



University of Wisconsin
**SCHOOL OF MEDICINE
AND PUBLIC HEALTH**

**Essential Information for
Residents Who Teach Primary Care Clerkship Students
2010-2011**

I. CURRICULUM and ASSESSMENT:

A. Clerkship Organization:

PCC is a required 8-week experience for M3 students. Students can select from regional sites in Appleton, Eau Claire, Fond du Lac, La Crosse, Madison, Milwaukee, Minocqua. The regional sites assign each student to work with community-based family physicians, general internists or pediatricians. Generally, students are scheduled to work in two clinics, one family medicine and one internal medicine or pediatrics; 3-4 half days a week each.

One half-day a week, PCC students at each regional site come together discuss a series of problem-based learning (PBL) cases and Doctor-Patient Communication, focusing on Motivational Interviewing. A faculty moderator is present to provide guidance and direction to the group.

B. Primary Care Clerkship Educational Goals:

By the completion of this clerkship the student is expected to possess the knowledge, attitudes and skills to:

1. Describe the nature and scope of primary care practice and how it interacts with other health professions.
2. Assess and manage common acute and chronic ambulatory medical problems.
3. Determine the health risks of patients and populations and make recommendations for screening and health promotion.
4. Identify community resources available to enhance patient care as well as barriers to optimal care.
5. Establish effective relationships with patients and families using patient-centered communication skills.
6. Practice life-long learning skills, including the application of scientific evidence in clinical care.

C. Learning Objectives & Competencies

The Learning Objectives constitute the PCC curriculum for which students may be tested. Collectively, they are the most frequent issues encountered in primary care.

<p><u>Symptomatic Conditions</u></p> <ol style="list-style-type: none"> 1. Abdominal Pain 2. Back Pain 3. Chest Pain 4. Headache 5. Musculoskeletal Pain 6. Acute Respiratory Infections 	<p>Objectives</p> <ul style="list-style-type: none"> ❑ Obtain history to generate a complete description of patients’s symptoms, identifying any ‘danger’ symptoms ❑ Perform appropriately focused physical exam, noting any ‘red flag’ signs. ❑ Succinctly present patient case to Preceptor, applying knowledge of epidemiology to generate and defend weighted differential diagnosis ❑ Present assessment in patient-centered manner, integrating diagnostic probabilities and evidence-based treatment recommendations. ❑ Appreciate process of negotiating management plan and incorporating patient preferences into care (ICS, PC, SBP, PBLI, Prof) ❑ Educate patient and family regarding monitoring, danger signs, self-cares, & community resources ❑ Check for understanding of follow-up plan, including treatments, testing, referrals, & continuity of care ❑ Ascertain patient/family beliefs regarding symptom causes and home treatment efforts
<p><u>Chronic Diseases</u></p> <ol style="list-style-type: none"> 1. Hypertension 2. Asthma 3. Depression 4. Diabetes 5. Hyperlipidemia 6. Substance Abuse 7. Obesity 	<p>Objectives</p> <ul style="list-style-type: none"> ❑ Apply knowledge of prevalence, risk factors, and outcomes to make informed recommendations for screening of common chronic diseases ❑ Differentiate among various level, stages and complications of chronic disease, e.g. pre-hypertension, Stage 1, Stage 2, Malignant hypertension ❑ Assess patients’ abilities to participate in treatment planning and integrate patient preferences into management ❑ Systematically monitor for disease control and complications ❑ Investigate barriers to chronic disease management and overall health and assist patients in recognizing and overcoming ❑ Analyze public health impact of chronic disease, effectiveness of population-level interventions, and risk factor reduction programs
<p><u>Systems of Care & Learning</u></p> <ol style="list-style-type: none"> 1. Evidence-Based Medicine (EBM) 2. Doctor Patient Communication 3. Preventive Services (Adult and child physical) 	<p>Objectives</p> <ul style="list-style-type: none"> ❑ Create your own learning goals; self-assess your own skills, behaviors; and seek and respond appropriately to feedback ❑ Formulate answerable clinical questions from your patient interactions, and answer these questions in the exam room whenever possible ❑ Incorporate understanding of patient’s state of mind, beliefs, preferences and background into verbal and written communication ❑ Differentiate preventive service guidelines from various organizations and critique recommendations ❑ Recognize work of primary care physicians to improve population health, suggest ways to enhance these efforts

II. CLERKSHIP EXPERIENCE REQUIREMENTS (ED-2 list of core conditions)

A. Clinical Care Skills: Observation and Feedback Checklist

Each student is required to be observed and receive feedback on the skills listed below.

Skill	Date(s) of Observation and Feedback	Faculty Initials
Observed History: Acute concern		
Observed History: Chronic problem		
Observed Physical: HEENT ¹		
Observed Physical: MSK ²		
Observed Physical: Cardiovascular ³		
Observed Physical: Abdomen ⁴		
Observed Physical: GU ⁵		
Observed Physical: Neuro ⁶		
Observed Physical: Psych ⁷		
Communicate plan of care with patient		

1. Includes proper (pencil-grip) use of otoscope: distinguish normal/abnl TM; use of ophthalmoscope, distinguish nl/abnl throat findings.
 2. Includes IPreSS (as in, 'When it hurts, IPreSS!'): Inspection, Palpation, ROM (active then passive), Strength, Special Tests. Focus on shoulder/back/knee.
 3. Includes cardiac PMI, detect dysrhythmias, perceive S3/S4, describe murmurs including response to maneuvers, palpate peripheral pulses, take BP accurately
 4. Includes detection of HSM, ascites, masses.
 5. Male or female. Inspection, palpation, description of common variants, student appears comfortable.
 6. Includes CN 2-12, Strength, sensation (monofilament), DTRs
 7. Includes Mini-Mental Status, screening for depression
- Please work with your students to ensure that they complete each required experience.

B. The **mid-rotation feedback** session will be a standard check in for clerkships and students to determine if there are outstanding core experiences remaining, and the plan for how they will be met before the end of the rotation. Mid-rotation feedback sessions are a joint responsibility of the student and primary preceptors to schedule; residents may be asked to give feedback but are not primarily responsible for this activity.

- A. **Required Readings:** articles are listed in the learning objectives matrix at: http://www.fammed.wisc.edu/files/webfm-uploads/documents/med-student/pcc/pcc_learning_topics_objectives_matrix.pdf The only required text is Motivational Interviewing in Health Care by Rollnick & Miller; each student is supplied with a copy and a copy is provided for each program library. Residents are strongly encouraged to review this text for their own learning as well as teaching. Additional teaching videos in Motivational Interviewing can be found on the website.
- B. **Feedback:** Feedback is information provided to someone with the aim of enhancing performance. It can reinforce positive behaviors or correct behaviors needing change. Our most frequent concern from students is lack of feedback, especially from direct observation of their skills. Suggestions for giving feedback effectively can be found at: <http://www.fammed.wisc.edu/med-student/pcc/preceptor/week>
- C. **Clinical Evaluation:** Residents will be asked to fill out an evaluation if they have worked with a student 3 or more half-days. If you have less contact than that, the student's primary preceptor may ask you for your evaluation comments to include in his/her evaluation. The evaluation form will be sent to you; you

can preview at <http://www.fammed.wisc.edu/files/webfm-uploads/documents/med-student/pcc/pcc-clinical-eval.pdf> Most students should be ‘competent’ in most areas.

III. LOGISTICS:

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IV. POLICIES

Absences: Students should never ask residents/preceptors for time off; this requires the clerkship director’s approval. In illness or emergency, students should contact their scheduled preceptors and regional site coordinator. If a student calls you because of illness, please remind them to also call the coordinator.

Holiday Schedule: Students are off during these holidays: Martin Luther King Day, Memorial Day, 4th Of July, Labor Day, Thanksgiving. M3 students have a winter break from the 3rd Friday in December until the 1st Tuesday in January.

Dismissal on Core Days: Students are excused from their rotations during all three Core Days. Details are included in the Core Day Dismissal policy.

Work Hour Policy: The policy describes the limited duty hours students are required to spend in clinical and educational activities during clinical rotations. Violations must be reported to clerkship administrator, dean of students, or the ombudsperson.

V. GENERAL EXPECTATIONS:

A. Teaching expectations –

The preceptor's role is to supervise the student in their development of skills in patient interviewing, physical exam, presentation and use of the medical literature. In the M3 year, the students' focus should be on diagnosis. Initially, you should orient the student to the office, discuss your role, review student goals and progress to date, and review your expectations. Go over your schedule for the clinic session, noting patients that would be particularly desirable for the student to see, and drafting a plan for how the session will (e.g.

Preceptors may have their student shadow at the beginning of the rotation to determine the student's level of clinical expertise; the level of independence should increase as the preceptor becomes more familiar with your student’s strengths and weaknesses. **At our residency sites, a challenge is that students**

frequently work with multiple residents/faculty; if each preceptor ‘starts from scratch’ with the student, the student may often end up merely shadowing. Thus it is very important to communicate with the preceptors as a team, talk with your student about her/his roles and experiences, and ensure an appropriately graduated level of autonomy. PCC preceptors are encouraged to observe their student performing all aspects of patient care: history acquisition, physical examination, care plan development and discussion of the plan with the patient. Students are also strongly encouraged to assist in clinical procedures

B. General teaching tips See <http://www.fammed.wisc.edu/medstudent/pcc/preceptor/resources>

a. Adult learning: The seven key factors found in learning programs that stimulated adult development are:

1. An environment where students feel safe and supported, where individual needs and uniqueness are honored, where abilities and life achievements are acknowledged and respected.
2. An environment that fosters intellectual freedom and encourages experimentation and creativity.
3. An environment where faculty treats adult students as peers--accepted and respected as intelligent experienced adults whose opinions are listened to, honored, appreciated. Such faculty members often comment that they learn as much from their students as the students learn from them.
4. Self-directed learning, where students take responsibility for their own learning. They work with faculty to design individual learning programs which address what each person needs and wants to learn in order to function optimally in their profession.
5. Pacing, or intellectual challenge. Optimal pacing is challenging people just beyond their present level of ability. If challenged too far beyond, people give up. If challenged too little, they become bored and learn little. Pacing can be compared to playing tennis with a slightly better player; your game tends to improve. But if the other player is far better and it's impossible to return a ball, you give up, overwhelmed. If the other player is less experienced and can return none of your balls, you learn little. Those adults who reported experiencing high levels of intellectual stimulation--to the point of feeling discomfort--grew more.
6. Active involvement in learning, as opposed to passively listening to lectures. Where students and instructors interact and dialogue, where students try out new ideas in the workplace, where exercises and experiences are used to bolster facts and theory, adults grow more.
7. Regular feedback mechanisms for students to tell faculty what works best for them and what they want and need to learn--and faculty who hear and make changes based on student input.

In contrast, in learning programs where students feel unsafe and threatened, where they are viewed as underlings, life achievements not honored, those students tend to regress developmentally, especially in self-esteem and self-confidence. In programs where students are required to take identical lockstep courses, whether relevant to professional goals or not, and where they are often expected to spend several years working on a dissertation that is part of a professor's research project instead of on a topic of their choice, they grow less. In other words, students grow more in student-centered as opposed to faculty-centered programs.

Seven Characteristics of Highly Effective Adult Learning Programs by [Dorothy D. Billington](#)

- b. One Minute Preceptor** resources: The “One-minute Preceptor” is a widely accepted teaching model that summarizes five important tasks or “microskills.”
<http://www.stfm.org/fmhub/fm2003/jun03/stevens.pdf>
 1. Get a commitment,
 2. Probe for supporting evidence,
 3. Teach general rules,
 4. Reinforce what was done right, and
 5. Correct mistakes.
- c. Bedside teaching tips: an ambulatory adaptation of bedside rounds is**

PRESENTING IN THE PRESENCE OF THE PATIENT

Learner presents to resident/faculty in exam room

Learner should be skilled at basic presentation

Inform learner in advance

Learner should use language understandable to patient

Patient should be actively involved in clarifying or adding to presentation

- d. Professional expectations** – honor/integrity, confidentiality, accountability, respect for others, appearance (see appendix A: Stanford School of Medicine *Guidelines for Optimal Resident Interactions*)

Appendix A. Stanford School of Medicine Guidelines for Optimal Resident Interactions

Residents should:

- Introduce students and provide a description of their role to patients, families, and other health care staff.
- Inform students of expectations and their role in the group at the beginning of a rotation.
- Include students so they feel like active members of the team.
- Encourage students to take "ownership" of their patients.
- Give students an appropriate amount of responsibility in caring for patients.
- Discuss with students how to present themselves professionally; this includes dress, demeanor, language, punctuality, etc.
- Provide appropriate and constructive feedback based on observed student interactions with patients and other members of the health care team.
- Be patient with students.
- Encourage questions.
- Be accessible to students.
- Give specific feedback frequently.
- Give praise and thanks liberally.
- Make sure tasks assigned to students have learning value.
- Focus on teaching pertinent physical findings.
- Lead by example. Residents are important role models for students.
- Treat all health care providers (nurses, therapists, administrative assistants, techs) with respect at all times.
- Observe patient confidentiality at all times.
- Show empathy and compassion for patients and families, both in their presence and when discussing patients with colleagues.
- Always behave in a respectful manner with honor and integrity.
- Teach cultural sensitivity and follow ethical principles.
- Share a "pearl" daily.
- Explain the purpose behind ordering labs, studies, or consults.
- Admit when they don't know the answer.
- Teach something about each patient everyday.

Residents should not:

- Take credit for students' work.
- Talk disrespectfully about other healthcare providers (i.e., ancillary staff, other medical specialties).
- Use inappropriate language.
- Introduce students as "Doctors."
- Make negative or disparaging comments about students in front of other students or patients.
- Interrupt or joke during student presentations.
- Have confrontations in front of patients and families.
- Reprimand students in a publicly humiliating fashion.
- Say "You should know that by now."
- Compare different students' knowledge in front of other students.
- Ask questions in a belittling manner.
- Have unfair expectations of students' medical knowledge or ask questions beyond the scope of students' knowledge.
- Send students on menial errands that have no learning value.
- Allow interactions with pharmaceutical representatives to defer from practicing evidence-based medicine.
- Make sexual advances or references to students.