How to get the most out of precepting

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Expectations:

- That you will do your best to get here on time (not always possible with conferences and such; do your best).
- That you will present every patient (even if 10 seconds) and give me each chart to sign off.
- That we are here to learn-teach and to serve, and that we will do them as best we can in a way that we can all have fun.
- We will learn together.
- It is fine to have your own style and opinions.

Tips/Flow:

1. **Preclinic Huddle**: arrive to clinic on time and we will go over your schedule, then you can review it with your MA and tell them what you need. I will try to do this with whoever has the busiest schedule first or has a patient waiting. If you are not here I will take a look at your schedule and see if anything jumps out.
    a. Tell me about the problems that you will likely encounter and what you might need help with. Procedures, medical, psych, social issues.
    b. Discuss most difficult patients at the beginning of clinic.
2. **During Visit:**
    a. Enter Room: have at least looked at last note, med list, prob list and be present.
    b. How to get/ stay present during clinic:
        In Room: Breathe while seeing patients, Shift and activate (heart math), Chart breath. **Between patients**: Bathroom shake, Washing hands ritual (these tips are Ben specific tips-others may have their own).
    c. Focus of visit
        i. Patient's agenda
        ii. Your agenda
    d. Triage: Urgent, Emergent, Important, Can wait
    e. DDx: What is most likely and what is most serious
    f. Brief Negotiations helpful here even if just running a visit
        i. Negotiate the agenda
        ii. Handle what the patient thinks is most important and what you think is most important.
        iii. Close the visit (summarize)
        iv. Have fun and enjoy your time with your patients as much as you can.
    g. Note taking: SOAP notes
        i. 2 styles: most important is to find one and get good at it
            1. SO one place for all problems and then the A/P by problem.
            2. Separate SOAP for each problem
        ii. Efficiency tips:
            1. Write while taking the history and before telling them the plan in the room.
            2. Easiest to forget the plan so write what problems you discussed and what you did.
            3. Set yourself up for your next visit. NV: order 1 hour glucola, discuss DV, consider US if ?position.
3. **Post Visit: Presentations**:

a. Preferences
    i. Many like to hear 'what to listen for' and then hear about the patient. E.g., this is a 22 y/o woman with vaginal bleeding and I want to know if I need an ultrasound. Then go into the presentation.
    ii. Others like to hear about the patient in general and then move toward what your conclusion and needs are.
    iii. SNAPPS: **S**ummarize briefly the history and findings. **N**arrow the differential to two or three relevant possibilities. **A**nalyze the differential by comparing and contrasting possibilities. **P**robe the preceptor by asking about uncertainties, difficulties, or alternative approaches. **P**lan Management for the patient's medical issues. **S**elect a case related issue for self-directed learning.
b. Generally err on the side of brevity (2 minute presentations or less).
c. I like to see the charts/hear about the patients before the patient has left and I understand that this is not always possible or practical.

4. **Post Clinic Teaching Huddle:** opportunity to discuss some of what was learned today and what we are all seeing. If time or interest, briefly review a topic of interest.
5. Most preceptors like to know what you enjoyed most from your patient visit.

For the Preceptor: **The Five (or Seven) Microskills of precepting:**

1. **Setting expectations (above)**: Decide what the point it of this discussions. Figuring out the differential diagnosis? Choosing an antibiotic? Practicing an oral presentation?
2. **Getting a commitment**: after hearing the history and/or physical exam, make the learner tell you what he/she thinks is going on before you them him/her what you think.
3. **Probing for supporting evidence**: Ask the learner what made him/her come to that conclusion.
4. **Reinforcing what was done well**: Make sure you are specific ("Your history was very well-organized; I could really follow the chain of events even though it was really complicated").
5. **Correcting mistakes**: Be specific and give details of what could be done differently next time ("Your physical exam was not as complete as it could have been; next time you have an asthmatic you should be sure that you report the respiratory rate, whether there is grunting, flaring and retracting, and the quality of the air entry as well as whether or not you heard wheezing").
6. **Teaching general rules**: Point out how this situation is like other common situations. Don't make an exception to the rule sound like the norm.
7. **Encourage reflection and integrations**: Ask the learner questions that make him/her think about the situations like "Was it hard for you to talk to the parent about this?" or "Did this child look like the last asthmatic you saw?"

Not every interaction requires all seven steps. Do what makes sense!

Table 1. Guidelines for the Outpatient Case Presentation

1. Should be less than 2 minutes long
2. First sentence — patient's primary concern and learner's question(s): *"I'm seeing Mr. Smith, a 45-year-old man with cough; my question is whether I should prescribe antibiotics."*
3. *History of present illness*
   a. At least one half of total presentation time
   b. Is *chronologic* (correctly describes sequence and rhythm of illness; if today's problem is a direct extension of some ongoing chronic illness, it begins with description of chronic illness, summarized by use of "key words"*)
   c. Is *attentive to detail*: e.g., not *"chest pain,"* but rather *"well localized, superficial, sharp, pleuritic, nonexertional, left anterior chest discomfort"*
   d. For symptoms and epidemiology, includes *pertinent negative findings*
4. *Major other ongoing medical problems*, summarized by:
   a. Name only (more appropriate to residents)
   b. Use of "key words"* (more appropriate to medical students)
5. *Medications and allergies*
6. *Physical examination and laboratory data* — includes only the pertinent positive findings
7. *Assessment and plan*

* *"Key words" are (1) date of original diagnosis, (2) usual symptoms, (3) current treatment , (4) complications, (5) recent objective measure. For example:* "He has a 1-year history of ischemic cardiomyopathy, characterized by chronic orthopnea and 1/2 block dyspnea on exertion, recurrent hospitalizations for pulmonary edema despite furosemide, nitrates, and lisinopril, and an ejection fraction 2 weeks ago of 20%."