UNIVERSITY OF MISSOURI

SCHOOL OF MEDICINE

DEPARTMENT OF FAMILY AND COMMUNITY MEDICINE

FAMILY MEDICINE

PRECEPTOR GUIDE

2025-2026

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MU FAMILY MEDICINE CLERKSHIP
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WHAT DOES UMC EXPECT FROM PRECEPTORS?

We appreciate you opening your practice to our students. To help things run smoothly, we suggest that you spend 15 minutes on the first day going over things with the student. Explain how your office runs, find out what the student expects out of the four weeks, and negotiate a game plan. Topics to cover could include

1) How your office runs
    a) Staff and their responsibilities
    b) Characteristics of your patient population
    c) Your special skills and interests
    d) Space they can use (for coat and books, space for studying, etc.)
    e) Office labs and procedures
    f) Charting
2) The student's specific goals
    a) "What do you want to get out of this experience?"
    b) "What kind of things do you want to learn in this next four weeks?"
    c) Negotiate and clarify goals and expectations.
    d) Expectations regarding feedback.
    e) Review the student's Clinical Skills Inventory (they should have a copy with them)
3) How you plan to work with the student
    a) Degree of independence (see below).
    b) Patient flow. How the student will know what to do next.

How much independence should you give the student in seeing patients? There is a dynamic tension here between the preceptor's need to work efficiently and effectively, the patient's right to see his/her chosen physician, and the student's need to have hands-on experiences with some degree of independence. We recommend that your nurse first ask patients if they mind seeing a medical student. If it's acceptable to the patient, let the student do a problem-focused history and physical, then discuss findings and tentative plans with you. You then can evaluate the patient yourself and adjust the plan as needed. In most situations, this can be done **five or more** times each day. For certain patients or types of problems (*e.g.* gynecological), you may need to limit the student's activity; for others, more independence is possible. Students should not, however, be left on their own. A physician should always be readily available whenever the student is providing care for a patient.

If possible, arrange for the student to see some patients more than once. Experiencing continuity isn't always possible on a 4-week preceptorship, but we'd like for the student to have a taste of what it's like.

We also want students to spend half a day or two with some other health professional. The students will need your help to make the necessary contacts. A student might, for example, spend a half day with a social worker and another half day with a home health care nurse making home visits. Or, as part of preparing for writing the paper, the student might visit a patient's home. The objective is to help the student acquire a broader understanding of the context of illness. If the student plans clinical contact with a patient when you're not around (as, for example, a home visit), remind the student that they aren't licensed to practice medicine yet.

Schedule time during each day for the student to read about the patients and problems they've encountered. Many of us involve students in searching out answers to our own clinical questions, and this time can be used for that. One to two hours during each day would be appropriate.

Give the student **frequent feedback**, both your own observations and comments from patients, office staff, and hospital personnel. If time is available, once a week watch the student taking a problem-focused history and doing a limited physical exam. Within that same day, discuss with the student one or two things you observed them doing that were appropriate and one or two that could be improved.

During the second week of the four weeks, review with the student how things are going. Facilitate a mid-course correction, if one is needed.

Feel free to **call us if problems come up** at 573-882-0974.

GOALS FOR THE FAMILY MEDICINE CLERKSHIP

The following are competencies and skills that we expect medical students to cultivate and develop during the clerkship.

1. *Effective Communication Skills.* Students should be able to communicate effectively with patients and their families. This includes the ability to obtain useful information to make diagnoses and formulate management plans. It also includes the ability to provide information and emotional support, to educate, to promote healthy behavior and to develop constructive doctor-patient relationships.

2. *Skills in Critical Thinking and Clinical Decision-Making.* Students should be able to engage in a systematic and logical process of decision making that involves the collection, organization, integration, analysis and interpretation of appropriate information, the synthesis of relevant inputs and analyses into clinical hypotheses or conclusions, the implementation of resulting decisions, and the evaluation of the effects.

3. *Knowledge of the Biopsychosocial Model.* Students should have some understanding of the complex confluence of biological, cultural, psychologic and social factors as determinants of health and illness. They should recognize the importance of behavioral and psychosocial contributions to the pathogenesis of health impairment. They should recognize the value of integrating a behavioral and psychosocial focus with a biomedical focus in the management of patients and in the maintenance and promotion of health.

4. *Skills in Managing Primary Care Problems.* Students should have basic skills in the clinical management of problems commonly encountered in primary care. This includes, but is not limited to, such chronic diseases as diabetes mellitus and asthma, such acute illnesses as upper respiratory tract infection and vaginitis, and such undifferentiated problems as aches and pains and anxiety. Students should understand appropriate strategies for managing such conditions in the ambulatory primary care setting. They should also understand the role of the primary care physician as a source of continuity and comprehensive care, as a coordinator of care and as an efficient and conscientious user of health care resources.

5. *Skills in Providing Preventive and Health Maintenance Services.* Students should be competent in assessing the need for and value of preventive and health maintenance services. This includes the ability to evaluate screening procedures and to select those appropriate for the individual patient or the specific population. Students should be competent in providing health education and assisting patients with behavioral changes designed to promote health or reduce risk. Students should be able to look beyond the individual patient to consider prevention and health promotion in the broader context of the family and the community.

6. *A Commitment to Life-Long Learning.* Students should recognize that the maintenance of medical competence requires a strong commitment to continuing education throughout the medical career. Students should have self-directed learning skills.

7. *Ability to Balance Personal and Professional Need.* Students should recognize the vital importance of balancing their personal needs with the professional demands on their time and energy. Students should have effective psychosocial skills for coping with stress, managing their time and making satisfactory choices between competing demands. Students should have emotional resources and social support to allow them to function in a professional environment characterized by ambiguity and uncertainty.

8. *Awareness of the Ethical Aspects of Medicine.* Students should be able to think about and discuss ethical issues relating to patient care, the medical profession, and the health care system. These abilities presuppose a knowledge and consideration of the differing value orientations, perceptions and rights which underlie all ethical dilemmas.

CLERKSHIP GENERAL INFORMATION

Patient Logs
Students are required to keep track of certain diagnoses/symptoms/skills. The student is encouraged to work with you to ensure they meet the required minimums. A list of these requirements is enclosed. They do not have to meet all of these during the four weeks they are with you. They will fulfill some of these requirements during the four weeks they are at the family medicine clinic in Columbia.

Evaluation
Please review the attached evaluation form carefully. **This should always include written comments.** Regular, timely feedback is essential. Ideally, all comments on the evaluation should already have been discussed with the student. Some preceptors find it useful to jot down notes and specific examples at the end of each clinic session to aid in the evaluation process. Observation is a crucial piece of this – finding the time to observe parts of the clinic visit will be important.

Teaching Tips – general
- Keep it simple – use teachable moments
- Involve them as active participants in your clinic as much as possible
- Make them feel of value to you – their histories and notes can be very helpful
- Let them observe you initially with the first 2-3 patients to get a feel for your style
- Make your expectations of them clear. e.g., do not cover this, do ask about that, when is the best time for asking you questions, etc.
- Help them focus on particular skills (e.g., history of present illness, lung exam, presentation skills, etc.) Involve them in selecting which patients they are to see.

- Have them see some patients in follow-up if at all possible.
- Find time to observe them – even if it is for a three-minute window.
- Share your thinking and strategies with them – what you tried to do and whether you felt it worked well. Have them observe a particular aspect of your interaction with the patient and give you feedback.
- Consider giving them focused assignments to report on at the next visit – but be sure to ask them for their report!
- Put them to work – look up answers to questions you have.
- Time limits can be very helpful, e.g., "Go and get the history of present illness, I'll come get you in five minutes."
- Demonstrate areas of history and physical and then have them practice.
- Be sure and point out common findings – skin lesions, joint deformities, murmurs, edema, etc.
- If you see an interesting physical/x-ray/microscope finding, try to share it with the student

Teaching tips – course specific

- We do not expect the students to see/have responsibility with **every** patient, but they do need to have some responsibility with several patients. We hope they will feel a part of 6-10 patient visits in each clinic session.
- Shape the experience to your learner – their knowledge, skills, etc. The learner's abilities will dramatically change as the year goes on.
- It is okay to have them look up and read on a topic briefly during clinic, especially if the clinic is very busy and you need to pick up the speed.
- Encourage them to share their ideas about assessment and plan.

Teaching tips – feedback and evaluation

- Ask them for their ideas, questions, and reasoning. Find time for answering their questions.
- Feedback, feedback, feedback. Remember to focus on specific behaviors. Also, get their feedback on how things are going.
- Do sit down with the student halfway through your experience together for a brief mid-block evaluation session. Ask them for feedback on how the experience might be improved from their point of view. Have them evaluate themselves. Review their progress toward their specific goals.
- Similarly, sit down with the student at the conclusion of the 4 weeks and once again give them feedback.
- *Complete the detailed evaluation of the student immediately after your last clinic session and return it to the course office ASAP. It is critical that you include comments as well. (Hopefully all ones you have already shared with the student.)*

STUDENT ASSIGNMENTS DURING CLERKSHIP

Throughout the clerkship, students are encouraged to complete 24 of the fmCASES. The Family Medicine Computer-Assisted Simulations for Educating Students (fmCASES) is MedU's virtual patient program for the Family Medicine clerkship. fmCASES's 40 interactive virtual patient cases encompass the learning objectives of the Society of Teachers of Family Medicine (STFM) Family Medicine Clerkship Curriculum. These cases help build clinical competency, fill educational gaps, and help instill the core values and attitudes of family medicine. fmCASES fosters self-directed and independent study, builds clinical problem-solving skills, and teaches an evidence-based and patient-centered approach to patient care.

PATIENT LOG REQUIREMENTS

Please enter **all patients seen during weeks 1, 2, 3 and 5** that meet any of the log entry possibilities and for whom you have had **full participation**. Work with your preceptor to ensure you meet the required minimums. Full participation means you could write a reasonable clinical note based on your participation with this patient. Simulated cases are allowed in a few instances but can only be entered after discussing with Drs. Allmon/Swofford. You may code up to three separate diagnoses/symptoms/skills/or special domain entries for each patient. You are encouraged to enter patients throughout the entire block.

ACUTE LIMITED Dx/Sx	**# of required (20 total)**	**Simulated allowed**
(URI) EENT: any; Respiratory: Cough, URI, Hoarseness, Bronchitis	4	0
Musculoskeletal: (any except DJD, Rheumatoid arthritis gout or fracture)	2	0
Headache	2	0
Acute limited Other: General (any); Skin (any); Cardiovascular: None; GI: diarrhea, nausea/vomiting, constipation, dyspepsia, gastroenteritis, GERD; hemorrhoids; Breast: none, Male GU- nocturia, dysuria, prostatitis; Female GU- Vaginal discharge, vaginal itching, vaginitis; dysmenorrhea; menstrual disorder; nocturia; dysuria, UTI, incontinence; peri/postmenopausal disorder; Endocrine: none: Psychiatric: none;	10	0
ACUTE SERIOUS Dx/Sx	**# pts (8)**	**Simulated**
(GI) Abdominal Pain; Diverticulitis; Cholecystitis; Change in Bowel movement; Pancreatitis; Appendicitis; Hematemesis; Blood in stool; Ulcer disease; Mass; GI Malignancy; Inflammatory bowel disease; Jaundice	2	0
Cardiovascular: Chest pain, palpitations, MI, Thrombophlebitis/DVT; Arrhythmia;	1	1
CNS: Dizziness/ Vertigo; CVA; TIA; Syncope; Weakness/paralysis; Decreasing mentation;	1	1
Acute Serious Other: Resp: Pneumonia; Influenza; RSV; Hemoptysis; Lung cancer; Pleural effusion; Pulmonary embolus; Shortness of breath, Breast: any; Male GU: STI/STD, Penile discharge; Hematuria; Pyelonephritis; Elevated PSA, Kidney stone; Epididymitis; Bladder/kidney cancer; Venereal warts; Prostate nodule; Prostate cancer; Female GU: STI/STD; PID; Venereal warts; Abnormal PAP; Pyelonephritis; hematuria; abnormal mass/swelling; abnormal bleeding; Bartholin's gland abscess; Pelvic pain; abnormality of ovaries; pelvic mass; bladder/kidney cancer; Musculoskeletal: Fracture/dislocation; Gout; Heme-Onc: Anemia; Abnormal bleeding/bruising; HIV; Endocrine: Thyroid mass;	2	0

CHRONIC DIAGNOSES	25 required	Simulated Allowed
Hypertension	5	0
Diabetes Mellitus 1 or 2	5	0
(Heart) Coronary Artery Disease; CHF	2	1
Dyslipidemias	3	0
(Lung) Asthma/COPD/emphysema	2	0
Obesity	2	0
(Rheum) Osteoarthritis/DJD; Rheumatoid arthritis;	2	0
(Mental) Depression; Anxiety; Panic disorder;	2	0
(Chronic Other): **CNS**: Seizure disorder; Sleep disorders (apnea); Dementia; Parkinson's; ADD/ADHD; **CV**: Venous insufficiency; **GI**: Cirrhosis; Irritable bowel syndrome; **Male GU**: ED/ Impotence; BPH; **Female GU**: Decreased libido; **Endocrine:** Hypothyroidism; Hormone replacement female; **Psychiatric:** Eating Disorder; Substance abuse (ETOH, tobacco, drugs),	2	0
SKILLS	**15 Required**	**Simulated**
Obtaining History (any- See PLOG)	2	0
Education/Prevention (any-See PLOG))	2	0
Behavior Change Counseling (any- See PLOG)	2	0
Examination, Wound/Trauma, Invasive, Resuscitation: None required in this domain		
Administrative: Any (See PLOG)	3	1
Interpret: Any (See PLOG)	6	2

SPECIAL DOMAIN	Required	Simulated
Care of Infants and Children: None required in this domain		
Trauma: None required in this domain		
Patient Type:		
(Cultural) Caring for a patient from a culture not your own	2	1
Preventative Care:		
(Child Exam <age 20) Well child check or adolescent exam or sports physical	2	0
(Adult Exam) Well Male Exam or Well Female Exam (>age 20)	2	0

STRATEGIES FOR EFFICIENT OFFICE PRECEPTING

Many family physicians teach because they enjoy the personal satisfaction of working with students and want to share their enthusiasm for family medicine while contributing to the education of the next generation of physicians.[1,2] However, most office-based teachers are unpaid volunteers,[3] and evidence indicates that time spent teaching can lengthen the preceptors' working day[3-5] and/or decrease their clinical productivity.[3] Fortunately, preceptors can use several strategies to minimize the added tasks of teaching while optimizing students' educational experience. Preceptors who use these strategies have reported practicing more efficiently with a student than without one.[6] In this article, we summarize some practical strategies for efficient office-based teaching that are likely to be highly valued by preceptors and students.

Planning and Preparing

Agree on Daily Goals

The vast amount of potential learning material in each session can overwhelm both teacher and student. To better manage this learning material, spend 1 or 2 minutes before each session agreeing on mini-learning goals that relate to the clerkship objectives and are achievable that day. For example, it may be too time-consuming to observe a student conduct a complete physical exam, but it is practical to observe and give feedback on two abdominal exams in one session and ensure that the student has mastered this part of the physical exam. Achieving such mini goals over several sessions results in an impressive amount of clinical observation, teaching, and feedback.

Limit the Number of Patients That Your Student Sees

Seeing too many patients often prevents students from reflecting on how clinical experience aids their learning. Depending on the number of clerkships completed, the clerkship's goals, and the patients' clinical complexity, third-year students should see between three and six patients for each 4- hour session.

Encourage "Just in Time" Learning

Between patients, students should review content related to the patients they see. For example, after seeing a child with a sore throat, students can use their handheld computers or the Internet to look up the risk factors for strep throat and determine the sensitivity and specificity of the "rapid strep" test. This "just in time" learning, especially when combined with formulating clinical questions, encourages students to seek and use evidence-based medicine. Such integration of evidence-based medicine into practice has been reported as one of the top three factors students associate with effective teaching.[7]

Debrief and Plan for the Next Session

At the end of each session, it is efficient to spend a few minutes debriefing on the teaching session, reviewing how well the student met the mini goals, agreeing on any homework, and planning for the next session.

Maximizing Learning Efficiency

Limit Presentation Time

Students must learn to give a focused 2–3-minute patient presentation that includes pertinent positive and negative findings and their assessment and plan. Students consistently report the opportunity to formulate assessments and plans as one of the top factors associated with high-quality clinical teaching.[8]

Use the Five Clinical Teaching Microskills

Most preceptors are familiar with the five microskills of clinical teaching[9] but may not use them because they think that completing all steps after every patient is too time consuming.

However, all five microskills do not need to be completed for every patient. For example, if a patient presents with a sprained ankle, the preceptor can use the microskill "teach general rules" in discussing and demonstrating a proper ankle exam and use the microskills "reinforce what was done right" and "correct mistakes" in giving the student feedback about his/her actual exam of the patient's ankle. For other sprained ankle issues such as understanding why an X-ray was or was not ordered, the teacher can direct the student to find the Ottawa ankle rules as "just in time" learning between patients and discuss their application in more detail later.

Make Feedback Routine

Giving feedback challenges most preceptors because they see it as time-consuming and fear it may upset the student. Yet students report receiving high-quality feedback as one of the top two factors associated with excellent clinical teaching.[8] Feedback that is based on observation, consistent, fair, routine, and given in a spirit of unconditional positive regard will be accepted and appreciated. For example, while observing the student perform an abdominal exam, a preceptor might say, "You correctly palpated all four quadrants superficially and deeply, but you forgot to observe and listen first! Remember: always observe the abdomen first, listen to it second, and then palpate it."

Teaching With Patients

Develop a Cadre of "Teaching Patients"

Every physician has patients who have interesting stories to share. If these patients have conditions that add to students' learning, both student and patient usually enjoy spending extra time together. Such regular "teaching patients" can become familiar with students and may even learn to evaluate them and give informal feedback on students' performance. Such patient feedback is particularly powerful for students.

Seize Unexpected Learning Opportunities

Besides planning in advance which patients the student will see, one should seize unexpected learning opportunities. For example, where a patient has a newly discovered goiter or heart murmur, the student may be briefly introduced to the patient simply to experience the abnormal sign.

Hear Presentations in the Exam Room

When all parties are comfortable and the clinical problem is suitable, it is efficient and mutually satisfying to have the student present his/ her findings and for the preceptor to teach in the patient's presence. Patients can then give immediate feedback on the accuracy and completeness of the student's presentation.

Using Service Learning

Use the Students for Administrative Tasks

Many non-clinical tasks can aid student learning. For example, students can learn a great deal by performing administrative tasks under the preceptor's guidance and supervision. These tasks may include filling out lab requests, writing referrals, updating problem lists, and doing telephone callbacks.

Let Students Write Notes

Writing notes aids students' learning and helps students present the patient's issues to the preceptor in an efficient and organized manner. According to Health Care Financing Administration documentation guidelines, only a small portion of a student's note is billable, and the preceptor must still write or dictate a note and personally document major aspects of the patient visit.[10] However, preceptors can still save time by using the student's note as a guide when dictating or writing their own note. In one study, students' notes saved preceptors 3.3 minutes of charting time per patient.[11]

Use Students to Teach Patients
Students learn a great deal by teaching patients about such topics as smoking cessation and weight loss. Teaching patients sharpens students' communication and negotiation skills and makes them aware of the many reasons patients don't comply with medical advice.

Conclusions: Using these simple strategies can help office-based teachers improve the teaching experience for themselves and their students. Devoting a few minutes each day to these activities can maximize the teaching session's efficiency and minimize extra work for the preceptor.

SAMPLES OF BEHAVIOR SPECIFIC EVALUATION COMMENTS

A. Understanding (problem solving, synthesis of knowledge, originality, analytical ability)

Is able to get to the important parts of a history. Able to communicate well with both patients and family and to respond to them at their level of understanding.

Sara had a bit of a hard time applying and adapting her textbook knowledge to fit the "real life" cases that are part of every family practice. While this really threw her at first, I noticed significant improvement by the end of her time here.

Wonderful ability to approach problems and people in unique ways. Really stretched beyond the "book learning" of med school to get at the heart of the problem with each patient.

B. Skill (rapport, histories, physical examinations, laboratory organization, adaptability, use of hands, functions under pressure)

Very good histories. Needed to focus more to speed things up, but did this by end of rotation.

Appears to be truly concerned about patients and their problems, easily establishing rapport.

Sam developed rapport with patients easily. His histories were thorough and usually appropriate to the patient's concern; occasionally he would digress from the patient's stated reason for being in the clinic

Matt responded very well to specific feedback on technical skills and showed good improvement.

C. Knowledge (scope and depth of factual information)

Mike has a good knowledge base; when he doesn't know something he will tell you, not try to bluff through it.

Never afraid to ask in-depth, and sometimes difficult, questions. Frequently went to other various resources (computer, books, and journals) for further information on a case.

Knowledge of medicine is superior, and she is very adept at discovering data. Comfortable with her knowledge and willingness to defend her position.

Jason worked hard to improve his differential diagnosis skills. By the block's end he was performing at a very appropriate level for a third-year student.

D. Attitude (intellectual curiosity, respect, integrity, recognizes limitations)

Kind and courteous to the staff at all times. Obviously respects people and their differing points of view. This became a real strength when working not only with patients, but also with others in the office. The staff actually had a going away party for this student! Should do very well in practice.

While knowledge regarding routine chronic problems was good, I noticed a rather lackadaisical approach to seeking new information about some of the more acute or undifferentiated cases.

While Carlos was extremely competent in almost all areas, I was especially impressed by his willingness to seek me out when he had questions or felt "out of his league" when it came to some of the really difficult and complex cases.

He never seemed really interested in what was happening or in improving areas where he was weak (like doctor/patient communication skills) despite specific feedback.

E. General Comments (Strengths and Weaknesses)

Jim is truly concerned about his patients and is able to relate to them in a caring and professional manner. Good knowledge base. Enjoys learning new things. Consistently he read about patients we had seen and was able to incorporate his new knowledge well. He even brought in a few articles for me to read that were quite helpful to me!

Well-rounded, well-educated and highly ethical. Nicki related easily to a wide range of my patients and many of them specifically commented on how comfortable she made them feel. She was never afraid to ask questions or say she didn't know something. I really enjoyed working with her. She will do very well in whatever field she chooses.

Scott has very 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, quiet style that I predict will make him a sought-after physician once he is in practice. I think he would do very well in family medicine.

Particular strength:

Sincere, conscientious and compassionate. Has good common sense not only regarding medicine, but also when working with people of a variety of ages and personalities.

Extremely thorough, careful and patient. Willing to take the time to make people feel relaxed but was also able to get the job done in a competent and efficient manner.

His recent basic science training in your problem-based curriculum helped him be able to solve problems at a sophisticated level. He was a resource for me on some newer immunologic theories.

Sense of humor. Not only did this make it fun for all of us to work with Maureen, but it also made patients feel comfortable and enabled them to open up to her about all sorts of personal issues. In addition, her technical skills were first rate, and her knowledge base was solid.

Needs further work:

Brian is a quiet and reserved person. 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.

Robin needs more experience to fine tune history-taking and physical exam skills. Specific areas that seemed less strong were sexual history, social history, musculoskeletal exam and cardiac exam. I think some of this can be achieved through books, and tapes, but should push himself to work on these through additional clinical experiences.

Dan is a very bright and articulate student. He is not always aware when his choice of words, both medical and non-medical, were fairly technical or abstract. He needs to work on this because I saw it affect his ability to relate to some of my patients and not talk over their heads. This tended to distance patients and make them unsure about asking him questions. He is aware of this and just needs more observation and feedback in the future. I wish I had had the ability to videotape some of his patient encounters as I think he would have a much better understanding of this if he could see it.

While breadth of knowledge seemed very good, John appeared anxious about applying it in an outpatient setting. I think the undifferentiated nature of many of the problems seemed to make him less sure of himself initially. As time went on, this changed and he definitely improved, but there is still room for improvement. I have encouraged him to use primary care texts as his initial reference as they approach problems from a symptom approach which I think is the perspective that needs strengthening for John.