Welcome to Precepting

Part 4

EAST TENNESSEE STATE
UNIVERSITY

Precepting Medical Students Series

Part 1: Introduction to Medical Student Precepting

Part 2: How Medical Students Learn in Clinical Settings

Part 3: Providing Feedback

Part 4: Providing Evaluations

Part 5: Learners Experiencing Difficulty

Providing Evaluations

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Disclosures

- No conflicts of interest
- No compensation from outside sources
- Free from commercial bias
- This lecture series is based on, at times extracted directly from, the Society of Teachers of Family Medicine's, "Teaching Physician".

Objectives

- The Preceptor will recognize the difference between providing formative feedback and giving summative evaluations.
- The Preceptor will distinguish between a judgement and a direct observation.
- The Preceptor will identify evaluations specifically covering problem solving, knowledge, originality, and analytical ability.
- The Preceptor will be able to formulate an evaluation based on the student's current education level.

Feedback vs Evaluations

- Timely and systematic evaluation is part of learning. Evaluation is different than feedback. Feedback is input designed to help the learner improve. Evaluation is a rating or ranking of an individual's status at a given point.

- Feedback is linear and occurs in real time. Often verbal and makes one point and sets one goal.
- Evaluation is used for progress and promotion. Is definitive and has consequences. Usually checkboxes and commentary.

Content of Evaluations

- Generally will include rating scales covering:
  - **Patient care**
  - **Medical Knowledge**
  - **Professionalism**
  - **Interpersonal and Communication Skills**
  - **Practice-based Learning and Improvement**
  - **Systems-based Practice**

Evaluations are based upon

- Direct observation: professionalism, communication, ability to learn
- Verbal Presentations
  - Organization
  - Content
  - Extraction and analysis of data
  - Synthesis of data into appropriate assessments
  - Formulation of plans
- Written Presentations
- Tests

Evaluations are based upon

- Document observations regularly throughout the clerkship/rotation. This ensures more accurate appraisals than relying on memory.
- Make notes on feedback being used to improve (engagement)
- If applicable, have other clinicians and staff in your practice document observations to ensure that the evaluations uses feedback from multiple observers on multiple occasions.
- The more “objective” the better.

Objectivity

- Easy objectivity: test scores, timeliness (showing up on time, turning in assignments on time)
- Difficult objectivity: improvement, professionalism, communication skills

- It is important to provide timely feedback, especially on the area of difficult objectivity, in order to allow for improvement. Set SMART goals that are attainable within the time frame of the clerkship. This can bring objectivity to subjective categories.

Example of a SMART Goal

Ahmed, I've noticed that you anchor in to a diagnosis very quickly. This may cause you to miss something important. Let's set a goal for you to have three differentials for the chief complaint by the end of the week. Is this something that you think that you can achieve?

- **S**pecific: yes, "be able to have three differentials for one chief complaint by the end of the week."
- **M**easurable: yes, three differentials
- **A**ttainable: yes, something all students can master
- **R**elevant: yes, three differentials helps physicians avoid anchoring in to a single possibility.
- **T**ime bound: yes, "by the end of the week"

Knowing the Learner's Education Level

- When performing a summative evaluation, consider the stage of professional development of the learner, whether the learner has been given sufficient feedback, and whether goals and objectives were clear at the outset of training.
- ORIME: observer, reporter, interpreter, manager, educator
  - Observer: high school and college students
  - Reporter: first year and early second year medical students
  - Interpreter: mid second year to late fourth year medical students
  - Manager: late fourth year medical student to beginning second year of residency
  - Educator: second year residents and beyond

M1-First Semester

- Start taking a history
- Gathering SH, FH, Meds, and Allergies
- Very few PE skills but need to learn normal
- Little to no ability to form an assessment or plan
- Little to no ability to interpret labs or medical data
- Presentation skills will be awkward and disorganized but should attempt
- Focus on communication and professionalism

M1-Second Semester

- Taking a history will be slow but mostly accurate
- Gathering SH, FH, Meds, and Allergies should be solid
- Still learning PE skills
- Can try an assessment or plan but will not be accurate
- Little to no ability to interpret labs or medical data
- Presentation skills will be improved and less disorganized but may not flow well.
- Focus on communication, professionalism, presentation skills

M2 (known now as third semester)

- Taking a history will be mostly accurate
- Gathering SH, FH, Meds, and Allergies should be solid
- PE skills should identify normal and basic abnormalities
- Should try an assessment or plan but will not be completely accurate
- Will try to interpret labs or medical data but likely incorrectly
- Presentation skills should flow easily and contain most data
- Focus on communication, professionalism, presentation skills, lab interpretation, and attempting an assessment

M3-Welcome to Clerkships

Expect better skills as the year progresses

- Taking a history should be completely accurate
- Gathering SH, FH, Meds, and Allergies should be solid
- PE skills should be solid but may miss advanced findings
- Assessment or plan should be mostly accurate but somewhat disorganized or missing vital components on complex patients.
- Interpreting labs or medical data should be at a basic level
- Presentation skills should be solid
- Focus on communication, professionalism, presentation skills, and especially the assessment of data for a differential diagnosis. Try a plan but may fall short on complex patients

Direct Observation

- Enables you to establish a baseline for each learner in terms of abilities, comfort level with patients, etc.
- Reinforces the importance of the learner—it communicates that you care
- Enables you to assess a learner's abilities in key areas
- Enables you to identify specific strengths and weaknesses, rather than making global judgments

Direct Observation

- When used regularly, "direct observation and feedback is noted to enhance interpersonal, communication, physical exam, history taking, medical decision making, and time management skills."
- Allows you to give immediate feedback
- Allows you to set goals
- Allows you to become more objective in providing evaluations

Direct Observation

- Evaluate the learner based on his or her current level of knowledge and skill development, as well as any noticeable improvements in performance.
- Focus first on what the learner has achieved, then highlight areas where you think growth is needed.
- Avoid personal biases and comparisons to others when assessing the learner's performance.

Prepare from the beginning

- **Before the clerkship**:
  - Understand medical school expectations.
  - Review the clerkship goals and objectives.
- **During the clerkship**:
  - Gather information from multiple sources.
  - Provide regular feedback.
  - Use a systematic method of recording.
- **Perform a formal mid-clerkship evaluation.**
- **At the end of the clerkship**:
  - Prepare for the final evaluation.
  - Schedule and conduct a final evaluation session with the student.
- **Complete and submit the final evaluation**.

Formative versus Summative Evaluations

Formative Evaluations

- help students identify their strengths and weaknesses and target areas that need work
- help faculty recognize where students are struggling and address problems immediately
- Are not part of a permanent record

Summative Evaluations

- Provide assessments of experiences and knowledge that is a permanent record
- Summarizes outcomes of participation, tests, skills.

Written Evaluation-Understanding

- John is able to get to the important parts of a history. He came across as kind and understanding.
- Susan was able to communicate well with both patient and family and respond to them at their level of understanding.
- Sheila had a bit of a hard time applying and adapting her textbook knowledge to fit the real life cases that are part of family medicine. While this reality threw her at first, I noticed significant improvement by the end of her time here.

Written Evaluation-Skill

- John needs to work on taking a brief general history, then concentrate on a more detailed history of the current problem.
- Susan was well received and respected by the patients. She needs to include more pertinent information (eg, physical findings, plans, etc.) into medical records.
- Bill does a good exam but is occasionally casual in his attitude; incomplete notes and not as thorough as he could be. Not so great with his hands, but makes up for it with strength of personality. He will be popular with his patients.

Written Evaluation-Knowledge

- Kathy's knowledge of medicine is superior, and she is adept at discovering data. She's comfortable with her knowledge and willing to defend her position.
- Ann had a fairly narrow field of knowledge regarding many of the cases we encounter in practice. Additional exposure to textbook physical diagnosis would help her improve in this area.
- John worked hard to improve his differential diagnosis skills. By the clerkship's end, he was performing at an appropriate level for a third-year student.

Written Evaluation-Successes

- Stan has good communication skills and establishes rapport easily with a wide range of patients. He was able to get some information from a complicated and uncommunicative patient that has helped me greatly in that patient's care. He has a gentle style that I predict will make him a sought-after physician once he is in practice.

Written Evaluation-Challenged Student

- Brad is quiet and reserved. I know that he cares about people, but sometimes his natural reserve can come across as uncaring. He needs to continue to work on comfortable ways to demonstrate warmth and build rapport during one-on-one patient encounters. We discussed specific strategies such as concentrating on eye-contact, using more non-verbal prompts, and having a more relaxed posture during the interview.

1.Gather a history: {EPA 1) {IEOs: PC 2; KP 1; ICS 1; ICS 7; P 1, 3, 5; PPD 1, 5)

DOES NOT MEET EXPECTATIONS : *does not collect accurate historical data *is disrespectful in interactions with patients. *fails to recognize patient's central problem

BUILDING COMPETENCE: *Gathers excessive or incomplete data *Does not respond to patient verbal and nonverbal cues.* Questions are not guided by the evidence and data collected . *May Generalize based on age, gender, culture, race, religion, disabilities, and/or sexual orientation. *Does not prioritize of filter information .

APPROACHING COMPETENCE: *Demonstrates effective communication skills, including silence, open- ended questions, body language, listening, and avoids jargon.* Is able to filter signs and symptoms into pertinent positives and negatives.* Uses a logical progression of questioning.* Incorporates responses appropriate to age, gender, culture, race, religion, disabilities, and/or sexual orientation.

COMPETENT FOR PRACTICE WITH LIMITED SUPERVISION: *Obtains a complete and accurate history in an organized fashion. *Seeks secondary sources of information when appropriate. *Adapts communication skills to the individual patient's needs and characteristics. *Demonstrates astute clinical reasoning through targeted hypotheses-driven questioning.

INSUFFICIENT OBSERVATION or N/A

Learners in Difficulty

- The challenge many clinical teachers face is overcoming their own hesitancy to identify and report a learner in difficulty, whether because of inexperience and self-doubt, the investment of time in remediation, fear of student retribution,[9] or simply not wanting to negatively impact the learner.
- It is not the community preceptor's responsibility to correct the student's difficulty. The community preceptor should discuss concerns with the Clerkship Coordinator and Director and allow us to intervene.
- Don't wait until the end of the Clerkship. Intervene Early.