Teaching Points—A 2-minute Mini-lecture
Closing the Deal
By Robert Mallin, MD, Medical University of South Carolina

Editor’s Note: The process of the 2-minute mini-lecture is to get a commitment, probe for supporting evidence, reinforce what was right, correct any mistakes, and teach general rules. In this scenario, Dr Mallin (Dr M) works with a third-year student (M3) who is helping a patient make a healthy behavior change.

MS3: Ms Smith is a 52-year-old woman who returns for a persistent cough. After looking at your previous visit notes, and talking with her—you have already discussed with her that the cough is caused by her smoking.

Dr M: That’s correct, she appears to have a typical smoker’s cough, and we have been working on getting her to make a quit-smoking attempt. How is she doing?

MS3: Well, I used the five A’s that we talked about, and Asked her about her smoking and Advised her to quit in the correct way—clear, strong, personalized—the way that you taught us in workshop and that we practiced. Um, the final A’s are Assess, Assist, and Arrange. I know that next we are supposed to Assess her willingness to make a quit attempt and, after that, Assist her in that attempt and then Arrange for follow up. I’m not really sure about the next step with her, though.

Dr M: Excellent job recalling the five A’s. So we’re in the Assessment phase. What is your assessment about her willingness? What stage of change is she in?

MS3: She says she doesn’t want to quit right now, so she’s in the Precontemplation stage?

We are all facing unprecedented changes in health care delivery with the expansion of electronic medical records (EMRs), the increasing use of disease registries for chronic care management, and the promotion of personal health records for patients’ use and many other overlapping uses of Health Information Technology (HIT). While family physicians as a group are some of the highest adopters of EMRs, with estimates of 40% currently using systems, most have been installed in stand-alone fashions that do not take advantage of the full potential of these tools. Yet there is a growing recognition that to facilitate the best care for patients, physicians must use EMRs in a significant and meaningful manner.

Systems themselves must be capable of being easy to use in patient care; able to exchange clinical, administrative, and quality data in standardized formats; and able to support data aggregation for quality improvement and population management. We owe it to our patients and the next generation of students and residents to actively engage them in helping us all collectively achieve meaningful use of these emerging technology tools.

With the signing of the American Recovery and Reinvestment Act (ARRA) HITECH Stimulus Bill in early 2009, the president and Congress put in motion the possibility of significant ($19 billion) payments to physicians who adopt and use “certified” EMRs and HIT in a meaningful way over the next few years, as well as eventual reductions in payment for those who don’t. This can be as much as $44,000 from Medicare or up to $60,000 per
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**Closing the Deal**

**Dr M:** Be careful here; remember that the Pre-contemplation stage patient doesn't think that smoking is a problem for them. Is that true for her?

**MS3:** Actually, she says she knows she needs to stop smoking but isn't sure that she can do it. That would be more like Contemplation, right?

**Dr M:** That's right. As you remember, the other stages of change are Preparation, identified by setting a date, Action, when patients actually begin the new behavior, and Maintenance/or Relapse.

**MS3:** So what do we do now?

**Dr M:** Actually, I was just about to ask you that question. She is in the stage of Contemplation, and we are helping her move to Preparation. We would know she had moved forward if she set a quit date. How do we help her move from Contemplation to Preparation?

**MS3:** Well, she brought in some homework that you asked her to do on your last visit. She has this list of pros and cons about her smoking. For the pros: she describes liking the taste of tobacco, smoking helps her relax, and she actually says that having a cigarette reduces her cough. For the cons, she said her family is nagging her to quit, cigarettes cost too much, and it makes her clothes smell bad.

**Dr M:** So how did you respond to that?

**MS3:** I remembered what you told us about de-bunking the pros and supporting the cons. I told her how the relaxing effect of smoking was really the result of treating the anxiety that goes along with nicotine withdrawal that starts in 2 hours after the last cigarette. She seemed interested to hear that.

**Dr M:** It sounds annoying. Tell me, do you know anyone who has had lung cancer?

**MS Smith:** Gosh, yes. They are relentless; both of my adult children never stop, and my husband, who quit smoking 2 years ago like it was no big deal, keeps on bringing up lung cancer.

**Dr M:** How old were you when this all happened?

**MS Smith:** 22–23.

**Dr M:** How old are your children now?

**MS Smith:** James is 24, and Mary is 21.

**Dr M:** (long silence) I wonder what it would be like for your children to have to go through what you did, with you being the one with lung cancer.

**MS Smith:** (very tearful now) Oh my, that would be terrible.
Dr M: You might be willing to do anything to avoid that, wouldn’t you?

Ms Smith: Yes, of course.

Dr M: Well, you know the one thing you can do that would most prevent that from happening, don’t you?

Ms Smith: Stop smoking.

Dr M: That’s right. Do you think you’re ready to give it a try?

Ms Smith: This is terrible, but I don’t think I am. I need to think about it some more.

Dr M: OK. Would you like to hear a suggestion about how you can think about it in a way that will help you to decide?

Ms Smith: Yes.

Dr M: Until you come back to see me, I would like you to try to think about that scene of your children standing around your hospital bed watching you dying from lung cancer each time you light a cigarette.

Ms Smith: Oh my. I don’t know if I can do that.

Dr M: Well, I don’t really expect you to do it every time, but I’d like you to try. Think of it as a dose of reality.

Ms Smith: I’ll try.

[Dr M completes the encounter. After Ms Smith leaves, Dr M and MS3 finish the discussion.]

Dr M to MS3: Well, what did you think of that?

MS3: Wow. That seemed over the top. I can’t believe you said those things in there.

Dr M: Yes, the last student I worked with felt the same as you. Emotions are a powerful tool in the decision to change behavior, especially when that behavior involves the reward center of the brain. Do you know why?

MS3: Because it all happens in the mesolimbic system of the brain?

Dr M: I have to be careful what I say around you, don’t I? You remember everything! Ms Smith knows intellectually that she needs to stop smoking, but she is overwhelmed by the craving for cigarettes. She needs a feeling as powerful as that craving for a motivator. So our job is to help her connect her behavior to authentic emotions that give weight to the pros and cons on her list. We are helping her make what she knows is the right decision, by putting emotional weight on some of the pros or cons that she is balancing.

MS3: So this approach might work for other addictions like alcohol or cocaine?

Dr M: Sure, to the extent that we are helping motivate the person to start the changing process. Also, this approach can apply to behavior changes related to obesity, exercise, and adherence to treatment regimens.

Alec Chessman, MD, Medical University of South Carolina, Editor
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Educating Learners and Ourselves

physician from Medicaid. (See www.centerforhit.org for a good summary of the legislation and payment policies and projections.) Over the last 9 months the meaningful use of electronic health information has been hotly debated in various public and private forums with involvement by many different organizations. There is a legitimate concern that the definitions of meaningful use may be either too vague or too far out of reach of the average current family physician within a short timeframe. Also, there is concern about how to develop an appropriate and easy reporting process to verify meaningful use of an EMR to CMS to receive the incentive payments.

These issues are not yet resolved, yet there is a large and focused effort by many individuals within government, the HIT industry, and academic informatics leaders to try and develop thoughtful solutions. As of late December (after the writing of this article) the first formal definition of meaningful use will be released by Dr David Blumenthal, a primary care internist formerly from Harvard and the current leader of the Office of the National Coordinator for Health IT (ONCHIT). (Search http://healthit.hhs.gov for meaningful use.) A specific set of criteria will be released at that time that will likely be focused on using an EMR for the high-risk, expensive to care for patients with chronic conditions in an evidence-based fashion. This will include such things as documenting directly from the EMR the number and percentage of diabetics who are currently under control with HgbA1c levels, LDLs, and adherence to yearly eye exams as well as documentation of the number and percent compliant practices are with regard to adolescent immunizations. The criteria will also increasingly require the exchange of appropriate clinical data between PCPs, area hospitals, and labs and pharmacies, etc. This all will of course have to occur via a certified EMR product. Some Web sites that can be helpful in gaining a better understanding of this are the Markle Foundation (www.markle.org), which is a nonprofit focused on interoperable health care to facilitate improved quality and the Certification Commission for Health Information Technology or CCHIT (www.cchit.org/get_certified).

How Can We Collaborate With Our Learners to Improve the Use of HIT in Our Offices?

Most, but not all, of our current learners have grown up using technology in a way that is drastically different than the majority of family medicine faculty and preceptors. Students are generally very comfortable using smartphones, IPods, instant messaging, Facebook, Tweeter, YouTube, and many other examples of Web 2.0 technologies. Yet few of them have given significant thought about how that technology gets integrated effectively into their daily lives or workplaces, and even fewer have seen HIT integrated into clinical care in a truly transformational way. Yet when asked about how to improve the way you utilize your EMR almost all imagine and tell you of many specific ways to do things better. This is often in stark contrast to what I have noted about faculty, however. It is rare that I go more than a month these days without seeing a resident or student utilize a form of technology in a new way as a work-around to try and make things easier for them and their peers. This ingenuity ranges from finding ways to store data that is used repetitively and simply copy it into the right spot on the hospital admission form the next time, to developing creating ways to sign out critical lab values through texting or instant messaging with a peer. Most of these work-arounds save time and effort but are not compliant with current HIPAA security regulations. So I am often the bearer of the bad news of a “Cease and Desist” order to protect patient privacy.

Instead of trying to stand in the way of their desire to improve the way we do things, we need to capture that ingenuity and drive to help us all use technology in a more meaningful way that will help improve our patient care and help sustain the extra cost of using that very technology. In addition, students and residents are often willing learners and participants in projects if they can see real and tangible benefits for the patients they are caring for and their own skill acquisition.

There are a number of potential steps you can take with your learners as family physicians to move in this direction. Here are a few ideas with some associated rationale.

(1) Develop a fourth-year student elective focused on helping family physicians with specific elements of meaningful use. (E-Prescribing, Health Information Exchange, Improving Health Disparities, etc.) Have them do an initial gap analysis between what you are currently doing and the literature and best practice scenario for a comparable site. This will require a dedicated student who is willing to learn quite a bit but can leave your practice with a valuable product at the end.

(2) Have students join efforts with the forming Regional Health Extension Centers within your state or region and volunteer (or get paid if they are sufficiently skilled) to help primary care doctors adopt and optimize their use of EMRs as part of a longitudinal elective within their offices. This could be led from the medical school side and would offer students an excellent opportunity to be involved in a ground up effort to get HIT into many primary care offices. The one caveat here is that it will take considerable time for a student to be adequately trained and comfortable in this role, so perhaps this is a summer role for a first-year student or a longitudinal elective.

(3) Involve students directly in your Continuous Quality Improvement (CQI) projects within your office and have them help improve the way you do things by suggesting ways to use your technology more efficiently. They can often be set free on the Web sites of your EMR vendor, the online help documentation for this software, or on the listserves with other customers who often share best practices. Most doctors
are too busy to read this information, but a savvy student will be able to see opportunities quite quickly. This will work best perhaps for a student who has a background or proclivity for computer science and or engineering, but you will have several of those individuals in every class.

(4) Give students explicit training in care management and patient portal software use and ask them to help co-manage a group of diabetic or asthmatic patients with you and your nurse manager. This improves your patient’s care and teaches the student about a Patient-centered Medical Home via a hands-on approach that students will likely value. It will also help advance your transition to a medical home. This will require an advanced student and/or resident but can be quite a win/win since the student will be learning a skill that most of his or her peers do not have, while your practice will gain the energy and time of a learner working on this issue. You will of course have to provide adequate oversight for this work.

(5) Have students check with their peers at other sites and get good ideas about how they are optimally using HIT and teaches the student about a Patient-centered Medical Home via a hands-on approach that students will likely value. It will also help advance your transition to a medical home. This will require an advanced student and/or resident but can be quite a win/win since the student will be learning a skill that most of his or her peers do not have, while your practice will gain the energy and time of a learner working on this issue. You will of course have to provide adequate oversight for this work.

(6) If you have a Quality Improvement or informatics committee, invite student and resident members to participate on them. They often will ask the obvious questions—such as “Why can’t we get this information electronically?”—that often are not verbalized by more experienced members of the team. They can also be asked to participate in developing the much more specific questions that are needed to provide appropriate data and will learn the limitations of how we enter data in our EMRs as well as those of the actual EMR products. They will be able to improve their documentation, just by understanding how it can be used in the long term if collected in a standardized format initially.

(7) Have learners participate when you are redesigning a particular workflow or form in your EMR. They will often ask questions about possible functionality that would be overlooked by physicians or staff not familiar with the latest Google API or Apple APP that can be downloaded freely from the Internet. It is wise to remind them of the appropriate evaluation of timeframe and stability testing that might need to occur to consider implementing within your HIT system in a safe fashion. A parallel can be made between when a new medication gets released and when we choose to use it to protect our patients and ourselves from that infrequent but not rare adverse event that might occur.

Involvement of our learners in helping to transform our health care system will be critical to our overall success. It requires their participation for appropriate buy-in, to attract them to the new way primary care will be practiced in the near future, and simply because we will need their ingenuity and energy to effectively make the transitions ourselves. So let’s find ways to engage them in improving the ways we use HIT wherever they are in their learning process from first-year medical student through third-year resident. Additional medical informatics training for some faculty or family physicians might be needed or desired. A good first resource to consider is the American Medical Informatics Association-sponsored 10x10 program (https://www.amia.org/10x10), which is a short 10-week online certificate course that outlines the basics in health care and clinical informatics and helps folks get past the initial knowledge deficit and enables them to more actively participate in the local HIT transformation that is about to get into full swing. Some additional curricular materials from a 4-hour preconference workshop for the Society of Teachers of Family Medicine Predoctoral Education Conference in 2008 can be found and freely downloaded and modified at the STFM Resource Library (FMDRL) at www.fmdrl.org/1503. Have a great new year!

Richard Usatine, MD, University of Texas Health Science Center at San Antonio, Editor

Thomas Agresta, MD, University of Connecticut, Coeditor

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Evidence-based Answer
Screening for tuberculosis (TB) with a purified protein derivative (PPD) is probably indicated for all immigrants over 6 months of age. Screening for hepatitis B and anemia may also be indicated depending on origin of region. HIV and syphilis screening should be done if not carried out prior to immigration. (SOR C, extrapolation from cohort studies.) Immigrants should also receive routine health screening appropriate for their age and sex. (SOR A, based on guidelines from the US Preventive Services Task Force.)

Evidence Summary
Potential immigrants to the United States must undergo a medical examination by a physician certified by the Centers for Disease Control and Prevention as part of the immigration application process. For immigrants aged 15 years and older, this examination includes screening for TB with a chest X ray, serology tests for syphilis and HIV, and review of routine vaccination status. It also includes a complete history and physical, including screening questions for chancre, gonorrhea, granuloma inguinale, lymphogranuloma venereum, Hansen’s disease, mental disorders, and substance abuse.

Screening for TB using a PPD may be indicated for every immigrant older than 6 months regardless of bacille Calmette-Guérin (BCG) vaccine status. In 2003, 14,874 cases of active TB infection were recorded in the United States, 6,903 (41%) of which were in people born outside the United States. DNA fingerprinting of 546 TB strains isolated in New York City between 1990 and 1998 suggested that patients born outside the United States had an odds ratio (OR) of 0.31 (95% confidence interval [CI]=0.14–0.66) for a newly transmitted infection, compared with having a reactivation of a latent infection. This finding suggests foreign-born patients with active TB have more reactivation than new infections.

A large study from The Netherlands compared cases of latent TB discovered through screening with those discovered passively in immigrants. Cases discovered through screening were less likely to have positive sputum cytology (OR 0.5, 95% CI=0.3–0.8) and less likely to require hospitalization (OR 0.2, 95% CI=0.1–0.2). This study also found that 302 of 454 (66%) of new TB cases found through screening were discovered during the first 6 months that the immigrant resided in The Netherlands, compared with 114/368 (31%) of cases discovered passively. The authors estimated that screening decreased the total infectious time by 30%.

Screening for hepatitis B is another consideration for high-risk patients. Hepatitis B is endemic in many parts of the world, including Asia (8%–10% chronic infection rate), Eastern Europe, the Middle East, the Amazon basin, and the Indian subcontinent (2%–5% chronic infection rate). Because there is a vaccine for this disease, screening will allow the physician to identify and vaccinate household contacts of infected persons, thereby preventing transmission. Testing stool for ova and parasites is indicated if height or weight is less than the fifth percentile or if anemia or gastrointestinal symptoms are present. Prevalence of parasites in refugees of all ages in Minnesota was found to be 22%. The highest prevalence is found in Southeast Asian and Latin American populations. One study of Southeast Asian refugees in Canada found that screening and treatment of clinically significant intestinal parasitic infections decreased the prevalence from 70% to 31% (P<.01) over 6 months.

A higher prevalence of anemia is often found in immigrants secondary to iron deficiency, hemoglobinopathies, infection with hookworm, and malaria. A study from Denmark comparing pregnant women from eastern Mediterranean and Asian regions with pregnant ethnic Danish women found a higher prevalence of anemia in the immigrant group (20.0%) compared with the Danish group (4.9%) (P<.0001). Most of the anemic immigrant women were found to have iron deficiency anemia. Women found to have hemoglobinopathies were excluded from this study.

Besides the tests that are indicated based on the patient’s country of origin, all patients should receive screening examinations and preventive care appropriate for their age and sex.

References

Jon O. Neher, MD, University of Washington, Editor

HelpDesk Answers are provided by Evidence-Based Practice, a monthly publication of the Family Practice Inquiries Network (www.fpin.org)
POEMs for the Teaching Physician

~ 1% of Patients With Acute Back Pain in Primary Care Have Serious Pathology

Clinical Question: How often are serious problems identified among patients with acute back pain seeking care from primary care physicians?

Setting: Outpatient (primary care)

Study Design: Cohort (prospective)

Funding: Government

Synopsis: These Australian authors report on 1,172 consecutive patients older than 14 years with acute low back pain who sought care from a primary care physician. Each patient was asked about the presence of any of 25 (that’s right: 25!) “red flags,” that is, symptoms associated with serious causes of back pain such as cancer, cauda equina syndrome, infection, or fractures. The primary care physicians in this study were trained to use a clinical decision guide to categorize patients into one of three categories: simple backache, nerve root compromise, or suspected serious spinal pathology. Not all patients received X-rays. The gold standard was based on clinical follow-up 12 months after the initial consultation. Additionally, the patients were evaluated by phone 6 weeks, 3 months, and 12 months after the initial visit. At these interviews the patients were asked if they had been given a diagnosis of a fracture, infection, cancer, or arthritis. A study rheumatologist independently evaluated 20% of all patients (chosen randomly) and also evaluated any patient suspected of having a serious cause of their pain. Although 80% of patients reported having at least one “red flag,” only 0.9% of the patients had confirmed pathology: eight patients with fracture, one with cauda equina syndrome, and two with inflammatory arthritis. None of the patients had infection or cancer.

Bottom Line: In this prospective study of patients with acute low-back pain seeking care from primary care physicians, approximately 1% had serious underlying pathology. Although one might question whether the diagnostic standard was rigorous enough, the true rate is nonetheless likely to be quite low. (LOE = 2b)

Clinical Factors Identify Children at Low Risk of Traumatic Brain Injury

Clinical Question: Can clinical factors identify children with head injury who are at low risk for clinically important traumatic brain injury?

Setting: Emergency department

Study Design: Cohort (prospective)

Funding: Government

Synopsis: This team of researchers systematically evaluated more than 42,000 children presenting to emergency departments within 24 hours of sustaining head trauma. The researchers excluded children with trivial injuries (eg, trip and fall, walking into stationary objects) and children with penetrating injuries or preexisting neurologic disorders. Each child underwent a standardized clinical assessment. The researchers defined clinically important brain injuries as those that resulted in death, neurosurgical intervention, intubation, or more than 2 days in the hospital. A pediatric radiologist unaware of the child’s clinical characteristics interpreted radiographs whenever CT was performed. The decision to perform CT was left to the discretion of the emergency department physician. To identify children with clinically important brain injuries missed during the initial assessment, a researcher contacted the children’s parents between 7 days and 90 days of discharge from the emergency department. The researchers also split children into two age groups: younger than 2 and 2 years and older. The researchers used data from the first 2 years of the study to derive clinical prediction rules. These were subsequently validated on children during the last 6 months of the study.

Approximately one third of the children had CT, of whom 5% had radiographic signs of traumatic brain injury, and 1% had clinically important brain injuries. For children younger than 2 years, the presence of any of the following clinical factors were useful in identifying children with clinically important brain injuries: altered mental status, occipital/parietal/temporal scalp hematoma, loss of consciousness for longer than 5 seconds, severe mechanism of injury, palpable skull fracture, or parent report of not acting normally. The researchers defined severe mechanism of injury as: motor vehicle crash with ejection of the child, death of another passenger, or rollover; pedestrian or bicyclist without helmet struck by a motorized vehicle; falls of more than 1.5 meters (5 feet) for children 2 years and older and more than 0.9 meter (3 feet) for those younger than 2 years; or head struck by a high-impact object. In the validation set, the presence of any of these factors was 100% sensitive (95% CI, 86.3%–100%), but only 54% specific (51.6%–55.8%). In other words, a child having none of these factors is very unlikely to have a serious injury and does not need CT. For children 2 years and older, the presence of any of the following clinical factors helps identify children with clinically important brain injuries: altered mental status, loss of consciousness, vomiting, severe mechanism of injury, clinical
signs of basilar skull fracture, or severe headache. In the validation set, the presence of any of these factors was 97% sensitive (89%–99.6%), but only 60% specific (58.6%–61%). A child having none of these factors is very unlikely to have a serious injury and does not need CT.

**Bottom Line:** In this large study, clinical factors identified which children with head injuries were unlikely to have a serious brain injury. Since computed tomography (CT) uses enormous amounts of radiation, and children are especially vulnerable to potential adverse effects of radiation exposure, these factors can help reduce the use of CTs. (LOE=1b-)

Excerpted from “For the Office-based Teacher of Family Medicine”

Patient Witnessed Precepting: Faster Precepting That Is Effective and Fun
by Caryl J. Heaton, DO, UMDNJ-New Jersey Medical School
(Fam Med 2009;41(10):696-8.)

The traditional process for teaching in a family medicine residency may not be the best choice for teaching students in a private office. Residency teaching has usually encouraged the faculty preceptor to stay in the “precepting office.” The faculty is assigned from one to four residents who come to knock on the door. The faculty physician is “unencumbered” with patient care of their own. Teaching can be brief or in depth, but it takes place, primarily, out of the view of the patient.

I would like to introduce a different model of teaching—Patient Witnessed Precepting (PWP). Teaching medical students can be more effective and more rewarding, at least for me, if the teaching takes place directly in front of the patient. Our three-person office takes a student year round, and my partners still use the traditional model of having the student present in our faculty office before seeing the patient. My process is different. If the student starts to present, I say, “Wait a minute, tell me when we get in the room.”

PWP has also been called “exam room staffing” and “teaching in the patient’s presence” (TIPP). There have been few objective evaluations on patient witnessed teaching, but the early research suggests a preference by patient and faculty1 and a split decision as to the degree to which the learners like it.2 The components of PWP are listed in Table 1.

Setting Expectations

The introduction to PWP occurs on the first day that I work with a student. I explain that I do all teaching in front of the patient. I introduce the student to the patient and ask them to take a history of the chief complaint and to do an appropriate physical examination. I tell them that I will double check all pertinent physical exam findings. I tell them I am happy to double check their “normals,” and I must be told about all “abnormals,” even if they aren’t sure. I tell them that I may do parts of the physical exam while they are presenting the patient. I ask them to have an assessment and plan ready and that we will discuss this in front of, and with, the patient.

I go to see another patient while they are in the room. They can take their time, but I will interrupt if they take too long. If they finish before me, they can start writing the note. All of our students have access to our electronic health record. I tell them that I may do parts of the pertinent history but that they should tell me privately about any “loaded” history such as substance abuse, dangerous mental health symptoms, or possible abuse. We establish a code to leave the room, if needed. Lastly, I have them act as a “scribe” of the encounter for me in writing the note. They only record the things that we discuss together and the physical examination that I perform in the note. I double check and co-sign any note they write. I warn students that the temptation may be to write more, but the note must be a record of only what the licensed physician knows, says, and does.

Student Presentation

The process of teaching with the patient looking on is not so different from teaching done in your office. After greeting the patient I say something like, “You’ve already talked to Jeff; he’s a third-year student getting pretty near to the end of his rotation, and he is going to tell me what he found out.” The student presents the history, and I ask clarifying questions using the one-minute preceptor microskills steps.3 I may not always get the order in exactly the way it was first described, but I stick to this process pretty faithfully.

There are several advantages in PWP. The patient can immediately fill in any gaps in the history. If there are any questions the student forgot to ask, we can turn directly to the patient. The patient learns from the teaching. Questions such as “Do you think this patient will benefit from antibiotics?” or “What options do we have to lower the blood pressure?” lead to a discussion that helps the patient to have a better understanding of their condition. In addition, the patient feels that they are an integral part of the process. The patient is reassured that their story has been accurately told and that you heard every word. The student writes the note. This saves some (maybe a lot of) time at the end of the day. The notes are usually specific and complete but still require me to do some editing.

Focus of the Encounter

The challenge of PWP is to keep your focus on the student when the student is presenting and to appropriately turn it to the patient when the teaching is done. It is easy to take over the encounter if the student has missed an important question. The key is to turn back to the student and resume teaching. I will say

| Table 1 |
| Components of Patient Witnessed Precepting |
| 1. Set expectations. |
| 2. Focus and respond to the student presentation. |
| 4. Provide feedback and teaching to the student and the patient. |
| 5. Wrap-up and summarize expectations. |

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The Teaching Physician

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something like, “OK, now let’s see what Jeff thinks is going on,” to get back to the student.

I try to make sure that at some point I turn all my focus to the patient. It is often to make sure that they were following the discussion. I used to worry that if we got into basic science or pharmacology they would be somehow annoyed, but that does not seem to dim their enthusiasm for this process at all. I still do the critical parts of the physical exam, and occasionally I perform parts of the exam that the student did not do. Patients appreciate that they have been examined by two physicians.

Summarizing the Plan

PWP does not diminish my standing with patients, if anything, I feel that they are more impressed with the fact that I am a teacher of medical students. A discussion of “Is this good control?” helps the patient put the state of their chronic medical condition into perspective. The follow-up question “What does she need to do to get her diabetes under excellent control?” can become a robust group discussion with the patient taking an active role. At times I give both the patient and the student an assignment based on the visit. I have even been known to give myself an assignment, to model lifelong learning.

Even patients with difficult or confusing problems can be included in PWP. I will occasionally describe my thinking about my toughest patients to the student in that patient’s presence. It reaffirms (to the patient) that I have considered multiple possibilities and that I have done appropriate testing. To this point I have never had a student who came up with a clear answer that had stumped me, but that day may come, and it may be right in front of the patient. I am prepared for it, because these students are pretty bright.

If you have a student function as a scribe for your notes, you should have documentation in your office that attests to the process. (See Table 2.) This attestation should be signed and documented by every physician in the practice that uses PWP. Your organization’s legal department (if you have one) may also want to have a look at this.

Table 2

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<td>“Medical students from — (University or Universities) — will see patients in this office and write a note in the medical chart that documents my direct activity with the patient. They will document only the components of the visit that are discussed and evaluated by myself. I review all medical documentation, and my signature attests to activity, evaluation, and discussion performed by myself.”</td>
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PWP has allowed me to see patients faster with students than without them. I have to spend some time reviewing their notes, but this is more than compensated for by the fact that they save me time doing the “scribing” first. Occasionally I have to send an e-mail to a student about an important change that I may have made in the documentation, and this gives good immediate feedback to the student. But the best reason for PWP is to bring the patient overtly into the teaching process. I can’t prove its better care, but I am sure that it’s more fun. You might want to give it a try.

Correspondence: Address correspondence to Dr Heaton, UMDNJ-New Jersey Medical School, Department of Family Medicine, Behavioral Health Science Building E 1559, 183 South Orange Avenue, Newark, NJ 07103. 973-972-7828. Fax: 973-972-7997. heaton@umdnj.edu.

References