Communications

A Training Program for Community Physicians Serving as Preceptors in Family Medicine

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As greater opportunities are sought to provide medical students with clinical training and supervised experience in primary care, many medical schools are asking community physicians to serve as part-time preceptors. These preceptors tend to have little experience in teaching medical students. It is important, therefore, to train and support such community physicians for their new teaching role. A training program which was set up in the Department of Family Medicine of the University of Cincinnati is described in this communication.

The first step in designing the training program required a technique to elicit the preceptors' perceptions and prioritization of the problems related to teaching. The Nominal Group Process[1] was adopted and became the basis for the first meeting with the preceptors.

During the initial meeting each participant listed the problems he or she encountered in teaching students in a preceptorship. A discussion leader then elicited each problem and a scriptor recorded the problems. Once all the factors were recorded, the participants then selected and rank ordered the problems they considered most important and a group consensus was reached.

A number of high priority problems emerged. The preceptors were uncertain about the teaching goals and objectives and felt that the level of their responsibility was not clear. A second problem was the issue of time management. Many of the preceptors felt that the presence of the student slowed up their practice and caused difficulties for their staff. A third problem area was evaluation. The preceptors did not feel well prepared to evaluate a student's performance. In addition, they indicated that their teaching effectiveness was not being critically evaluated and that they were not getting useful feedback on their teaching performance.

These high priority problem areas became the focus of the three subsequent workshops. The first of these was conducted by an expert in time management. The goal was to help preceptors answer three key questions regarding time and the many tasks or activities in which they engage. The questions asked were: "What would happen if an activity were not done at all?" "Which of the activities could be done by someone else just as well, if

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0094-3509/79/051063-03$00.75
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not better?'' and ''Which of the activities waste someone else's time without contributing to their effectiveness?''

In order to try to answer these questions the preceptors were asked to record how they used their time during the previous day. They then formed trios, compared their utilization of time, and discussed the three questions. The trios then merged into three larger groups and summarized their responses. Finally, a spokesperson from the three groups presented a summary report to the group at large.

Some of the outcomes of this workshop are best illustrated by selected comments from a post-workshop evaluation form.

''Excellent review of different methods of managing time''

''Could help our practice of medicine, efficiency, and daily living''

''Made me reappraise my use of time.''

The next workshop dealt with the goals and objectives of a preceptorship. The preceptors had been introduced to the overall educational goals in previous workshops and through correspondence. However, they had difficulty in translating the general goal statements into specific facts, concepts, principles, skills, and attitudes, to be taught from day to day. Therefore, the workshop was designed to train the preceptors in writing exemplar learning objectives which were realistic, specific, and observable.

The workshop was introduced by a mini-lecture on types of instructional objectives. This presentation distinguished between general objectives on the one hand and specific, enabling objectives on the other. The latter type of objective indicates specific student behaviors that could signify attainment of the general objectives. When writing enabling objectives, the preceptors were told to list a representative sample of student behaviors rather than to be exhaustive.

Following the mini-lecture on objectives, the preceptors were divided into small groups. Each group was assigned general objectives and asked to derive specific objectives for each. The following example illustrates a set of specific objectives the preceptors formulated.

General Objective: To gain an awareness of family medicine and health related activities in community settings, including the relationship of the physician to patients and families.

Specific Objectives: The student will be able to:

1. Identify the types of services provided by the physician to the patient/family, eg, crisis intervention (medical, psychological, social), preventive care, episodic evaluation, long-term continuity of care;
2. Identify roles and responsibilities of office personnel;
3. Describe and explain office procedures (eg, records, billing, appointments, telephone, patient flow, etc).

The final workshop dealt with the evaluation of student learning. In a preliminary mini-lecture, two important concepts were explained, namely, ongoing and terminal evaluation. The first type of evaluation is to provide information to both teachers and students in order to improve the ongoing teaching/learning process. It is done at frequent intervals and serves as a basis from which to (1) diagnose strengths and weaknesses in the teaching/learning process and (2) prescribe changes to maximize student growth. Terminal evaluation, on the other hand, provides a basis from which to assign a grade. It is done with the intent of making global and terminal assessments of student growth and/or progress toward the achievement of learning objectives.

After this initial presentation, the preceptors were divided into groups and asked to generate lists of strategies they were currently using or might use for ongoing evaluation of students. The groups then evaluated the strengths and weaknesses of each strategy in terms of its utility as an ongoing evaluation device using practicality, effectiveness, and efficiency as criteria.

Virtually all the preceptors realized that they frequently engage in ongoing evaluation when they work with a student during a preceptorship. Some of the specific procedures reported were: (1) chart review, (2) student diary, (3) case presentations, (4) frequent discussion of objectives with students, (5) direct observation, (6) peer evaluation, (7) office staff evaluation of student, and (8) patient evaluation of student.

The next part of the workshop allowed the preceptors to discuss and recommend procedures for terminal evaluation of the student. The preceptors had previously expressed some dissatisfaction with existing grading procedures, noting that almost every individual student seemed excellent when graded. It was clear, however, from later

judgment that some students had actually been quite superior to others.

During this part of the workshop, the groups listed the strengths and weaknesses of the terminal evaluation procedures currently used. They then discussed possible modifications of these procedures. They agreed that such an evaluation should include rating scales of specific student competencies and that the scales should provide explicit criteria of performance so that greater objectivity could be achieved in evaluating students.

References

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Teaching and Learning Style Preferences of Family Medicine Preceptors and Residents

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Clinical teaching in the health professions involves a great deal of one-to-one instruction which is highly influenced by the match of instructor and learner. Learning style preferences offer one means of analyzing variations in these teaching interactions. Learning styles are relatively constant attributes or preferences of an individual which interact with instructional circumstances in such a way as to produce differential learning as a function of those circumstances.[1] Numerous instruments are available to measure and quantify these learning preferences.[2-5]

This pilot study addresses the following questions:

1. What are the teaching and learning style preferences of preceptors and residents in a family medicine residency program?

2. Do the teaching and learning style inventories identify the compatibility of preceptor/resident pairs?

3. Do these instruments increase insight into the teaching and learning process in family medicine?

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Method

Subjects of this study were 22 preceptors and 18 residents in a university-affiliated family medicine residency program located in a city remote from the university. The residency program has been in operation since 1972.

As part of a faculty development program, a workshop on teaching and learning styles was conducted for preceptors and residents in January 1978. Prior to the workshop, preceptors were mailed an Instructional Styles Inventory[3] and a Self-Assessment Inventory for Clinical and Classroom Teaching in Medicine[6] while residents were sent a Learning Styles Inventory.[2] Sixteen out of 22 preceptors and 15 of 18 residents responded.

The Learning Styles Inventory[2] and the Teaching Styles Inventory[3] developed by Canfield were selected because they provide complementary forms to compare preceptor and resident preferences for 17 instructional variables. Preferences are assessed for conditions of learning (eg, well-defined and organized instruction), interest in subject matter areas (numbers, words, people, things), and preferences for modes of learning (listening, reading, viewing, direct experience).

Separate workshops were held for preceptors and residents. During the workshop, participants completed another form. Preceptors identified three residents they liked to teach most and three they preferred to teach least, along with reasons for

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