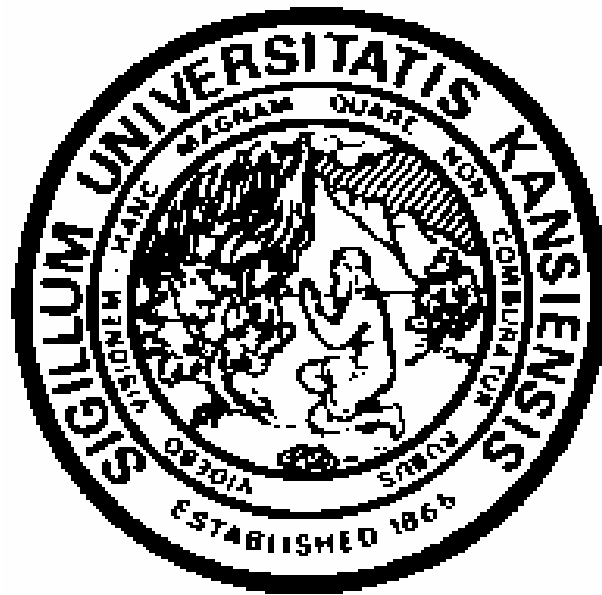


RURAL PRECEPTORSHIP MANUAL



**The University of Kansas
School of Medicine-Wichita
Department of Internal Medicine**

FOREWORD

The rural preceptorship has been in existence for over fifty years, beginning during the administration of Chancellor Franklin Murphy. Initially, students went to communities of less than 3,000 without restriction as to specialty. Over the years, the program has evolved to include only Family Practice, General Internal Medicine, and General Pediatrics. Unfortunately perhaps, the definition of what constitutes “rural” has enlarged to include suburbs and metropolitan cities. Goals of this rotation have been somewhat vague at times. “Seeing what it is like” and ultimately recruiting physicians to rural practice have been two commonly-agreed-upon goals.

This manual for rural primary care preceptors has been created to clarify the purpose and educational goals of the rural rotation and provide guidelines for you, the rural preceptor, in defining your role and responsibilities in the educational process. Its content has been developed from evaluations of medical students who have taken the rural preceptorship, what we have learned from rural preceptors, and what we believe are weaknesses in an urban-based educational process which trains medical students for rural practice. Much of its content reflects what preceptors have been doing for many years.

The University of Kansas School of Medicine-Wichita has a strong interest in preparing physicians for rural practice and increasing the supply of physicians in rural Kansas. The rural preceptorship is the primary strategy for teaching rural medicine. The rural preceptorship will continue to evolve in partnership between the medical school and you, the practicing rural physician. We encourage your comments about the rural preceptorship anytime.

SITE SELECTION

Volunteer faculty play an essential role in the training of medical students at the University of Kansas School of Medicine. The participation of volunteer faculty contributes much to the excellence of its graduates. The contribution made by rural preceptors is of special significance, without which the rural rotation would be impossible.

It is for these reasons that we ask for and keep records of your credentials. Board certification in the discipline of the rotation, i.e., Family Medicine, Internal Medicine, and Pediatrics, is an important consideration. Students may spend some time during the rotation with physicians who are in other specialties, but the primary supervision and teaching should be provided by you, the primary care physician of the appropriate specialty.

There have been many sites for the rural rotation utilized over the years. Sites should be rural and not in metropolitan areas. Emphasis has been placed on developing sites in communities with populations of less than 15,000. Some departments, Pediatrics notably, have difficulty developing more rural sites because of the more urban distribution of pediatricians. An attempt has been made to limit the number of sites to facilitate the ongoing development of each site's educational value. Any student who has expressed a strong interest in ultimately practicing in a specific rural community which is not normally a rural preceptorship site may be allowed to take the rural preceptorship in that community if its educational value can be assured.

HOUSING

It is the rural preceptor's responsibility to provide room and board for the medical student while on rural rotation. At this time, there is no funding available to the University of Kansas School of Medicine to provide housing or board. Students must reside in your community during the rotation, and not attempt to commute back and forth from Wichita on a regular basis.

A room provided by the hospital is acceptable if it is private and provides a comfortable sleeping environment. There should be adequate lighting for reading, a comfortable chair, a bed with linen and blanket, and a desk adequate for a laptop computer. A television should be in the room, as the student will be there for an entire month. The student should be able to lock the door.

An apartment or house is probably ideal, but understandably difficult to arrange or afford. Staying in the preceptor's home for the entire month is not appropriate unless the student's need for privacy and his or her own "space" is addressed. Past experience has shown that students staying in preceptors' homes can be burdensome for the preceptors' families as well.

Motel rooms, while expensive, are also adequate for student housing. Students have been encouraged to take their families with them, but this rarely happens with spouses working and older children in school. Spouses and families may, however wish to join their medical student spouses on weekends. Certainly, motel rooms or staying in the preceptor's home is acceptable at those times.

Meals provided in the hospital is a satisfactory arrangement for board. Students can also be reimbursed for their meals. It may be difficult for the preceptor to provide all the student's meals in his or her home.

GOALS FOR THE RURAL PRECEPTORSHIP

The goals of the rural preceptorship are applicable to any rural site. The specifics of any objective may vary somewhat from site to site due to the circumstances of your primary care specialty, practice, community, and local health care resources.

I. Recruitment opportunity for rural practice

To some extent, students are recruited during each clinical rotation during medical school; however, this recruitment has special importance for rural communities because of the shortage of rural primary care physicians and the very limited exposure to practice in rural environments. Medical students have urban-based rotations in all the primary care specialties, but there are differences.

Preceptors should be willing to discuss the challenges and rewards for their practices. If you are pessimistic about the future of practice in your specialty in rural areas, you will not be a very effective recruiter.

Although some students will only want to participate in the professional aspects of the rural rotation, providing them with the option to participate in the social and recreational aspects of your community is encouraged. Fairs, arts and craft shows, sporting events, community theater productions, hunting, and fishing are only a partial list of what may be available during their month in your community. Students have done novel things, such as watching a calf being delivered and touring the local feedlot. This does not mean that you are expected to be an entertainment director for the student, nor is the student to have a month of bucolic bliss. The rural preceptorship is an important part of the professional training of physicians.

II. Appreciation of rural health care delivery by medical students who will ultimately practice in urban areas

Many students who take this required rotation will not enter practice in rural areas. For many, this will be the only time in their entire professional lives spent in a rural environment. Many will provide care to patients who live in rural areas, and will share care of patients with rural physicians and other rural health care providers. It is invaluable that they have some understanding of rural health care delivery, referral patterns, and what rural physicians actually do.

III. Better understanding of health problems that may be more common in your rural community

1. Be able to identify the major employers and occupations in the area and understand some of the associated health problems and their management. As examples, farming families are at increased risk for skin cancer, certain respiratory ailments, and trauma;

welders are at increased risk for eye injuries; and meat packers are at increased risk for carpal tunnel syndrome.

2. Be able to identify demographic features which increase the incidence of certain health problems. For example, pockets of poverty may increase the incidence of child abuse; frail elderly who live alone may have difficulty accessing tertiary health care when needed.

IV. Gain experience in the delivery of medical care using available resources

1. Provide excellent medical care without immediate availability of high-tech imaging procedures or sophisticated lab tests.
2. Identify the advantages of delivering health care in a rural environment. For example, knowledge of the patient's environment and support systems is easier to obtain because of the more intimate nature of small rural communities.
3. Be exposed to the use of non-professionals in delivering health care in rural areas. For example, ambulance services may be staffed by volunteers; the elderly may have to rely more on friends and neighbors for care-giving, without all the programs which assist in the continuum of care for the elderly.
4. Be able to explain the function of the local health department in providing health care. Some departments make home visits to remote areas and provide progress reports to the physician. Allowing the student to spend a half day or day with the county health nurse would be beneficial in some circumstances.
5. Explain or utilize networking. Networking can be as simple as calling a consultant on the phone, or sharing a radiologist with several hospitals. It may be as complex as cardiac telemetry of patients monitored by ICU nurses at another hospital, or computer and telecommunication links among physicians and hospitals.
6. Observe the utilization of allied health personnel in a rural environment. Nurses may play more of a generalist role than their urban counterparts. Mid-level practitioners may provide more health care.

V. Understanding of the expanded professional and community roles of rural physicians

1. Be able to list the various professional roles that rural physicians fill. For example, primary care physicians act as emergency room physicians, county health officers, county coroners, and serve as consultants to various organizations such as the local EMS.

2. Appreciate the leadership role that rural physicians play in their communities. Physicians may be on the school board, in positions of leadership within their church, in charity organizations, and in various other organizations.

VI. Learn medicine

Although the rural preceptorship provides exposure to the rural dimensions of primary care specialties, it is training in the discipline of the preceptor's specialty. No medical student is ever a "completed" physician. Even if you think a student will learn about a certain disease, procedure, treatment, medication, etc., on another rotation, it is important for you to share your knowledge and skill with the student. The primary rationale for this rotation is the rural environment, but much of what the student learns is part of the practice of clinical medicine in general.

In the "Clinical Skills" section, the Departments of Family Medicine and Internal Medicine have listed specific skills that would be appropriate to help students develop during the rural preceptorship in those specialties.

Objectives/Competencies for Students on the Rural Preceptorship

<u>Objective</u>	<u>Competency</u>
Patient Care	
1) Obtain an accurate and complete history from a hospitalized or ambulatory patient or, alternatively, his/her caregiver.	Achieve the objective at an acceptable level over the assigned number of patients.
2) Perform an appropriate physical exam on a hospitalized or ambulatory patient.	Achieve the objective at an acceptable level over the assigned number of patients.
3) Perform supervised office procedures as deemed appropriate by the preceptor.	Adequately perform procedures under observation.
4) Demonstration of ability to interpret data commonly collected on hospitalized and office patients (CBC, ABG's, ECG's, PFT's, electrolytes, chest x-ray, hepatic panel)	Adequate thresholds of interpretive skill.
Patient Care and Communication Skills	
1) Create a written record of the history and physical.	Create a legible document of sufficient detail on each assigned patient.
2) Perform daily reassessments of assigned patients as appropriate and create a progress note.	Create an accurate and legible daily progress note.
3) Verbal presentation of assigned patients.	Make concise and complete verbal presentations to attending.
Medical Knowledge	
1) Develop a basic foundation of concepts and facts regarding problems on hospitalized and office patients.	Demonstrate an adequate knowledge base.
Practice Based Learning	
1) Analyze patient problems utilizing research of medical reference.	Adequate analysis of assigned cases as reflected in patient assessments.
Professionalism	
1) Interacts with patient and healthcare team in a professional manner.	Interact appropriately with all patients. Demonstrate understanding of & adherence to concepts of patient autonomy, benevolence, & distributive justice of healthcare.
Systems-Based Practice	
Encouraged: know how physicians partner with health care managers and other providers to assess, coordinate and improve health care and know how these activities can affect system performance. *The student may be invited to observe the preceptor in other roles such as chairing committees or serving on advisory boards.	

CLINICAL SKILLS IN INTERNAL MEDICINE

This section highlights those learning experiences in which students participate as opportunities present. All should be preceptor-supervised. This list is not meant to restrict or limit what kinds of skills or procedures the student may be taught or is exposed to during the rural preceptorship.

1. **Pelvic and Rectal Examinations**

There are times when a patient may not be willing to allow a medical student to do a pelvic exam and/or rectal or male genitalia exams. Whenever possible, students should do these examinations.

2. **Trauma Care**

Evaluation, triage, associated procedures, stabilization.

3. **Lacerations**

Evaluations, cleansing and debridement, suturing materials and technique, local anesthesia.

4. **Electrocardiography**

EKG's, cardiac arrhythmias, treadmill stress testing.

5. **Radiology**

Reading of plain films.

6. **Obstetrics**

Consultation for managing medical problems in pregnant patients.

7. **Geriatric Care**

Students receive geriatric training in several rotations, but usually have difficulty gaining experience with ambulatory patients who are relatively self-sufficient.

8. **Occupational Medicine**

Students may understand the injury involved, but not understand the information needed from the physician.

9. **Surgery**

Pre and post-operative care/evaluation.

10. **Other Procedures**

Other procedures as deemed appropriate by the Internal Medicine preceptor.

STUDENT EVALUATION AND FEEDBACK

At UKSM-W, much of the teaching is done by volunteer faculty in private practice. Your evaluation of the student is no less important than evaluations provided by any other faculty, volunteer or full-time.

Any student behavior which is inappropriate should be documented and discussed with the student in a timely manner to allow the student an opportunity to correct the behavior. Please inform the Clerkship Director immediately of any student performance concerns.

Students need critical as well as positive feedback. Encourage to students to discuss any difficulties they may be encountering with the rotation. It is preferable to give initial formative feedback midway through the rotation to allow the student time to correct deficiencies.

The preceptor determines the student's final grade for the rotation, based on the student's overall performance and taking into account any improvement that has occurred after constructive feedback. If several physicians have served as preceptors during the month, all are encouraged to participate in the evaluation process and there should be a consensus on the final grade. We strongly encourage providing specific written comments regarding the student's performance.

Your evaluation of the student should be completed and returned to the appropriate department at UKSM-W as soon as the student completes the rotation. In most instances, the final grade must be in the student's academic record within 30 days. Frequently, however, students need the final grade almost immediately for graduation requirements or other educational opportunities such as residency placement. Sending the evaluation at the completion of the rotation is essential.

After completion of each clinical rotation, students evaluate the rotation. This provides a needed perspective for improvement of each rotation and the entire curriculum. Included in the manual is the *Rural Preceptorship Evaluation Form* which medical students use.

SCHEDULING AND SUPERVISION OF LEARNING EXPERIENCES

Preceptors should sit down with students and discuss with them any specific learning experiences that they may wish to have during the month. As one preceptor stated, “We discuss what is possible during the month and what is not.”

As you know, you are legally responsible for everything that the student does in regard to patient care. The level of supervision the student requires is dependent upon your judgment. Supervision can range from “physical being present” when the student is providing medical care for a patient to “being available by phone” if there are any questions. However, the student must always have access to direct supervision either by you or a designated licensed physician. Any student who requests direct supervision must get it. We would advise against consistently allowing the student to act on his or her own judgment without discussing it with you. You need to know what the student is doing.

Supervision does not mean always telling a student what to do without allowing the student to formulate his or her own management plan. Students need to develop judgment; however, it does not mean that the student will always be allowed to act on that judgment by you. Discuss with the student where you differ and where you agree. Frequently, the differences may be options which are equally acceptable, and students need to know that.

Students must participate in the care of ambulatory patients in your office. This does not mean that they must be in the office every time that you are, but a significant amount of time must be spent in the office seeing or doing what you do with supervision. It is helpful to have students to observe you with patients initially, but it will not be a maximally productive learning experience if that is all that they are allowed to do.

Students must participate in the care of your hospitalized patients. This does not necessarily mean that they have to follow every patient that you admit to the hospital. There may be legitimate reasons for them not to. History and physicals, discharge summaries, and progress notes are all important skills for students to do and refine, a process that will require your input if it is to be beneficial. Students gain confidence whenever they are able to assess patients and formulate diagnostic and treatment plans with your agreement.

Physicians in most rural communities also act as emergency room physicians. Allowing students to participate in this activity is encouraged, but should be balanced to include patient care activities in all areas of your practice.

Students rarely have any opportunities to observe or interact with mid-level practitioners. Providing students with such an opportunity is worthwhile, if your practice utilizes physician assistants or nurse practitioners. Supervisors and teaching responsibilities for the student should not be delegated to the mid-level practitioner, however, as these remain your obligation. Some

preceptors have expressed concern regarding what the relationship of physician assistants to medical students should be. The main intent is for the students to understand what mid-level practitioners are capable of, and how you utilize them in your practice. Students may also learn something from them, just as they may from other health professionals.

You may know of other experiences that students would find beneficial in learning more about rural health care. Visiting with the Director of the local EMS or seeing what the County Health Department does are two possible examples. Attending medical staff meetings and going to local medical society meetings are commonly done.

Students need opportunities to study and simply to relax during the rotation. If you have an afternoon or evening off each week, it would be appropriate to allow the student to have one also. The variation in the volume of patients seen precludes setting rigid guidelines on time off during the week. Some students may never want to participate in patient care after hours; clearly, this should not be an option for them. Some students will want to be available all the time. Those students may need to be encouraged to take time off, particularly if they have missed several nights of sleep.

Students should have at least one weekend off during the month. They should take call and stay in your community at least one weekend during the month, and preferably two. From time to time, a student may request additional time to return to Wichita. This should be discouraged, particularly if it is for personal reasons. It is unacceptable for a student to leave town without your knowledge; unfortunately, this has happened in the past. It would be uncommon for a student to have to return to Wichita during the week because of a medical school obligation. If there are any questions in this regard, please discuss it with the involved department coordinator at UKSM-W.

In group practices, it is essential that one physician act as Coordinator during the rotation. Students may spend time with different physicians, but students have had some difficulty in adjusting to several preceptors when continually being rotated from physician to physician during the month. However, the physician acting as Coordinator may change from month to month.

Student Duty Hours Policy

We note that students are never allowed to write orders without explicit approval and oversight by a licensed physician, are not responsible for patient care activities, and do not perform procedures on patients without direct, on site, close supervision by a licensed health care provider. As a result, student fatigue should never lead to patient care errors or misjudgments. While students must learn that high quality patient care requires personal sacrifice including, at times, loss of regular sleep patterns, erratic meal times, and absence from customary social events and personal recreation, they must strive to discover compensatory strategies to maintain physical and mental health, as well as appropriate social and personal relationships. Therefore, the following standards must be followed by students, faculty, and staff:

1. Students should never be asked or encouraged to provide professional services without appropriate supervision.
2. Students must be instructed on the signs and consequences of sleep impairment and emotional fatigue.
3. Students must be provided resources to address the causes and correction of sleep deprivation and/or emotional fatigue.
4. Students must not spend more than 80 hours a week, averaged over a four week period, in the School of Medicine patient care related environments, classroom activities, or other structured educational programs. This does not include time that students may elect to study outside the formal, structured, scheduled learning environment. Also, students may elect to volunteer time at other health care facilities that are not part of their assigned clerkship experience.
5. Student assignment for 24-hour “call” experiences should be scheduled based on student learning requirements and never on any service needs of the institution. Certainly, certain types of learning opportunities arise more frequently in the overnight hours and resource availability is often modified during late night and morning times. The student should learn about the unique aspect of health care that occurs at that time of the 24-hour day/night cycle. It is advisable that the supervising faculty/residents provide the student with 4-5 hours of continuous sleeping time if the educational opportunities are not critical to the student’s learning. If extremely valuable learning opportunities override the opportunity for student rest and/or sleep during the 24-hour call time block, the faculty/residents should monitor the student’s alertness and ability to participate in the learning program. If the student’s learning is compromised severely because of fatigue or sleep deprivation, they should be allowed to rest.
6. Students must have adequate, private sleeping facilities at every teaching site in which 24-hour call activities occur. These facilities must be available to the student 24 hours a day.

7. If a student feels that s/he may be at risk when operating a motor vehicle because of fatigue or sleep deprivation, they should obtain sleep at the on site call room before departing the premises or ask someone to take them home. The faculty must encourage the student to avoid driving if they feel the student is impaired because of fatigue or sleep deprivation.
8. Students must have, at least, one weekend (from 5 p.m. Friday evening until 7 a.m. Monday morning) free of all formal activities associated with a clerkship every 4 weeks.
9. Faculty (and residents) must monitor students for symptoms and signs suggestive of impairment (including learning impairment) due to sleep deprivation and/or emotional fatigue. The faculty must advise the student appropriately if such observations are confirmed.
10. Faculty must notify the Associate Dean of Student Affairs of any student who suffers continued, persistent signs of sleep deprivation or emotional fatigue.
11. Students should notify the Associate Dean of Student Affairs if they feel their learning is impaired due to sleep deprivation or emotional fatigue.

Guidelines for Clinical Activities by Medical Students

Medical students rotate in clinical settings to learn all aspects of patient care, including obtaining patient histories, performing thorough physical examinations, formulating differential diagnoses, learning to make decisions based on appropriate laboratory and radiological studies and procedures, interpreting results of special studies and treatment, communicating with patients on all aspects of disease and prognosis and communicating with members of the health care team.

To this end, the medical student may participate in the following activities:

1. Access patients to obtain a medical history, perform a physical exam, and follow the inpatient and /or outpatient course.
2. Access the patient's entire medical record, including laboratory reports, x-ray reports, etc.
3. Perform appropriately supervised procedures as authorized by the patient's attending physician. For procedures such as drawing blood that the student has been trained for and declared competent in, the student may draw blood and perform independent of direct supervision.
4. Perform basic laboratory studies such as urinalysis, under appropriate supervision and review.
5. When the student is clinically prepared, write orders for specific patients. All of the orders written by a medical student must be reviewed and countersigned by the responsible resident or attending physician before forwarding to the nursing service.
6. Write progress notes that the responsible resident or attending physician will review and countersign.

Students CANNOT:

1. Write orders independently, without review and counter-signature by the responsible faculty member or resident.
2. Be the primary line of communication in the critical value reporting process.
4. Have sole responsibility for communicating vital patient related information to the patient or family members.

POLICY ON STUDENT ABSENCES

1. **Excused Absences:** All students are expected to notify the responsible individual* prior to any anticipated absence from required activities.

A. **Absence Due to Illness:** The student must notify the responsible individual* whenever it is clear that he/she will be absent.

B. **Absences NOT Due to Illness:** The student must notify the responsible individual* prior to the absence.

***Responsible Individual:**

1. Lecturer or discussion group leader in case of absence of up to two hours.
2. Attending or preceptor in case of absence from clinical duties.
3. Departmental clerkship director or department chairperson in case of absence from a clerkship for more than two hours.
4. The Office of the Associate Dean for Student Affairs in case of absence of three or more days.

Excuses from clerkship activities will be granted as follows:

1. Absences of two days or less will be granted by the Department Chairperson, or his/her designee, and need not be reported further.
2. Absences of three to five days, the student must obtain approval from the Office of the Associate Dean for Student Affairs.
3. Absences of more than five days must be approved by the Curriculum and Education Committee, upon recommendation from the Associate Dean of Student Affairs. A majority vote of the C&E Committee will suffice to approve the absence.

2. **Unexcused Absences:**

A. **Two Days or Less:** This type of absence will be handled by the department concerned, which will decide on disposition, remedial work, etc. for the absence. All unexcused absences should be reported to the Office of the Associate Dean for Student Affairs and a notation of the unexcused absence will be entered into the student's permanent record.

B. **More than Two Days:** This type of absence will result in automatic suspension from enrollment of the student. To be readmitted to the school, the student must apply to the Associate Dean for Student Affairs who will investigate the case and recommend an action to the C&E Committee. The C&E Committee will decide, by a majority vote, the question of readmission. The student may make a personal appearance at the C&E Committee prior to its vote.

3. **Appeals Procedure:**

A. A student who disagrees with the decision of the C&E Committee (in cases of absences greater than two days) or of a department chairperson (in cases of absences of two days or less), may appeal the decision to the Dean of UKSM-W.

B. Decisions of the Dean of UKSM-W may be appealed according to the procedure outlined in the Student Handbook Grievance Procedures.