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Feature Editor

Editor's Note: In this month's column, Rich A. Londo, MD; Michael L. Glasser, PhD; and Jeffrey A. Stearns, MD, share their experiences with long-term medical student preceptorship. The column authors are associated with the Rural Medical Education Program at the University of Illinois-Rockford.

I welcome your comments about this feature, which is also published on the STFM Web site at http://stfm.org. I also encourage all predoctoral directors to make copies of this feature and distribute it to their preceptors (with the appropriate *Family Medicine* citation). Send your submissions to Paul Paulman, MD, University of Nebraska, Department of Family Medicine, 600 South 42nd Street, Box 983075, Omaha, NE 68198-3075. 402-559-6818. Fax: 402-559-6501. E-mail: ppaulman@mail.unmc.edu. Submissions should be no longer than three to four double-spaced pages. References can be used but are not required. Count each table or figure as one page of text.

Perspectives on Longer Community-based Preceptorships

Rich A. Londo, MD; Michael L. Glasser, PhD; and Jeffrey A. Stearns, MD

Depending on the educational goals and objectives of a given medical school, the length of office-based clerkships in family medicine varies greatly. For some institutions, the experience may be limited to 2 or 4 weeks; this is intended as an introduction for the student to the scope and philosophy of family practice and to give the student some understanding of the skills needed to provide ambulatory primary care. These clerkships also give academic validity to family practice by providing "a place at the table" with clerkships in the other core clinical disciplines.

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From the Rural Medical Education Program, University of Illinois-Rockford.

Other schools have chosen to lengthen the community experience by using up to 9 months of the curriculum for community-based instruction. Examples of this approach are the Minnesota Rural Physician Associate Program[1] and the Rural Medical Education Program of the State University of New York Health Science Center-Syracuse.[2] Such preceptorships are directed toward much different outcomes than are the short introductory experiences. Often, one goal is to increase the number of graduates choosing to practice family medicine in the rural and underserved communities that have been involved in the instruction process.

The impact on the community preceptor of having a student in the office has been described in the literature.[3,4] The main effect seems to be an increase in the number of hours worked by the preceptor, with minimal effect on productivity and income. Other than the benefits to preceptors in recruiting future associates for their practices, what rewards are there for preceptors who commit to participate in student teaching? This question has been addressed by Crouse et al,[5] who listed the following benefits: 1) discounted or free continuing medical education credits, 2) savings on the purchase of computers and software through the academic center, 3) library and Internet access, 4) increased satisfaction with professional status, 5) improved retention of rural physicians, 6) enhanced knowledge base of the preceptor, 7) enhanced patient perception of preceptor and quality of care, and 8) improved community health status from medical student involvement in community projects.

Other frequently mentioned rewards include "the joy of teaching" and "the sense of giving back to my school and society" by teaching the next generation of physicians.

The University of Illinois-Rockford has been operating its Rural Medical Education Program (RMED) since 1993. A major element of the curriculum for RMED is a 16-week rural preceptorship during the fourth year of medical school. Besides the usual clinical family practice training, this clerkship includes the requirement that the students complete two projects. The first project is an evaluation of the structure of the community in which they are completing their clerkship, in regard to its socioeconomic, political, environmental, ethnic, and educational characteristics and the effect of these characteristics on health care delivery. The second project is student involvement in a community-oriented primary care (COPC) project. These two project elements are included in the clerkship so the student can appreciate the multiple dimensions in which rural family physicians function within their community. These dimensions have been described by Pathman et al[6] as 1) participating in health activities in the community, 2) sociocultural awareness in the care of patients, 3) informed and appropriate use of the community's health resources, and 4) community participation and assimilation.

It was expected that, during a clerkship lasting 16 weeks, the student would achieve a role of "junior partner," becoming a type of physician extender. This level of functioning in the office setting was thought to be necessary for the student to fully appreciate the previously mentioned issues of community. In addition, it was felt that the time management burden for preceptors would be reduced as the students improved their skills in the office. Finally, an important goal of the clerkship is that students experience the continuity and comprehensiveness that makes family practice unique. These goals led to the decision to adopt the 16-week format.

To determine if and when our RMED students reached a point of being an asset to the practice of the preceptor, surveys were completed by the preceptors who worked with 19 RMED students during the 1997 and 1998 academic years. The preceptors were asked to rate the degree to which their student reached the level of junior partner: "completely," "to a large extent," "very modestly," or "not at all." The preceptors assessed all students as attaining this stage to some degree. The preceptors were then asked to estimate the point during the clerkship when this transition occurred. Responses included a range of times, from 4 to 12 weeks, with a mean of 7.62 (SD=3.25) weeks and a median of 8 weeks.

Based on this limited experience, we believe that rural preceptors who agree to have students in their offices for clerkships that exceed 2 months can expect to find practice benefits and a lessening of the time commitment as the clerkship progresses. In addition, the recruitment potential remains substantial. Our survey asked the preceptors to estimate the likelihood that their medical student would return to practice in their community in the future. More than 50% of the preceptors thought there was "some likelihood" to a "very strong likelihood" of this outcome.

Four months may sound like a long time, but the rewards are only beginning to be apparent. These are probably best illustrated by a quote from the clerkship summary submitted by one of our students this past year.

> (My preceptor) gave me two of the greatest compliments I could have imagined. The first one was that by the end of the rotation, I was actually saving him time. I felt that I was learning a great deal and also helping instead of hindering his functioning. The second, and greatest, compliment was an invitation to join him and his partners in their practice at the completion of my residency. I still think about that constantly. I can't seem to get that generous offer out of mind.

So, don't be astounded when your predoctoral director comes knocking and says, "How about having a student for 16 weeks?"

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