Behavioral Health Preceptor Teaching Certificate Session 1

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Chair, Behavioral Health

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Disclosure

- Neither I, nor an immediate family member (parent, sibling, spouse, partner, or child), has any financial relationship with or interest in any commercial interest connected with this presentation.

Objectives

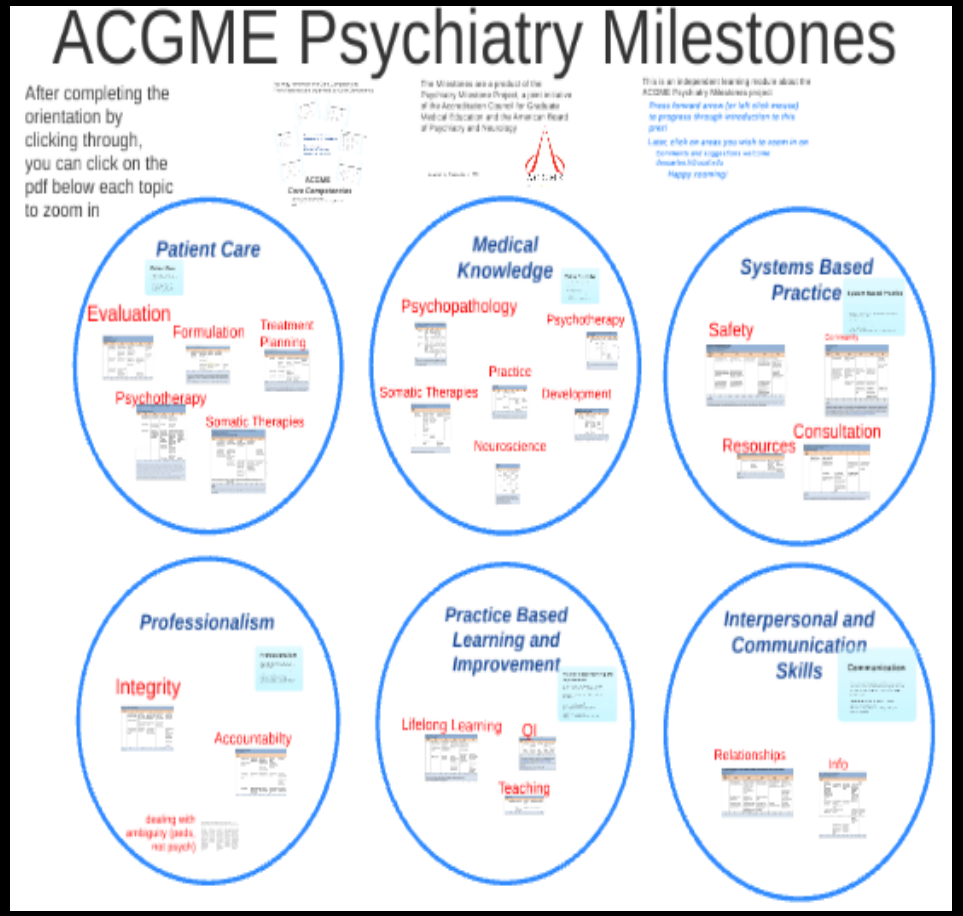
- To review Learning Goals 1 and 2
- Understand didactic foundation of OMS II Behavioral Medicine and Essentials of Patient Care courses at LMU DCOM
- Identify ways to build upon the OMS III student's didactic foundation using appropriate clinical experience/exposure to meet Learning Goals 1 and 2

What are the advantages of having a medical student in my practice?

- Skill set/ knowledge level is sharpened from teaching
- Reduction in feeling isolated from academia/peers
- Student happily does research and article review in order to present salient points – especially when you, the busy clinician, don't have time to review all the journals
- CME credit given for teaching (AOA/AMA) http://dcomcme.lmunet.edu/cme-precepting-credit-request
- Access to all the medical databases, e-journals and e-books LMU DCOM provides (see CME offering – "Quick Reference Guide to Databases and Medical Library Services" http://library.lmunet.edu/medlib)
- Stipend paid to organization or private practice
- Connection to the next generation of physicians

Learning Goals Overview:
7 Core Competencies for Osteopathic Medical Students

1. Medical knowledge
2. Patient care
3. Systems based practice
4. Interpersonal skills and communication
5. Professionalism
6. Practice based learning
7. Osteopathic principles and practice*



*Required for osteopathic medical schools

Learning goal 1: Clinical Medical Knowledge

1.1 Describe normal psychological development across the lifespan

a. Apply knowledge of the expected changes across the lifespan in the care of patients with mental illness and medical disorders

1.2 **D**escribe the biological theories and diseases for psychiatric disorders and SUDs (Substance Use Disorders).

a. Apply knowledge of major psychiatric disorders in the assessment and care of patients.

b. Apply knowledge of the SUDs in care of patients.

c. Describe scientific basis for the diagnostic tests used in psychiatry.

Learning goal 1: Clinical Medical Knowledge

1.3 Describe the psychopharmacological, neuromodulation, and psychotherapy treatments for psychiatric disorders.

a. Psychopharmacology in development of treatment plans.

b. Demonstrate basic skills used in motivational interviewing and supportive psychotherapy.

1.4 Demonstrate knowledge of psychiatric concepts, components of psychiatric MSE, and cognitive screening.

a. Defense mechanisms, transference, countertransference in patient care duties.

b. Ability to complete a MSE.

c. Demonstrate ability to perform a cognitive screening exam (MMSE, MOCA)

OMS II Behavioral Medicine Course Layout

- Initial lectures focus on psychiatric interviewing, conducting of MSE and cognitive assessments
- Lecture on biopsychosocial development focuses on development across the lifespan with primary focus on 0-18 but addresses adult and geriatric development via Eriksonian staging

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OMS II Behavioral Medicine Course Layout

Each major area of pathology i.e., Mood Disorders, Anxiety Disorders, Trauma and Stressor Related Disorders, Obsessive Compulsive and Related Disorders, etc. all receive 1-2 hours of didactic on epidemiology, risk factors, diagnosis, prognosis, medication and psychotherapeutic options for treatment

Doctorate level pharmacologists deliver separate lectures on biological mechanism of action, indication, contraindication, drug interactions, etc. for each diagnosis related category of medications

MONDAY 20	TUESDAY 21	WEDNESDAY 22	THURSDAY 23
Behavioral Med **GUEST** 5 **(DCOM Aud 102 - ITV)** Mood Disorders I Boadie Dunlop, MD	**Musculoskeletal** 8 **(DCOM Aud 102)** Developmental Musculoskeletal Conditions TBA	**Musculoskeletal** 10 **(DCOM Aud 102)** Normal and Pathologic Gait TBA	**Musculoskeletal** 12 **(DCOM Aud 102)** Osteoarthritis Gina DeFranco, DO
Behavioral Med **GUEST** 6 **(DCOM Aud 102 - ITV)** Mood Disorders II Boadie Dunlop, MD	**Musculoskeletal** 9 **(DCOM Aud 102)** Musculoskeletal Physiology Review TBA	**Musculoskeletal** 11 **(DCOM Aud 102)** Rheumatoid Arthritis Gina DeFranco, DO	**Musculoskeletal** 13 **(DCOM Aud 102)** Neuromuscular Junction Disorders Teresa Campbell, MD
Behavioral Med **GUEST** 7 **(DCOM Aud 102 - ITV)** Anxiety Disorders I Boadie Dunlop, MD	**Clin Neuro** 6 **(DCOM Aud 102)** Pharmacology of CNS Infectious Disease Kali Weaver, PharmD	**Behavioral Med** 9 **(DCOM Aud 102)** Pharmacology of Depression and Anxiety TBA	**Behavioral Med** 10 **(DCOM Aud 102)** Pharmacology of Psychosis and Mania TBA
Behavioral Med **GUEST** 8 **(DCOM Aud 102 - ITV)** Anxiety Disorders II Boadie Dunlop, MD	**EPC IV** 5 **(DCOM Aud 102)** Neurologic Exam I TBA	**OPP IV** 7 **(DCOM Aud 102)** Rib Mechanics Juanita Brown, DO	**EPC IV** 6 **(DCOM Aud 102)** Neurologic Exam II TBA

Behavioral Health Topics delivered in EPC III-IV

In fall and spring of OMS II year, I deliver lectures with associated standardized patient encounters (SPEs) covering “How to Handle Difficult Patient Encounters” (fall) and “SBIRT” in spring

SBIRT: Screening, Brief Intervention/Motivational Interviewing and Referral to Treatment for Substance Use in Primary Care

Leah Cobb Snodgrass, M.D.

Sample Slides from SBIRT Lecture: Educational Objectives for SBIRT

- Screening :
  - Employ CAGE-AID screening tool to detect substance use disorders
- Brief Intervention:
  - Understand the components of a brief intervention
  - Employ basic tenets of motivational interviewing to effect behavioral change
- Referral to Treatment
  - When to refer
  - To whom to refer
  - How to refer

5 Stages of Readiness to Change

1. Pre-contemplation

   Patient is unaware or unwilling to recognize problem

   *agree to disagree

2. Contemplation

   Patient is aware there is a problem but unsure of what to do about it; willing to explore options for help

   *willing to discuss problem as a problem

3. Determination/Action

   Patient decides to make changes and takes steps to do so (locates resources, sets timetable, etc.)

   Patient is following through on planned course to change behavior

   *negotiate treatment plan and follow through

Prochaska JO (2009). Enhancing motivation to change. Principles of Addiction Medicine, 4th Edition. Philadelphia, PA: Lippincott, Williams, and Wilkins.

5 Stages of Readiness to Change continued

4. Maintenance

    Patient continues to actively make the new behaviors a habit, establishes “new normal”

    *relapse prevention

5. Relapse

    Return to previously undesired behavior; must start over at one of earlier stages of change

    *early identification and proactive outreach

Prochaska JO (2009). Enhancing motivation to change. Principles of Addiction Medicine, 4th Edition. Philadelphia, PA: Lippincott, Williams, and Wilkins.

Motivational Interviewing

- Collaborative, not directive
  - Active collaboration and joint decision making as opposed to expert doctor telling passive patient what to do
  - Vital to health behavior change because ultimately it is only the patient who can enact such change
- Evocative, not provisional
  - Evoke from patient their own motivation and resources for change as opposed to providing patient with what they lack (medication, knowledge, insight, skills, etc.
  - Evoke patient's own reasons and arguments for change
- Honoring autonomy as opposed to enforcing paternalism
  - Something in human nature resists being coerced and told what to do.
  - Acknowledging the other's right and freedom NOT to change sometimes makes change possible!

Motivational Interviewing

- 4 Guiding Principles of Motivational Interviewing: **RULE**
  - Resist the Righting Reflex
    - Physician's tendency :"set things right…help the patient get back on right track"
      - "I think you are drinking too much and should cut down or quit."
    - Patient tendency: to resist persuasion especially when AMBIVALENT – always argue the opposite side
      - "I don't think it is that bad…I don't drink THAT much after all and I still hold down a job and take care of my family."
  - Understand your patient's motivations
    - The patient's reasons for change will trigger true behavior change; your reasons will not
  - Listen to your patient
    - Not just until you can answer their question
    - Good listening involves empathic interest in understanding where the patient is coming from
  - Empower your patient
    - Help patient figure out how they can use their own ideas and resources to effect change in their health

Core concepts of Motivational Interviewing

- Asking, informing and listening come together to guide rather than badger; to encourage rather than shame; to negotiate rather than dictate.
- In talking about why change is important, patients decide change really is important. By voicing the good reasons to do it and how they might succeed, patients make change seem possible.
- In essence you are listening for what the patient is ready willing and able to do in the way of health behavior change. Don’t push the patient into it however; give the patient opportunities to arrive at it. (This requires patience and time.)

Application via Standardized Patient Encounter (SPE)

Student's Name: _____

Date: _____

Student Instructions
Interview Taping

You will be seeing Grace or Grant Hanson, a patient who has come for a return visit to discuss his/her possible alcohol abuse concerns. You saw this patient one week ago for a well visit check where they mentioned also experiencing some stomach pain. At that visit you found out there is a potential that this person is drinking too much and you ordered some lab tests. The patient has returned to discuss their lab results and their drinking. This patient is a recurring patient to this clinic and you should assume that you have already established a clinical relationship with them. Your role as the student doctor is to determine what stage of change this patient is in and help them with a plan to work on their alcohol abuse issues.

Relevant clinical information.
Lab values in the past have all been normal. Now AST is 85 (normal 8-20) and ALT is 42 (normal 8-20). Alcoholic pattern AST is twice the ALT (Clinical Pearl)

Long term alcohol abuse can harm the liver, nervous system, heart and brain. Some common health risks related to alcohol abuse include – cirrhosis of the liver, pancreatitis, stroke, some types of cancer, high blood pressure and Wernicke-Korsakoff syndrome (causing blurred vision, difficulty walking, and memory loss). There are also the social and safety risks associated with alcohol abuse such as accidents, increased capacity for violence, problems functioning at work or at home, and social isolation. Legal consequences can be harsh if driving while drunk including jail, loss of driving privileges, forced rehabilitation and loss of employment.

Application via Standardized Patient Encounter (SPE)

Student's Name: _____
Date: _____

Student Instructions
Interview Taping

You will be seeing Susan or Steven Collins, a patient who has come for a return visit to discuss his/her possible prescription medication addiction. You saw this patient one week ago for a well visit and to check on the progress of their back pain where you discussed the need for a second appointment to discuss their possible dependency on the pain medication. You should assume that you have already established a clinical relationship with them. Your role as the student doctor is to determine what stage of change this patient is in and help them come to a decision to work on cutting back their pain medications.

Relevant clinical information.
Mental Status exam results have decreased, especially short term memory. Patient is anxious, irritable, and having decreased appetite. All signs of medication withdrawal due to tolerance of the medication – they would need more medication or take closer together to take care of the "cravings".

Extended use of prescription narcotics will lead to dependence on the medication and addiction. The longer the medication is used the more you will need to take (higher dosage) to get the same effect as you initially did with the previous dose.

Long term use of opioids can lead to changes in structure and function of the brain which in turn lead to affecting an individual's self control and ability to make sound decisions. If combined with substances that depress the central nervous system (including alcohol) there is a much greater risk of respiratory depression and even death. The social/legal consequences can also be heavy for the individual including loss of employment, social isolation, loss of family, and in some instances jail and forced rehabilitation.

How can preceptor build on this foundation of knowledge of motivational interviewing?

- Allow students to do brief screenings for SUD via:
  - NIDA Quick Screen
  - NIDA Modified (NM) ASSIST
  - **CAGE-AID**
  - AUDIT
  - DAST
  - TWEAK
  - CRAFFT
- Allow student to develop facility with and understanding of scoring cut offs and how to proceed forward with Brief Intervention…or not if not indicated.
- Observe student's attempts to employ Motivational Interviewing Techniques; give constructive criticism and opportunities to improve skill set
- Ask the student to research options for referral to treatment for SUDs in your area including levels of care and barriers to care
- Make the didactic delivered in second year come to life as a real patient encounter in third year!

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Outline of mental status exam

I. General Description
   - A. Appearance
   - B. Attitude/Engagement
   - C. Motor activity

II. **Speech**

III. **Mood**

IV. **Affect** (Range, Intensity, Fixity, Appropriateness)

V. **Thought Process**

VI. **Thought Content**

VII. **Thought Perception**

VIII. **Sensorium and Cognition**

IX. **Insight, Judgment, Impulse Control**

X. **Reliability**

Example Section of OMS II MSE Lecture
I.A: Appearance

1) Ethnicity – be careful not to assume
2) Apparent or reported age and whether appears younger, stated age, or older
3) Grooming and Hygiene
    a) Well groomed vs. disheveled
    b) Good hygiene vs. poor i.e., body odor, halitosis, bad teeth,dirty nails, unkempt
    c) Combed hair vs. uncombed, tousled, matted, greasy hair

4) Dress

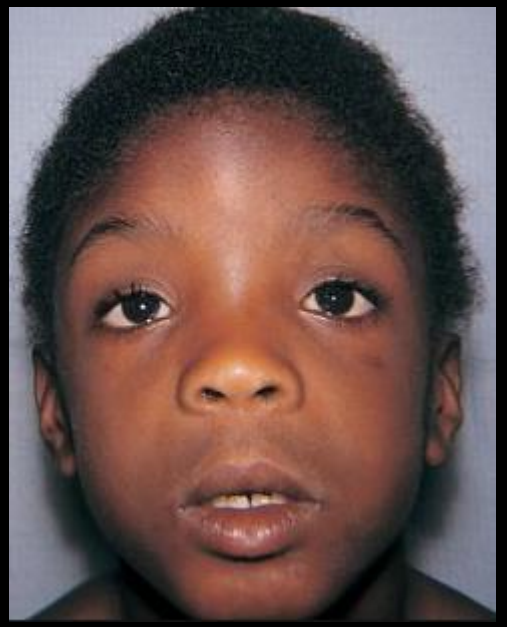
    a) Appropriately dressed for age, work, weather vs. inappropriately dressed
    b) Make up and dress are appropriate vs. too provocative, bizarre, garish
    c) Clothes are clean vs. dirty

Ia. Appearance continued…

- 5) Physical Features
  1. Build: well nourished, slender, cachectic, obese
  2. Facial features: exophthalmus, ptosis, nystagmus, dysmorphisms, assymetries
  3. Hair: alopecia (androgenetic = male pattern baldness vs. areata = autoimmune, includes eyebrows and lashes vs. trichotillomania)
  4. Skin: needle tracks, self injury scars, tattoos, stigmata of alcoholism

APPEARANCE…

Appearance…



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How can preceptor build on this foundation of knowledge of comprehensive mental status exam?

- Allow student to observe as you interview patients paying strict attention to collection of MSE information
- Allow student to practice verbally presenting cogent organized MSE
- Encourage student to do written MSEs in advance of graded SOAP/Full history note for review by preceptor and grade by Chair. Offer guidance/constructive criticism.
- Allow student every opportunity to develop facility with the MSE
- Make the 2D didactics come to life in a 3D patient!

Review Question

- A third year medical student joins your service on Monday. The student is shy, quiet, and not one to ask many questions. Which of the following would be an appropriate way to introduce the student to the practice of mental health care?
  a) Ask the student to observe preceptor's interviews the first few days and collect mental status exam information to present.
  b) Explain to the student it is best if they "shadow" the provider since most patients would not want to see a student.
  c) Have the student take vital signs on all patients so as to be useful to the practice.
  d) Tell the student he or she must be more aggressive and talkative in order to learn.

  ANSWER: A

Learning goal 2: Patient Care

2.1 Conduct patient interviews.

a. Student must independently conduct an organized comprehensive history including thorough psychiatric and narrative history.

b. Student is to demonstrate ability to use open ended and specific questions in appropriate context to engage patients.

Learning goal 2: Patient care

2.2 Diagnose psychiatric disorders.

a. Prioritize a differential diagnosis.

b. Discuss relevance of biopsychosocial formulation in developing treatment plans.

2.3 Propose evidence based therapy.

a. Indications, contraindications, potential adverse reactions, outcomes for a given intervention with attention to cost and quality.

b. Provide patient education re: prevention, diagnosis, treatment plan, and health promotion including ability to obtain informed consent.

c. Student must demonstrate ability to perform capacity evaluation.

Sample Slides from Introduction to Psychiatric Interviewing Lecture: Applying the DSM 5 in an Interview Setting…

- Be familiar enough with the BIG PICTURE diagnoses to be able to follow the patient's cues as to what is going on i.e., anxiety, depression, substance abuse, psychosis.
- Don't be ashamed to get out your pocket DSM 5/app and read the criteria in language the patient can understand. I still do this sometimes! No shame in my game. I can't remember all the details of every diagnosis, why would I? I have a little book/app to do that…
- Art vs. Science…not everyone fits in the box…

4 Phases of the Psychiatric Interview

- 1. “Hello” Phase
- 2. “How Are You?” Phase
- 3. “I Am Fine” Phase
- 4. “Goodbye” Phase

Just like an ordinary conversation…

“Hello” Phase

- First 30 seconds to one minute.
- Introduce yourself and learn patient’s name – even if you already know it from seeing chart – this is normal ebb and flow of meeting someone for first time.
- Explain nature of interview.
- Goal 1: To communicate you are:
    - Caring
    - Calm
    - Competent

Hello continued…

- Goal 2: Establish rapport

  Rapport is empathy and understanding conveyed by a clinician prompting mutual trust and respect. Be nice, be human, show concern/respect.

Goal 3: Observation begins - from beginning!

Observe from first time you see the patient until the minute they leave your sight for nonverbal behavior and physical state. Note items for mental status exam.

Review Question

- A third year medical student enters a room in which the patient is already seated with back to the door. The student decides to sit on the other side of the patient facing the door with the patient between the student doctor and the exit. Which teaching point needs to be reiterated based on this scenario?
  a. Avoid initiating handshake unless patient offers first. (Touch is powerful...)
  b. Maintain eye contact if tolerated.
  c. Maintain unencumbered equidistant (or shorter for you) path to the nearest exit in case patient becomes agitated.
  d. Stay at level of patient – he sits, you sit. He stands, you stand

ANSWER: C

Tips for Hello phase

- Maintain eye contact if tolerated.
- Avoid initiating hand shake unless patient offers first. (Touch is powerful...)
- Stay at level of patient – he sits, you sit. He stands, you stand.
- Maintain unencumbered equidistant (or shorter for you) path to the nearest exit in case patient becomes agitated.

“How Are You?” phase

- 1-8 minutes of letting the patient tell you their own story in their own words with little interruption or redirection…
- Start with demographics if not readily available (age, race (don’t assume), occupation, education, marital status, +/- parent?)
- Example: “Now I’d like to begin by asking you some background information. How old are you?...”

How are you? Cont…

- Move on to “CHIEF COMPLAINT” (CC)
- “I see you are here as an <in/out> patient receiving treatment. Can you tell me a little about the issues you are getting help with?”
- Note: Record the 1st one to two sentences in the patient’s own words as the CC. It doesn’t matter what it is, the CC is always in the patient’s words and is never right or wrong.
- Once CC obtained, if patient stops, simply ask them to “Tell me more about <issue>.”Stay with OPEN ENDED questions for this phase.

How are you? Cont…

- Goal 1: Exploration and getting the big picture in the patient's own words of what is going on.
- Goal 2: Attend to what major areas of pathology you may want to follow up on (ex: pt states CC is "depression", so you will ask in next phase about anxiety and substance abuse – often go together
- Goal 3: Track time course of illness/episodes, precipitants, nonverbal and verbal cues, connections and transitions among topics, physical appearance, speech, motor activity

Phase 3: “I Am Fine”

- “I” as in “I am now ready to collect specific information”…
  - History of Present Illness (your ?s)
  - Past Psychiatric History
  - Medical History (include Developmental)
  - Family Psychiatric and Pertinent Medical Hx
  - Social History
  - Formal Cognitive Assessment

History of Present Illness

- Focus on present episode or exacerbation of illness
- Determine where to separate current from past history ("placing the wedge")
- Assess present symptoms, treatment *and response to treatment* as part of HPI
- Always assess NOW – especially safety.
  - "Today, do you have any thoughts of hurting yourself or others? Today is there anyone in your care who is at risk? Or are you at risk of being hurt by anyone at home or in any situation?"

Past Psychiatric History

- Age of onset of initial episode of illness ?
- Prodromal symptoms?
  Premorbid fxn?
- Course of Illness (frequency, severity, interepisode recovery)
- Temporal relationship to triggers
- History of inpatient hospitalizations **and why?***
- History of outpatient treatment, type, and whether or not felt to be beneficial *
- History of medications tried and failed*
- History of suicide attempts or harm towards others WITH precipitants/ triggers*
- History of extreme treatment (ECT, Clozaril)

Review Question

- A medical student sees a young Latina female and her two small children in the emergency department for the children's fever and cough. The mother is noted to have significant facial bruising which she ascribes to a fall. A psychiatric consult is ordered by the ER physician. The medical student collects history and presents to the precepting attending, "The patient denies suicidal and homicidal ideation therefore she is safe to discharge." Which of the following risks will the preceptor focus on with regards to safety assessment?
  a. Assault risk
  b. Inability to care for basic needs
  c. Medical risk
  d. Risk of abuse of the patient
  e. Risk to dependents of abuse
  f. Self-injury

  ANSWER: D

Safety – a MAJOR concern in psychiatry

- ALWAYS assess safety in every patient in every setting (past history + **present** and **future** risk)
- 6 Types of Risk:
  - Suicide or self injury
  - Homicide or assault risk
  - Inability to care for basic needs risk
  - Medical risk
  - Risk TO dependents of abuse or neglect by patient
  - Risk OF abuse or neglect of the patient by others

Review Question

- Which of the following is frequently excluded from the medical history collected by medical students?
  a. Hepatitis status
  b. HIV status
  c. Kidney or thyroid disease related to lithium
  d. Obesity related illnesses
  e. Sexually transmitted disease history

  ANSWER: E

Medical History

- All general medical conditions
- Listed in non-axial system of diagnoses after major mental illnesses including personality and cognitive pathology
- Don’t forget:
  - STDs (professional interview – must ask)
  - HIV/Hepatitis B/C status
  - Illnesses related to medications
    - Kidney/Thyroid disease on Lithium
    - Hyperglycemia/Diabetes/Dyslipidemia on Atypical Antipsychotics
    - OBESITY…

Social/Family History

Social History

- School, Work
- Housing (adequacy)
- Family finances/ source of income
- Relationships (family, peers, SO*, support, caretaking responsibilities)
- Legal History
- Military History
- (Cultural sensitivity expected at all times…)

Family History

- History or psychiatric illness in blood relatives (preferably 1st and 2nd degree)
- History of substance abuse
- History of medical illness in blood relatives
- History of completed SUICIDE among family members

Developmental History if 21 or younger…

- Pregnancy and delivery
- Infancy and early childhood
- Developmental Milestones
- Traumatic childhood experiences
  - Social
  - School performance and learning problems
  - Ask about special ed classes

- Milestones include:
  - Motor
  - Cognitive
  - Speech/Language
  - Social
  - School performance and learning problems
  - Ask about special ed classes

Goodbye Phase

- Watch your time…ideally you want to get your diagnostic interview in about 30-60 minutes. Otherwise, both you and patient tire.
- Graciously thank the patient for participating.
- Watch the patient exit the room (pain on rising from chair? Gait? Body habitus?)
- Convey confidence and hope.

Tips...

- Establish rapport early.
- Write down chief complaint in pt's words.
- Develop provisional differential dx based on CC.
- Let patient talk freely enough that you can determine thought process.
- Use mixture of open and closed ended questions.
- Don't be afraid to ask difficult or embarrassing questions. This is a professional interview.
- **Always** assess for *current* SI/HI/Safety risk.
- If you are okay with answering, give patient opportunity to ask you questions at end of interview.

How can I ensure students have opportunity to interview patients?

Tips for integrating medical student into psychiatric outpatient practice

- Allow the student to observe first few days.
- Review upcoming schedule and identify some follow up patient(s) who would be willing to arrive 30-60 minutes early for their appointment with you.
- Allow medical student to see that patient while you see other follow ups. You see patient at their appointed time.
- Student can interview, prioritize differential diagnoses and propose evidence based medication and psychotherapy.

Tips for integrating medical student into psychiatric outpatient practice

- If you have time to allow student to present their H and P you may do so, but if not allow them to present during lunch, at end of day, or during a DNKA, or at an appointed time on another day.
- You know the patient already so you can pick up on correct information and flesh out areas that are weak in the student's presentation.
- This method does not slow you down and so long as the patient is willing to help in the student's learning process and does not mind coming to clinic early, it is a great way to allow the student to practice interview skills and develop facility with differential diagnostic skills and evidence based treatment strategies.

Review Question

- On a busy day on the inpatient service, several newly admitted patients are waiting to be seen. The attending psychiatrist must attend hospital administration meetings for most of the day. Which of the following would be the best learning experience for the OMS III student assigned to the inpatient unit?
  a. Follow up on consults seen earlier in the week who are still hospitalized
  b. Pre-interview new admissions and collect information for admission paperwork
  c. Read assigned journal articles to present salient points over lunch the next day
  d. Sit in on, lead or assist those leading inpatient groups

  ANSWER: B

Tips for integrating medical student into an inpatient psychiatric rotation

- Much more flexibility here since you have a group of full time patient cases for the students to access
- Students can pre-interview new admissions or co-interview with you or other team members observing or assisting.
- Students can collect the paperwork that is normally collected by the unit social worker, psychologist, etc.
- Students may sit in on, lead or assist those leading groups.
- Students can gather all the necessary information for consults on the floor and present to you prior to your going to see the patient

What are the advantages of having a medical student in my practice?

- Skill set/ knowledge level is sharpened from teaching
- Reduction in feeling isolated from academia/peers
- Student happily does research and article review in order to present salient points – especially when you, the busy clinician, don't have time to review all the journals
- CME credit given for teaching (AOA/AMA) http://dcomcme.lmunet.edu/cme-precepting-credit-request
- Access to all the medical databases, e-journals and e-books LMU DCOM provides (see CME offering – "Quick Reference Guide to Databases and Medical Library Services" http://library.lmunet.edu/medlib)
- Stipend paid to organization or private practice
- Connection to the next generation of physicians

Objectives Accomplished?

- Reviewed Learning Goals 1 and 2
- Better understand didactic foundation of OMS II Behavioral Medicine and Essentials of Patient Care courses at LMU DCOM
- Identified ways to build upon the OMS III student's didactic foundation using appropriate clinical experience/exposure to meet Learning Goals 1 and 2

Please contact me with any questions.

Please email if you would like a copy of today's slides.

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Dates to remember:

November 10 , 2017: Quarterly Zoom Meeting Preceptor Roundtable discussion from NOON EST to 1PM.

October 27: Session 2 for Preceptor Teaching Certificate will be available.