Jamie's Precepting Points

(1/2010)

HUDDLE: Define their role in clinic

- Number of pts to see
- Time to spend parts of exam to do
- Content and form of presentation and note
- How to review the chart, flow of presenting to you and preceptor
- Objective – for each visit, for the session, for the next week

Guidelines for Oral Presentations:

- Less than 2 minutes
- Start w pt's primary concern and learner's questions
- HPI ½ of total time
- Chronologic- key words – detail oriented – pertinent negatives
- Major ongoing medical problems
- Meds and allergies
- PE and labs
- Assessment and Plan

Microskills:

- Get a commitment
- Probe for supporting evidence
- Teach general rules
- Reinforce what is right
- Correct mistakes

Teaching Strategies to Consider:

- Ask them to demonstrate their understanding
- Demonstrate what they have learned
- Questioning as teaching tool
- Give feedback (sandwich) about behaviors not personality regularly
- Priming:
    - Preparing them before going to see patient
    - Differential diagnosis, supportive evidence, typical findings
    - Chronic care management
    - Preventive health
- Don't talk too much and give them time to answer your questions
- Think out loud – invite their opinions – be enthusiastic
- Modeling: Active Shadowing "watch how I …. ."
    - Procedures
    - Specific behaviors/Interactions
- Multiple medical problems – pick one for them to cover
- Teach at end of day – ask your preceptor to help prepare something
- Assignments to research for later in the day or next session

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%."