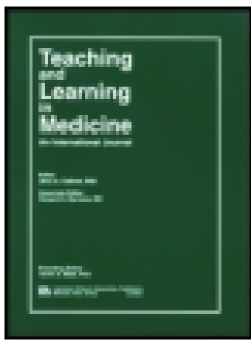

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Barriers and Strategies to Engaging Our Community-Based Preceptors

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OBSERVATION

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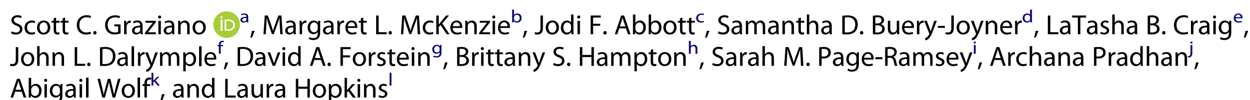

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ABSTRACT

Issue: This article, from the "To the Point" series that is prepared by the Association of Professors of Gynecology and Obstetrics Undergraduate Medical Education Committee, is a review of commonly cited barriers to recruiting and retaining community-based preceptors in undergraduate medical education and potential strategies to overcome them. **Evidence**: Community-based preceptors have traditionally served as volunteer, nonsalaried faculty, with academic institutions relying on intrinsic teaching rewards to sustain this model. However, increasing numbers of learners, the burdens of incorporating the electronic medical record in practice, and increasing demands for clinical productivity are making recruitment and retention of community-based preceptors more challenging. **Implications**: General challenges to engaging preceptors, as well as those unique to women's health, are discussed. Potential solutions are reviewed, including alternative recruitment strategies, faculty development to emphasize efficient teaching practices in the ambulatory setting, offers of online educational resources, and opportunities to incorporate students in value-added roles. Through examples cited in this review, clerkship directors and medical school administrators should have a solid foundation to actively engage their community-based preceptors.

KEYWORDS
engagement; preceptors; teaching

The transition and subsequent continuity of care between community-based, ambulatory environments and inpatient settings is a common practice pathway, particularly in Obstetrics and Gynecology (Ob/Gyn). Medical educators across the specialties should incorporate and make visible these distinct yet connected environments into their learners' educational experience. The Liaison Committee on Medical Education requires that "the faculty of a medical school ensure that the medical curriculum includes clinical experiences in both the outpatient and inpatient settings."[1] However, as institutions increase their enrollment to meet potential workforce shortages, educators must identify more effective clinical training sites to meet these demands. More medical schools are partnering with community practice sites across all core clinical clerkships to expand for provision of appropriate clinical experiences.[2]

Community-based sites provide opportunities for students to get one-on-one interactions with patients as well as faculty. Portions of the preprocedure workup, like diagnostic testing and informed consent, may happen only in the ambulatory setting. Although academic centers centralize the care of the complex patient, the community practices focus on more common conditions. These conditions usually represent a significant portion of the students' list of required core clinical experiences.

Despite these obvious benefits, engaging community-based preceptors remains a challenge. Traditionally, community-based preceptors have served as volunteer, nonsalaried faculty. Academic institutions have relied on intrinsic teaching rewards as ways to sustain this teaching model.[3–8] However, increasing numbers of learners

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across disciplines (allopathic, osteopathic, nurse practitioner, physician assistant), the burdens of incorporating the electronic medical record in practice, and increasing demands for clinical productivity make recruitment and retention of community-based preceptors more challenging.[8–12]

The 2013 Multi-Discipline Clerkship/Clinical Training Site Survey evaluated data provided by M.D. granting schools, D.O. granting schools, nurse practitioner programs, and physician assistant programs. They identified that 80% of medical schools had concerns related to the number of clinical training sites.[8] In addition, 70% of schools responded that it was more difficult to recruit new clinical training sites. Recruiting preceptors for primary care–based rotations was found to be the most challenging, with pediatrics and obstetrics and gynecology topping the list.[8]

This review summarizes the known barriers to recruiting and engaging the Ob/Gyn community preceptors and presents options for unique solutions to those challenges.

Barriers to engaging community based preceptors

Productivity constraints

Time and a decrease in productivity are frequently cited as chief concerns of community preceptors.[9–13] A survey of internal medicine, pediatric, and family medicine preceptors revealed that working with a student added an additional 60 minutes to the workday.[4] Several additional survey studies found preceptors estimating an additional 46 to 51 extra minutes per day.[9,10,14] These same surveys estimate preceptors losing $34 per day in family medicine clinics (in 1997 dollars).[14] Denton et al. directly observed internal medicine ambulatory clinics with and without 3rd-year clerkship students and found the addition of a student added about 32 minutes per half-day session.[15]

Community preceptors have competing demands on their time: clinical care, practice management, and teaching and assessment efforts. Many community preceptors cited teaching as increasing their overall stress level.[4] Stressed preceptors are more likely to precept students for shorter periods each year. A lack of familiarity with efficient teaching techniques may increase that stress level. Although community-based preceptors enjoy teaching, the requirement of providing evaluation and feedback serves as a barrier to recruitment.[13] One third of community preceptors feel uncomfortable with providing feedback and adjudicating students' performances.[5] In addition, 94% of preceptors want help with time management, evaluations, and efficient teaching techniques. A self-perceived lack of teaching skills, potentially adding to uneasiness and stress, may also serve as a barrier to recruiting community preceptors.[6]

Access to the electronic medical record (EMR) may be a technological barrier for the community preceptor. Data from a 2014 Liaison Committee on Medical Education survey revealed that 15%–30% of medical school clinical training sites limit students to read-only access when using the EMR.[16] The multiple number of EMR platforms students might encounter in the ambulatory setting present challenges to their preclinical preparation. Allowing login access to students may be difficult across multiple sites and platforms and may require additional time to achieve access to the system. In addition, faculty themselves may struggle using the EMR, making simultaneous teaching of medical students more difficult.[17,18]

Identification of teachers

Much of a clerkship director's administrative time is spent on the management of the curriculum and day-to-day flow of the clerkship. As such, time for identification of and communication with potentially willing community-based preceptors may be lacking. Academic institutions provide numerous teaching opportunities as well as faculty expectations as part of the recruitment process. Without direct contact from clerkship directors, non-teaching community physicians may be unaware of how to get involved in medical education opportunities.[6,7] So although the pool of teachers may not be exhausted, the traditional mechanisms of preceptor recruitment may require reevaluation.

Unique challenges in women's health

The sensitive nature of the history and physical examination of the female patient remains a significant barrier, particularly in Ob/Gyn. Patients and Ob/Gyn providers alike are less likely to allow student participation during the encounter, especially when the disclosure of sensitive information is necessary. Up to one third of women surveyed are uncomfortable with medical students performing the physical examination, when it includes the pap smear and pelvic examination.[19] An Australian study revealed that only 62% of women are ready to accept students for their intrapartum care, citing privacy as a main concern.[20]

Gender bias also generates a barrier for student participation. In addition to privacy concerns, Grasby et al. highlighted gender differences as well: Only 43% of women would allow male students to participate in

intrapartum care, compared to 61% for female students.[20] Physicians themselves may exacerbate these biases. Physicians tend to overestimate the potential negative impact medical students have on their patient's experience and underestimate the positive influence they can have on their practice, when compared to actual patient perceptions.[21] Physicians also overestimate the patient's need to speak privately to their Ob/Gyn provider.[22] These perceived gender issues and differences may develop early in physicians' careers. Medical students themselves identify Ob/Gyn as a female-dominated specialty and tend to agree that female patients prefer female providers.[23]

Removing the barriers to engaging community-based preceptors

Recruitment strategies

The first step to engaging community-based preceptors is identifying those with an interest in participating. Many community-based preceptors may not be aware of the opportunities available.[6,7] Ullian et al. highlighted a successful recruitment strategy for their longitudinal generalist preceptorship program.[24] They stressed the importance of partnering with well-established, respected community physicians to engage their own colleagues in the area. A well-respected colleague can facilitate recruiting additional community preceptors. Establishing effective lines of communication with clerkship administrators will also help solidify long-term relationships. Providing names, photos, and contact information of the clerkship director and coordinator will aid community-based preceptors with a reliable point of contact with the medical school. Any questions or concerns regarding a student can be quickly addressed. In their survey, Scott et al. recognized that teaching preceptors were more likely to be alumni of the program, so a targeted approach to recruiting may be warranted and more successful.[7] Partnering with a medical school's alumni relations board can help in contacting former medical school graduates in the area. Institutions with graduate medical education programs can also reach out to department chairs and program directors to identify recent resident graduates.

Benefits to the preceptor

Over the years, community preceptors have consistently cited several tangible benefits as desirable: library access, campus parking, faculty appointments, and free or reduced fee continuing medical education opportunities.[3–7,24–26] Reimbursement, in the form of a teaching stipend, has recently gained more traction. Survey data from 2011 showed that physician preceptors placed increasing emphasis on monetary support, compared to 2005.[27] Anthony et al. noted that although only 23% of Family Medicine clerkships surveyed are paying preceptors, this number may be growing.[28] Specialty type, as well as geographic location and competition in the market, can affect this factor. Several models compensating preceptors with educational value units and mission-based budgeting appear promising but may not be feasible for all institutions.[29–31]

Newly recruited community-based preceptors should be made aware of the positive impact that students have on their patients. Patients perceive that they themselves learn more when the preceptor is teaching the medical student, and there is significant benefit to their care when students are involved.[32–34] Eighty-seven percent of surgical patients felt more informed about their care, as students were able to answer their questions when their doctor didn't have time.[33] Ninety-two percent of postpartum women stated they learned something about their condition due to the student being taught by the faculty in their presence.[32] As new preceptors are recruited and oriented, sharing this historically positive and patient-driven data may encourage their continued participation in clinical education.

Clerkship directors and administrators should not be afraid to leverage the obvious intrinsic benefits of being a community preceptor. Most community preceptors are excited about contributing to student education, giving back to the next generation, and providing students with real-life clinical exposure.[3–5,7] They enjoy the personal interaction as well as the opportunity to learn something from the students.[6] Most students who receive encouragement to enter the field of Ob/Gyn do so from faculty in the clinical environment.[23] Community preceptors should be made aware of these intrinsic values of teaching and the influence they can have on future careers.

Faculty development

Community-based preceptors may benefit from faculty development directed at incorporating students into the clinical environment. This may assist with efficiency and productivity. Many community-based preceptors have utilized creative scheduling techniques to incorporate teaching students into their clinical practice.[13] Ferenchick et al. outlined a technique of wave scheduling to optimize patient access and teaching time, using one room for the faculty and one room for the student.[35] This effective technique allows the faculty to multitask

patient care, direct observation, and teaching time. A similar parallel model was evaluated with videotaped sessions, showing no significant difference in patient encounter times between physician only versus student involvement (13 minutes vs. 12 minutes).[36] That same parallel program also showed that when students were involved in the practice for 5 months, consult times dropped from 14 minutes to 9 minutes.[37] This model may help community-based preceptors who reach out with concerns of time pressure and productivity concerns.

Faculty development sessions can provide community-based preceptors with an educational toolbox of resources. This can reduce the stress of teaching, allowing them to develop into effective teachers. Usatine et al. evaluated four "exemplary" teaching faculty while working with medical students. Only 1 minute was added to the overall patient encounter. Although there were 30 seconds less faculty face time, patients did spend more time overall with the healthcare team.[38] They noted that exemplary faculty commonly utilized time efficient teaching strategies, such as orienting the learner, presenting the case with the patient present, and the 1-minute preceptor technique, originally described by Neher et al. This series of five actions encourages students to develop differential diagnoses, assessments, and management plans. It also encourages teachers to teach around patients and provide formative feedback.[39]

All medical educators, including community-based preceptors, are required to provide learners with rotation expectations and feedback. Several models for delivering feedback exist. Providing preceptors with a framework for feedback may help their comfort level. One such model emphasizes four components: the student's self-assessment, the teacher's assessment, an action plan, and a final meeting summary.[40] Additional online educational resources, such as the Association of Professors of Gynecology and Obstetrics Effective Preceptor Series pamphlets and videos and the online Medical Student Educational Objectives, may aid community-based preceptors as they transition students into their everyday practice.[41]

New community-based preceptors may feel overwhelmed during the first few ambulatory sessions, when both students and preceptors are developing skills.[42] Additional encouragement and support from administration during this time can be helpful. As patients are involved with students over multiple visits, it is more likely they will allow active participation, including pelvic exams and pap smears.[19] It is important that patients are aware up-front of student participation and that asking permission increases student participation, particularly when it is a personal request from the preceptor.[22,43]

Curricular structure

Clerkship directors and school administrators should work with community preceptors to help integrate students into the ambulatory setting. On-site orientation may facilitate integrating the student into the office practice.[44] Most ambulatory patients appreciate the attention they get from medical students during their visit.[45] Students are uniquely positioned to have an impact on patients in the clinic; they have time, technological skills, and problem-solving mind-sets.[46]

The Society of Teachers of Family Medicine published a document on how to better incorporate students to add value into an outpatient practice.[47] Having students reconcile medications and problem lists allows them to document required care activities in the EMR. Completing and reviewing after-visit summaries provides students with opportunities for face-to-face patient education. Community-based preceptors can coordinate interprofessional educational opportunities, having students interact with laboratory technicians, nurses, and medical assistants by drawing blood and administering immunizations.[44] In addition, if students are granted written access to the EMR, they may document the review of systems, past medical, social, and family histories in the chart, per the Centers for Medicare and Medicaid Services guidelines.[48] Using one or more of these suggestions encourages students to participate clinically, adds "practice value" to students caring for a patient, offsets some of the preceptor's time investment, and allows students to engage a patient on multiple levels.[44,47]

Longitudinal ambulatory experiences can have a significant impact on the clinical preceptor's perception of teaching. When working with a student for an extended period, a preceptor may develop more responsibility for a student's learning and discipline.[42] Students also form additional bonds, seeing the relationship as a partnership in learning.[49] Partnership in learning increases trust, which may create more opportunities for independent clinical work. Clerkship directors could consider a continuity-type clinical experience within their clerkship block, such as a half day of clinic every Monday with the same preceptor. A more longitudinal approach may increase continuity of the ambulatory experience and allow for better student integration into the community preceptor teaching site.

Medical schools can help orient students to the EMR prior to their clinical responsibilities. Oregon Health and Science University created a simulated EMR training

environment, designed to orient learners to basic EMR concepts and not specific platforms.[50] Preclinical training can incorporate the EMR into standardized patient exercises using virtual patient data to simulate entering notes and writing orders. Any curriculum introducing medical students to the EMR should have specific objectives with discrete, measurable outcomes to determine competence with the process.[51]

Open communication with community preceptor sites will allow schools to anticipate requirements for student access to individual EMR platforms. Verification of student sign-ins and initial passwords will allow students initial access when they present to their community preceptors. Offering online resources, such as the Association of Professors of Gynecology and Obstetrics Effective Preceptor series module on incorporating the EMR into teaching may also aid community preceptors.[41]

Elimination of bias

Three fourths of patients surveyed stated that the presence of a male medical student had no impact on the likelihood of choosing a physician for care. This increases as the patient has more experiences with medical students.[22] This is similar to survey data of patients selecting an Ob/Gyn provider. Female patients' preferences of their providers correlated more with physician behaviors, such as communication. Approximately 75% of patients responded the physician's gender did not matter.[52] Placing male medical students with male providers may benefit their clinical experience. Patients of male providers were almost twice as likely to allow male medical students to perform pelvic exams, compared to patients of female providers.[21] Additional education of community preceptors with objective data may help overcome this clinical gender bias.

Conclusions

The rapidly changing educational landscape has magnified the existing barriers to engaging community-based preceptors across specialties. However, solutions exist in the current literature. Reevaluation of current recruitment strategies may identify pools of untapped yet eager teachers. Many intrinsic and extrinsic benefits exist to support community-based preceptors. Medical schools should provide data on how a preceptor's patient can benefit through patient-centered teaching and value-added placement of students.

It is clear from the evidence that community-based preceptors are excited about contributing to the education of the next generation of doctors. Equally, the evidence suggests that these preceptors feel uncomfortable and unprepared for the task. This is an opportunity for clerkship directors and medical school administrators to provide preceptors with faculty development, highlighting online educational resources and effective teaching techniques.

Providing faculty development, reorganizing the clinical curricular structure, and highlighting the benefits of becoming a community-based preceptor may help integrate the students into the clinical environment and add value to the practice. Educating existing and potential community preceptors can alleviate potential biases, creating a safe and productive learning environment for all students. Using these recommendations, clerkship directors and medical school administrators should have a solid foundation to actively engage their current and future community-based preceptors.

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All authors serve on the Undergraduate Medical Education Committee, Association of Professors of Gynecology and Obstetrics, Crofton, Maryland, USA.

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No potential conflicts of interest were disclosed.

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