

## For the Office-based Teacher of Family Medicine

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Feature Editor

*Editor's Note:* This month's column addresses some important issues and originally appeared as a chapter in *Precepting Medical Students in the Office* and is reprinted with permission (Paul Paulman, MD; Jeffrey L. Susman, MD; and Cheryl A. Abboud, MPA, eds. *Precepting Medical Students in the Office*. 2000[Copyright Holder]. Reprinted by permission of The Johns Hopkins University Press).

I welcome your comments about this feature, which is also published on the STFM Web site at [www.stfm.org](http://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 Paul Paulman, MD, University of Nebraska Medical Center, Department of Family Medicine, 983075 Nebraska Medical Center, Omaha, NE 68198-3075. 402-559-6818. Fax: 402-559-6501. [ppaulman@unmc.edu](mailto:ppaulman@unmc.edu). 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.

## Pitfalls of Precepting

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### Key Points

- Precepting medical students is an enjoyable activity.
- There are pitfalls of precepting that can be anticipated and often avoided or altered to improve the teaching process.

Teaching medical students in your office can be rewarding. However, there are conditions that may interfere with the teaching process. Here are several points to consider.

*Don't precept a student when you are overcommitted and stressed.* The last thing students need to see are role models who reflect exhaustion, irritability, or even depression. Stressed preceptors may be tempted to vent with students. The students do not know how to put the stress of the preceptor in perspective, and

this puts an unfair burden on them (a student shouldn't be used as a therapist).

*Don't hesitate to discuss mutual expectations for the preceptorship.* It is unfair to be upset with students' performance when you have not discussed rotation goals and objectives. Also, students inevitably come with hopes and expectations about the preceptorship. You might simply ask, "By the end of 6 weeks, what measurable skills or knowledge do you wish to acquire or improve that you don't possess now?"

*Don't try to teach too much.* One of the hardest things to do is to avoid lecturing. All learners have limited attention spans and are unlikely to retain more than a fraction of what is said. Conveying one or two important pieces of information per patient will result in dozens of new insights for the student each day. If time is limited and your student has questions about a substantial issue, you can suggest discussing it over lunch or at the end of the day.

*Don't have students see everything you do.* It is important to give students specific tasks while you see other patients, dictate, use the telephone, or visit with a patient privately. Such variety tends to stimulate and energize. Having the students simply follow you about encourages passivity. Possible tasks for the student might include observing the lab technician for a couple of hours or reading up on a problem seen in the clinic.

*Don't make assumptions about your students' knowledge.* Students come from a variety of backgrounds and often have significant expertise in some areas. In addition, changes in curricula may provide earlier clinical experience than was the case in the past. Your students may expect a higher degree of participation than was true when you trained in medical school. Don't assume that all students have the same level of knowledge and experience, especially early in the clinical years.

(Fam Med 2001;33(10):730-1.)

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From the Department of Family Medicine, Oregon Health Sciences University.

*Don't fail to review your students' work.* Time may not allow a full discussion of things a student may want to share. The student will learn, when asked, to summarize the important points of an interaction with a patient.

*Don't assume that documentation by students is adequate or appropriate.* Even if the basic content is correct, the tone and focus of the student's visit note may vary significantly from your preferred documentation. In addition, some third-party payers, such as Medicare, have rules about documentation by medical students. When in doubt, check with specific carriers in your region. If uncertain, dictate your own note. Review student documentation for personal judgment or bias and medical-legal risk issues.

*Avoid giving the impression that you'd rather not have the student.* Students are generally quite sensitive to your needs and will likely be receptive or even appreciative that you communicate your concerns directly. If you feel pressed for time on a given day and find it difficult to cope with a learner underfoot, you might introduce the student to an associate, partner, or one of the staff who might be able to work with the student for a specified interval. Alternatively, simply ask the student to come back on a different day when it is less likely that conditions will be as stressful. Share with the student your need to keep the clinic schedule moving or to step in with difficult or time-consuming patients.

*Avoid misrepresentation.* In general, students don't mind being introduced as learners but sometimes can feel awkward, embarrassed, or guilty when they are introduced as "doctor." In addition, patients may feel misled (or even resentful) if they subsequently learn the true status of the medical student.

*Don't fail to assess student competence.* Ideally, discussion of a student's performance should take place apart from the exam room and out of the presence of the patient. Otherwise, either the patient or the student may well feel put on the spot.

*Avoid subtle putdowns of the student in front of the patient.* Although appropriate questioning and use of a Socratic method may be effective in some circumstances, these may not always represent the best approach. Strive to acknowledge significant strengths and experience that the student demonstrates.

*Don't fail to review your student's homework.* Students can come to resent a constant stream of suggestions for self-study, however well intended, when there is no follow-up or closure of multiple earlier directives.

*Don't fail to keep your commitments.* If a student expects to work with you and you are unavoidably delayed, make an effort to communicate this information to the student. Think of your consternation when you are asked to wait for even a few minutes without any clear explanation. Also, make yourself available so the student can inform you of his or her delays and schedule changes.

*Don't hesitate to mention issues that are a source of significant annoyance.* A student's behavior, dress, or even personal hygiene may cause you some irritation or frustration. We all try to learn sensitivity and tolerance of diversity, especially with religious or cultural differences. Some issues may interfere with the quality of precepting or patient care. If there are specific concerns, never ignore them by conveying to the student that he or she is doing fine. The last thing a student wants is to be reassured that all is well, only to learn of specific behavioral deficiencies long after the rotation is completed. One way of approaching behavioral issues might be to express your feeling directly but with sensitivity. For example, if you have concerns about dress, you could say, "I need to share my discomfort with you about your appearance in the office. While it would be fine for you to wear those sandals during your free time, they are not professional-looking enough for my office, and I would appreciate it if you wore closed shoes."

Having a student in your practice requires extra planning and attention to details. With such effort, preceptors can avoid these pitfalls.

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