oath and providing service to the ill are demonstrating humility, identifying the needs of patients, and striving to meet those needs. This should be done without seeking or expecting recognition or reward. In addition, each of us has our own testimony, the driving force that led us to pur-

(Fam Med 2004;36(5):314-5.)

From the Department of Community and Family Medicine, University of Missouri-Kansas City.

Teaching Module: **Feedback**

Few opportunities exist in medical training, and particularly in medical practice, for physicians to get feedback on interactions with patients. Even when working in teams, the interaction with the patient is rarely observed by peers or mentors. Feedback becomes a critical part of skill practice sessions, as these sessions provide an opportunity to hear from peers, faculty, and sometimes the patients themselves, how the patient interaction went.

RATIONALE:

While one goal of skill practice teaching is to help the learner develop self-assessment skills, giving feedback based on external observations can help the learner calibrate her own sense of her strengths and limitations.

- Learners often focus on their limitations, not aware of their strengths or what it is that they already do that is effective. Giving specific positive feedback reinforces things the learner is doing well.
- Without being videotaped or observed, it is difficult to know how one's body language, affect, or tone comes across to others. Providing feedback in these areas can help a learner move forward, as they can say the 'right' things but if mismatched with body language, the effectiveness of the communication skills will be limited.

PITFALLS

- It takes effort to give specific, constructive feedback. Targeting concrete behaviors takes careful observation. Often feedback is too general ("good job").
- Many of us have not had good role models for giving constructive feedback. It is more comfortable for us to stay in the realm of positive feedback without addressing areas that might need work.
- Alternatively, many of us assume that the positive behaviors do not need to be discussed. We miss an opportunity to reinforce what someone has done well.

- Learners can only absorb a certain amount of feedback. Giving some specific feedback while not overwhelming them is a difficult balance to strike.

SUGGESTED PROCEDURE:

Be specific. The most effective feedback is specific. Faculty can take notes during the patient encounter to capture specific phrases that the learner used that were particularly effective. Often learners will not remember what they said, or be conscious of the skills they are employing instinctively. Reinforcing the skills helps to bring them into conscious practice. In the exchange below, the faculty used the group to help the learner identify specific behaviors she was using that helped the conversation go smoothly. He starts by checking in with the learner and closes by offering his own observations and feedback.

***FACULTY:** So, let's stop for a minute and talk about how's it going before now. How's it going?*

***LEARNER:** I think it's going well. The patient's comfortable, he's makes me feel comfortable, we're on the same page, he doesn't want any more chemotherapy.*

***FACULTY:** So what are the things that you are doing that get you all that information that make it easier. What is she doing? [Turns to the group participants]*

[4 Participants respond with feedback]

***FACULTY:** I liked how you initiated the interview. You said, "I gave you a lot of information last time. Before we start I want to see what your questions and concerns are." so you started off very clear, you were organized, you said ... 'let's check in' at the very beginning. And then all the follow up questions were based on what he said. So he said something, you summarized and went further. It was like a dance and you were right in step.*

Tie Feedback to Learner Goals. If you have done the work of goal-setting at the outset, you have asked the learner for particular areas where he would like feedback. It is important to close the loop and given him feedback about how he did with those goals.

***FACULTY:** You've done some great things. You asked specifically about talking too much? You didn't. You did a really nice job. All the information you are giving has been in really tiny chunks; just little pieces and then getting his reaction. So, the thing that you were concerned about you are doing really well.*

In another exchange, faculty helps to problem-solve with the learner and extends the learner's goal to address the challenge that has come up in the encounter. Not all feedback needs to come at the end by way of summary statements. Giving feedback in the middle of a skill practice session can be very useful for helping the learner continue to work at his learning edge.

FACULTY: *Timeout. How do you feel about the way things are going?*

LEARNER: *I think I am sort of wandering. I don't think I am staying on track.*

FACULTY: *Give me an example of where you feel you were wandering.*

LEARNER: *Well, when he was going on and on about family and all of that stuff I wasn't quite sure whether to go in that direction or where to go. So I'm not sure that I was really focused... [Learner continues and group discussion occurs]*

FACULTY: *I know you said before that you wanted to follow his lead. And he was sort of bringing up all sorts of things –*

LEARNER: *– I wasn't sure where to go first. I was overwhelmed.*

FACULTY: *What I am hearing is that you wanted to follow him, but there was all this different stuff, and you couldn't prioritize – there was so much. So maybe what you could have done is ask him to prioritize it for you: "It sounds like this news is bringing up all sorts of things. What do you feel – if you can prioritize now – are your greatest concerns?" Do you want to try that?*

LEARNER: *Okay, sure.*

Tie Feedback to Behaviors. Feedback should also be tied to specific learner behaviors. What did he do, and what might he do differently? Sometimes a group member can give feedback that is not tied to a behavior, such as, *"I think the patient was really confused by what you were saying."* Faculty can work to reframe the feedback into something that the participant observed or heard, and what was said or done by the learner, e.g. *"When you said 'Phase I trial' the patient seemed to sit back and her eyes kind of glazed over for a second. What do you think Phase I trial meant to her? What would you like to be conveying to her right now?"* Faculty can also frame their request for feedback in very specific ways to encourage more specific feedback, e.g. *"Well, let's get some feedback, Okay? I'm curious what do people think about what has gone on so far? What did you observe?"*

The Feedback Sandwich. Much has been made about the "feedback sandwich" in medical education. The expectation is that you should frame your negative comments with two positive comments to be more palatable for the learner. There are strengths and weaknesses to this approach. Taking the best of what is intended might be the workable strategy for you.

We agree that learners should get feedback on both things that they are doing well and things that they might do differently. Starting with positive feedback can enhance a learner's sense of safety. A limitation of positive feedback in the sandwich is that if the learner has been socialized to the approach, they often say they cannot hear any of the positive feedback because they are waiting for the other shoe to drop. You can get around this by emphasizing with the learner that there

were specific things that she was doing that were really effective. You want to point them out to assure that she will do them again in the future.

The issue with negative, or “constructive”, feedback is that we do not have many role models for doing this well. Negative feedback can come across as tough criticism, or more often, can just get skipped because it is uncomfortable for both faculty and learner. Modeling giving and receiving feedback about areas to work on can help set the tone and expectation that there will be an open exchange of feedback with you. Making it part of the routine of what you give learners and what you ask for from them means that no one is singled out. Everyone has areas that they would like to continue working on. Playing to learner strengths is one of our strategies that we emphasize. You can frame feedback in terms of skills they could use more often (e.g. *“You did a great job with your first empathic comment to the patient. I think if you kept doing more of that throughout the interview, she would have felt even more connected with you.”*)

This strategy also works with a whole small group (e.g. *“One thing you guys are doing well is exploring. Maybe what you want to focus on is simply making empathic statements – acknowledging, legitimizing emotions first, before trying to take it to the next step to learn more about it”*).

PEARLS

- Feedback is the primary way to reinforce learning.
- Feedback can come from faculty, other group members, or the patients themselves.
- Emphasize specific behaviors learners are doing well.
- Work at the learning edge with learners by helping them to problem solve the places where they get stuck in the interview. By giving feedback about what you observed about the difficulty, the learner can often generate ideas about what to do differently.

REFERENCES

- Ende J. Feedback in clinical medical education. *JAMA*. 1983; 250:777
- Kurtz S, Silverman J, Draper J. “Running a Session: Analysis and Feedback in Experiential Teaching Sessions,” Chapter 5 in *Teaching and Learning Communication Skills in Medicine*. Radcliffe Medical Press, 1998.

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" (TIPP). There have been few objective evaluations on patient witnessed teaching, but the early research suggests a preference by patient and faculty¹ and a split decision as to the degree to which the learners like it.² 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 to 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 assessment 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 a "scribe" of the encounter for me in 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 temptation 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 talked 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.³ 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 patient 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 some (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. Mindfulness of the patient.
4. Provide feedback and teaching to the student and the patient.
5. Wrap-up and summarize expectations.

something like, "OK, now let's see what Jeff thinks is 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 got into basic science or pharmacology they would be somehow annoyed; but that does not 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 been known to give myself an assignment, to model lifelong learning.

Even patients with difficult or confusing problems can be included in

Table 2

Documentation

"Medical students from — (University or Universities) — 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 to activity, evaluation, and discussion performed by myself."

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.

PWP has allowed me to see patients faster with students than without them. I have to spend some time reviewing their notes, but this is more than compensated for by the fact that they save me time doing the "scribing" first. Occasionally I have to send an e-mail to a student about an important change that I may have made in the documentation, and this gives good immediate feedback to the student. But the best reason for PWP is to bring the patient overtly into the teaching process. I can't prove its better care, but I am sure that it's more fun. You might want to give it a try.

Correspondence: Address correspondence to Dr Heaton, UMDNJ-New Jersey Medical School, Department of Family Medicine, Behavioral Health Science Building E 1559, 183 South Orange Avenue, Newark, NJ 07103. 973-972-7828. Fax: 973-972-7997. heaton@umdnj.edu.

REFERENCES

1. Petersen K, Rosenbaum ME, Kreiter CD, Thomas A, Vogelsang SA, Lawry GV. A randomized controlled study comparing educational outcomes of examination room versus conference room staffing. *Teach Learn Med* 2008;20(3):218-24.
2. Anderson RJ, Cyran E, Schilling L, et al. Outpatient case presentations in the conference room versus examination room: results from two randomized controlled trials. *Am J Med* 2002;113(8):657-62.
3. Neher J, Stevens NG. The one-minute preceptor: shaping the teaching conversation. *Fam Med* 2003;35(6):391-3.

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TEACHING GOALS FOR ICM-1st YEAR

The following outline of the General Teaching Goals for ICM 1st year is used as a guideline for all WWAMI sites.

By the end of the first year, a University of Washington School of Medicine student shall have been introduced to, and have gained basic skills in, the following areas of study:

I. Professionalism /Becoming a Doctor.

Begin the transition to becoming a physician.

Be introduced to a variety of topics concerning the role and responsibilities of the physician in relationship to the patient, other health workers, and society.

Topics might include, but need not be restricted to the following:

1. doctor/patient relationship
2. "caring" for the patient and family
3. confidentiality
4. doctor's oath
5. doctor's responsibility to the community
6. the health care team
7. impaired physician
8. patients with disabilities
9. the role of the doctor in western culture

II. Interviewing Skills

Recognize and understand the functions of a medical interview, with special attention to the role of the patient's illness narrative.

Learn the basic skills of medical interviewing, including listening, questioning, facilitating, empathy, and the use of nonverbal techniques.

Introduce skills needed for interviewing population subgroups- examples might include:

1. elderly
2. children/youth
3. "difficult" doctor/patient encounters
4. patients from other cultures
5. sexual minorities
6. patients with disabilities

Become familiar with certain special interview techniques for obtaining information about:

1. sexual history
2. occupational history
3. substance abuse.
4. HIV/AIDS

III. Data Gathering and Documentation

Obtain all necessary and appropriate information for a complete medical database.

Learn to organize and write up the Complete Medical History clearly and concisely in the Problem Oriented Medical Record (POMR), format to include the following elements:

1. Problem list
2. Patient Identification/Chief Complaint
3. History of Present Illness
4. Past medical history
 - a. medical, psychiatric , gynecological history.
 - b. surgeries, injuries, hospitalizations.
5. Medications
6. Allergies.
7. Habits/exposures (tobacco, alcohol, drugs, sexual history, diet/exercise.)
8. Health maintenance.
9. Family History.
10. Social History.
11. Review of Systems.

IV. Basic Physical Examination

Learn the elements and techniques of a basic physical examination and their functions.

Learn to perform a basic physical examination in the proper sequence, using proper draping techniques, and within a defined period of time.

V. Oral Presentation Skills

Learn to organize, develop, and present oral case reports before faculty and fellow students, using information from the Complete Medical History.

VI. Clinical Reasoning

Learn a basic approach to clinical reasoning. Begin to use this approach to organize and discuss information from the Complete Medical History and to integrate it with findings from the basic physical examination and knowledge from other first-year courses.

VII. Special Topics

Be introduced to the following special topics, the study of which will be continued in subsequent years:

1. Substance abuse
2. HIV/AIDS
3. Sexuality
4. Medical ethics
5. Diversity/cross-cultural medicine
6. Death and dying
7. Local or site specific topics

ICMI QUARTERLY FEEDBACK FORM

Student Name:

Small Group Leaders:

Check all descriptors that apply for each area of evaluation; Use comments section to augment anchor description

Area of Evaluation	Initiating	Emerging	Developing	Mastery
Interviewing: Data collection [process and components of medical interview]	☐ Doesn't fully grasp basic principles and components of medical interview ☐ Unable to collect complete information	☐ Understands basic principles and components of medical interview ☐ Limited ability to collect complete information	☐ Good grasp of basic principles and components of medical interview ☐ Able to collect most elements of complete information	☐ Excellent understanding of basic principles and components of medical interview ☐ Collects all pertinent information completely and efficiently
Interviewing: Communication techniques [principles of patient-centered interviewing and direct communication]	☐ Doesn't fully understand basic principles of doctor-patient communication ☐ Has difficulty engaging the patient ☐ Lacks understanding of professional boundaries	☐ Understands basic principles of doctor-patient communication ☐ Engages the patient most of the time ☐ Demonstrates empathy most of the time ☐ Demonstrates basic understanding of professional boundaries	☐ Demonstrates good understanding of principles of doctor-patient communication ☐ Demonstrates good rapport with patient ☐ Demonstrates empathy while maintaining professional boundaries	☐ Excellent understanding of principles of doctor-patient communication (listening, validating, empathy) ☐ Demonstrates excellent rapport with patients ☐ Non-judgmental ☐ Maintains professional boundaries
Documentation [organization and structure of written medical data base]	☐ Write ups incomplete and/or poorly organized ☐ Doesn't demonstrate good grasp of the medical data base ☐ Judgmental reporting of patient's story	☐ Demonstrates good grasp of medical data base ☐ Write up complete in most areas, but lacking in some details and/or poorly organized in part ☐ Usually reports patient's story in non-judgmental fashion	☐ Write ups complete and well organized most of the time but lacking in some details ☐ Reports patient's story in non-judgmental fashion	☐ Excellent write ups with complete, well-organized data, focused, concise ☐ Data is not missing or inconsistent ☐ Reports the patient's story in non-judgmental fashion
Professional Conduct [understanding and demonstration of responsible behaviors for physician in training]	☐ Avoids issues ☐ Blames others for problems ☐ Demonstrates rigidity ☐ Fails to recognize boundaries ☐ Poor participation in class	☐ Usually respectful of colleagues, teachers, staff and patients ☐ Begins to appreciate impact of own personal beliefs ☐ Sometimes fails to appreciate other's perspectives ☐ Begins to understand professional responsibilities ☐ Uneven or sporadic participation	☐ Respectful of colleagues, teachers, staff and patients ☐ Begins to explore/challenge personal assumptions/beliefs ☐ Begins to explore other's perceptions with sincere interest ☐ Demonstrates good grasp of professional responsibilities ☐ Active participation in class	☐ Respectful and supportive of colleagues, teachers, staff and patients ☐ Actively works to improve group function ☐ Elicits other's perspectives ☐ Demonstrates excellent understanding and acceptance of professional responsibilities ☐ Fully engaged in class ☐ Assumes leadership role
Self Care [for feedback only; student self assessment of self-care]	☐ Disregards personal physical and emotional needs ☐ Avoids support networks	☐ Recognizes need for physical, emotional renewal and self care but often has trouble incorporating into routine ☐ Seeks support and reflects on stressful situations sometimes	☐ Recognizes need for maintaining physical and emotional health and handling stress ☐ Frequently engages in activities to promote this	☐ Engages in activities of self care regularly such as exercise, meditation, etc. ☐ Seeks out support ☐ Recognizes how self-care translates into care of others

Standards of Educational Conduct

Behavior	Meets Standard	Area of Concern	Comments
Respectful of others	☐	☐	
Punctual	☐	☐	
Receptive to feedback	☐	☐	
Prepared for class	☐	☐	
Assignments on time	☐	☐	

Status Report		Completed	Not-Completed
Continuity Reflections:	Patient Component	☐	☐
	Personal Reflection	☐	☐
	Physician Component	☐	☐
Preceptorship		☐	☐

Specific comments:

Interviewing skills - Communication techniques:

Interviewing skills - Data collection:

Documentation skills:

Educational conduct:

Professional conduct:

Standards of educational conduct:

Summary Comments:

Oral Case presentation guidelines ICM-1st Year

Introduction

The ability to give a concise, well organized oral case presentation is an essential skill for a physician. Practicing clinicians accomplish oral case presentations in various forms on a daily basis. Oral case presentation is included in the ICM I curriculum to allow students to begin learning this skill early in their medical school career.

Mastery of The Oral Case Presentation requires concerted effort and repeated practice. Be patient with yourself as you begin. During the next two years you will have opportunities to practice, to learn from your own mistakes and to learn from listening to your peers. By the end of this first year, you will be able to organize, develop, and present an oral case report before faculty and fellow students, using information from the complete medical history. At the end of second year, you will be able to deliver excellent oral case presentations using information from the complete history and physical in multiple settings, including at the patient's bedside.

Purpose

The purpose of the oral case presentation is to precisely communicate the patient's pertinent history, physical examination, diagnostic studies, differential and working diagnoses, and diagnostic/therapeutic care plans to your colleagues. This year presentations will be limited to the history.

Format

Oral case presentations vary depending on the clinical setting. Common settings for use of an oral case presentation include ICM class sessions, bedside teaching sessions, morning report, attending rounds, consultations, and formal grand rounds. A telephone consultation requires an extremely brief, concise summary of the clinical situation whereas a presentation given for teaching purposes can be more comprehensive and formal. Most oral case presentations are given without the use of written notes. Very formal case presentations can be read from a script. In ICM you are expected to work toward giving your presentations without notes.

The following outline can be used to guide your oral case presentations this year:

1. Introduction
2. History of the present Illness (HPI)
3. Past Medical and Surgical History
4. Medications
5. Family History (only as pertinent to the chief complaint)
6. Social History (brief)

Oral presentations in ICM this year should last no longer than 3-5 min.

It may help you to remember that the oral case presentation is not the time to report everything you know about this patient. If your attending wants more information, he or she will ask a question. This will give you the opportunity to impress your audience by expanding on the essential information in more detail.

Specifics

Introduction: This includes the patients initials, age, marital status, ethnicity and occupation followed by the time and setting of the patient's presentation and the chief complaint. eg *"RS is a 65 year old married Native American male truck driver who presented to my preceptor's office this morning complaining of shortness of breath."*

History of Present Illness (HPI): This should occupy 1/3 to 1/2 of your total presentation time. Describe the events in strict chronologic order, paying attention to detail. Remember to consider the classic characteristics of most symptoms (location, quality, chronology, severity, aggravating and alleviating factors, associated symptoms, disability and adaptation, and attributions). Include pertinent positives and risk factors for relevant diseases. Conclude the HPI with pertinent negatives from the Review of Systems (ROS) list that are relevant to the organ system involved in the chief complaint and from the general ROS questions.

Past Medical and Surgical History: Include only items of major importance that have not already been mentioned. If no such items need reporting, simply state that the past medical history is "non contributory."

Medications/Allergies/Substance use: List active medications without specific dose information. Briefly summarize complementary and alternative medicine use if any. List allergies to medications and the actual reaction the patient has. List cigarette use in pack years, alcohol use, and "street drug" use including durations if relevant.

Family History: Describe major familial diseases only if pertinent to the patient's current health management. If none, simply state that the "Family History is "noncontributory."

Social History: Mention only three thing: education/occupation, support systems, and ongoing important social issues such as medical insurance or housing situation.

Delivery Tips

1. Start with good posture, preferably standing without your hands in your pockets.
2. Establish eye contact with your audience, glancing at your notes only as necessary.
3. Use a clear, energetic and interested voice worthy of the importance of the story you have to tell.
4. Follow the suggested outline above in a linear fashion and keep your language precise.
5. Do not rationalize, editorialize, or justify reasons for things as you present. Just tell the "facts" as you obtained them.
6. Whenever you present a patient's medical information, be aware of confidentiality.

UNIVERSITY OF WASHINGTON SCHOOL OF MEDICINE
Evaluation of Student Performance in Preceptorship

Student's Name:

Student's ID Number:

Please evaluate the student's level of performance in each of the following categories by checking the appropriate box. If the area of evaluation is not applicable or not observed, please check the Not Applicable box.

AREAS OF EVALUATION		PERFORMANCE ASSESSMENT				
		Exceeds Expectations	Meets Expectations	Areas to Work on	Evaluator Concern	Not Applicable
Clinical Skills:	Interviewing					
	Physical Examination					
	Documentation					
	Clinical Reasoning					
Educational Attitudes:	(participation; inquisitiveness, enthusiasm, motivation)					
Professional Conduct:	(reliability; professional behavior)					
	(integrity; personal interactions)					

COMMENT SECTION: [Provide descriptive information on the student's performance. Required if evaluator concern(s) and/or student fails the course.]

Evaluator Concern or Areas to Work on: Required comments to document areas to work on or of concern.
Not for use in MSPE letter unless there is a pattern that is discussed with the student.]

Overall Performance: [Required comments to elaborate on areas of evaluation in checklist and/or on other areas of importance. For use in MSPE letter.]

Overall Professional Development: (Check one) _____ Meets Expectations _____ Needs Development _____ Unacceptable*

*Provide documentation to support this assessment

Preceptor's Name/Signature/Date: _____

Date:	Academic Period:	Dept/Course No:	Course Name:	Instructor:	Grade: Pass / Fail
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(sample form)

MEMORANDUM

TO: All WWAMI Students

FROM: Dr. Andrew Turner

SUBJECT: Preceptorship Evaluation

DATE:

In order to improve the preceptor experience for future students, I would appreciate it if you would write a brief evaluation of how your experience was this semester. Please complete and return this form to the WSU WWAMI Office by

Thank you!

Your Name: _____

Preceptor's Name: _____

Preceptor's Specialty: _____

Did the scheduled time work out? _____

If not, what other times did you meet? _____

Did you meet regularly with your preceptor? _____

Did you have sufficient contact with patients? _____

Were you able to interview your preceptor's patients for ICM? _____

How would you rate this site as a first year preceptor experience? _____

Additional Comments:



UNIVERSITY OF WASHINGTON

OFFICE OF RISK MANAGEMENT

EVIDENCE OF PROFESSIONAL LIABILITY COVERAGE

Covered: University of Washington – WWAMI Student program WSU

Term: 7/01/2009 through 06/30/2012

Limits: Coverage is unlimited per occurrence and in the aggregate

Policy Number: Not applicable; this is a statutorily self-insured program

Form: Occurrence

Conditions: Coverage applies to the negligent acts or omissions of the University of Washington and its employees, students, and agents acting in the course and scope of their University duties. The term "agent" includes volunteers to authorized University programs.

Contact: Garrett Stronks at (206) 543-3659, fax (206) 543-3773

Date Issued: July 13, 2009

UWSOM – WWAMI Medical Preceptor
Affiliate Clinical Faculty
Interest Form

Name: _____

Work Mailing Address: _____

Work Phone: _____

Medical Specialty Area: _____

Estimate of total hours involved in precepting WWAMI students (annual amount):
_____ hrs.

I _____ have/ _____ have not had a previous affiliate clinical faculty appointment at UWSOM. (If previous faculty appointment, please indicate years: _____).

I request that the WWAMI Medical Education Program initiate the paperwork for an affiliate clinical faculty appointment or renewal of my current appointment at UWSOM.

Signature of Physician-Preceptor

Please remove this form and return it by mail/Fax to either of the offices below:

Maureen Evermann
WWAMI Medical Education Program
PO Box 643510
Pullman, WA 99164-3510

Marlane Martonick
WWAMI Medical Education Program
PO Box 444207
Moscow, ID 83844-4207

Fax : 509-335-7420

Fax: 208-885-7910