Teaching Competencies for Community Preceptors

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BACKGROUND AND OBJECTIVES: Although community physicians provide one-fourth of the outpatient training received in medical school, usually there is no formal training of the preceptor. Currently there is no agreed-upon list of teaching competencies for community physician-preceptors. Using a modified Delphi process, the authors aimed to identify core teaching competencies for community preceptors for use in training and evaluation.

METHODS: A medical educator and three faculty members with expertise in faculty development created a list of teaching competencies organized in five domains. These competencies were finalized through a multiround modified Delphi technique with key stakeholder groups including (1) nonphysician medical educators, (2) academic physicians involved in faculty development, (3) community physicians who regularly precept medical students, (4) family medicine residents, (5) third-year medical students in a 9-month-long longitudinal clerkship. Proposed competencies were retained if 70% of the participants ranked it as “very or extremely important.”

RESULTS: In the first round, 24 competencies were evaluated by 40 physician preceptors participating in a rural faculty development conference. These were refined, and four additional competencies were added by the cohort. Subsequent rounds utilized a survey approach with broader audiences resulting in a final list of 21 competencies in five domains.

CONCLUSIONS: Five competency domains with 21 teaching competencies can now be used to guide community preceptors’ training and evaluation.

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The majority of medical students receive some of their training in community settings.1–4 Most American medical schools rely on practicing physicians in the community (hereafter referred to as community preceptors) to teach their students, particularly in the first and second year of medical school and for primary care clerkships.1,7,8 Most of these preceptors, while trained and experienced physicians, have no formal training in education,8–10 and preceptors, the trainees’ sponsoring organizations, and accreditation standards emphasize faculty development as one of their greatest needs.8,11,12 Much work has already been done to identify the needs of community preceptors,4,12,13 to provide formal training for preceptors,4,9,14 to help integrate students into busy clinical practices,15 and to assess the instructional quality of a clinical site,16,17 but as yet there is no consensus on the key criteria for identifying, training, or evaluating community preceptors. While there are established skills and behaviors (ie, milestones, competencies, observable behaviors, entrustable professional activities, etc) for medical students,18,19 residents,20 and for academic faculty21,22 there are currently no agreed-upon skills, attitudes, and behaviors for the diverse cadre of physician preceptors who teach students and residents.

Clearly defined preceptor competencies are needed to provide the foundation for preceptor development and evaluation activities. We sought to identify core community preceptor competencies to support preceptor needs assessment, development, and evaluation.21

Methods
The Delphi technique is a common method of semiquantitative research in the social sciences and in health-related education.23 Typically, a small group of experts first defines a list
Lindemann suggests that when no previous standard or more of the panelists were identified. To obtain consensus from domains and 24 competencies were relevant literature. Five competency Srinivasan’s work and from other student preceptor competencies from development extracted relevant medical for a total of 28 competencies. The annual meeting helps train physicians to be better educators and is attended by both full-time academic faculty from Wisconsin’s medical schools and residencies as well as rural community physicians who routinely precept medical students. The 40 attendees were divided into five groups which evaluated one of the five competency domains. They were asked to further develop the competencies assigned to each of the competency domains. The participants suggested four additional competencies to add to the original list of 24, for a total of 28 competencies.

**Phase 1, Round 2:** The 28 competencies were then emailed to the WCRGME workshop participants to complete a modified Delphi technique. Thirty-seven of the original 40 participants responded (93%). Using a 5-point Likert scale format (‘no importance’ to ‘extremely important’) participants ranked the competencies and added comments. Items that were rated as ‘very important’ or ‘extremely important’ by 70% or more of the panelists were retained, for a total of 26. The product of this session was also edited for clarity and redundancy based on feedback from the participants.

**Phase 2, Round 1:** We wanted to obtain consensus on the appropriateness and usefulness of these competencies from a larger number of stakeholders, therefore in phase 2 we invited a total of 383 people to review and rate the importance of the 26 competencies. These people represent a convenience sample drawn from five groups. Group one was a list of community physicians who regularly precept medical students for the family medicine clerkship at the University of Minnesota, the University of Wisconsin, or the Medical College of Wisconsin. Group two was a list of family medicine residents in one of five University of Minnesota affiliated programs. Group three was a list of third-year medical students in a 9-month-long longitudinal clerkship at the University of Minnesota. Group four was a list of academic physicians involved in faculty development at the University of Minnesota. Group five was a list of nonphysician medical educators at the University of Wisconsin school or the Medical College of Wisconsin. Participants received an

**Figure 1: Modified Delphi Process for Developing the Community Preceptor Teaching Competencies**

![Diagram of the Modified Delphi Process](image)
email with a weblink via Qualtrics and were asked to complete the survey within a week, with a follow-up email to nonresponders after 7 days. Anonymity was maintained throughout the study, so participants were unaware of the other panel members’ identities and all responses were given equal voting power. Of the 343 students, residents, educators, and physicians who received an email invitation to participate in our study, 106 people responded and completed the survey (31%).

As in prior rounds, respondents rated each of the 26 competencies using a 5-item Likert scale format (“no importance” to “extremely important”). Again, any item receiving an importance rating of less than or equal to “moderately important” by more than 30% of the respondents was eliminated, resulting in 21 competencies being retained.

**Phase 2, External Validation:**
To obtain external validation from an outside audience we presented this second iteration of our competencies during an interactive seminar presentation at the 2017 Society of Teachers of Family Medicine (STFM) Medial Student Education (MSE) meeting. This was attended by 33 people who identified as either full-time academic faculty, community preceptors, or clerkship coordinators. During the small group breakout session the attendees volunteered to review the competencies with special attention to utility and applicability given their perspectives as family medicine educators. Feedback was used to further enhance clarity of the competencies.

The final consensus reached through our modified Delphi technique application is a list of 21 competencies. These encompass the key teaching concepts of commitment to the learner’s success, communication, role modeling, feedback, and use of evidence-based medicine (Table 1).

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<th>Domain</th>
<th>Goal</th>
<th>Competencies</th>
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| Learner centeredness      | Demonstrate a commitment to the learners’ success and well-being leading to the learners’ growth in to their professional roles. | 1. Prepare the clinical environment, including staff, patients, and other colleagues, for the learner.  
2. Orient the learner to the community, to local resources, and to the clinical environment.  
3. Ascertain each learner’s knowledge, skills and attitudes related to rotation expectations and link to your patient’s/clinic population.  
4. Assess and respond to the learner’s cultural context.  
5. Help learners develop learning goals aligned with patients’ needs. |
| Interpersonal and communication skills | Teach and communicate effectively.                                     | 1. Clearly communicate expectations to the learner.  
2. Tailor precepting style to the needs of the learner.  
3. Identify barriers to learning (eg, housing, geography, psychological, economic, family, etc).  
4. Maintain a safe learning environment for the student (ie, approachable, supportive, encouraging, student can admit limitations). |
| Professionalism and role modeling | Demonstrate best educational and evidence-based practices and role model those behaviors for learners. | 1. Display enthusiasm for teaching.  
2. Respectfully respond to each learner’s unique needs and learning goals related to patient care.  
3. Be available and accessible to learners.  
4. Acknowledge when beliefs/attitudes are influencing the teaching/learning environment.  
5. Model highest standards of the profession. |
| Practice-based reflection and improvement | Role model continuous self-assessment and lifelong learning. | 1. Model the appropriate use of evidence-based medicine in clinical practice.  
2. Seek feedback from the learner and rotation director; identify and act on improvement goals.  
3. Engage in continuous learning as physician and teacher with targeted teaching goals. |
| Learner assessment         | Provide appropriate feedback.                                         | 1. Solicit student self-assessment.  
2. Provide timely formative and actionable feedback to the learner regarding their progress (eg, learning goals; rotation competencies; knowledge, skills, and attitudes).  
3. Check that formative feedback was heard and understood and that the learner initiated a feasible action plan.  
4. Provide summative feedback to the learner and the medical institution. |
Discussion
Designing an educational intervention begins with a needs assessment informed by the expected competencies and observable behaviors needed by a person to perform a task—in this case community preceptors of medical students. Using this modified Delphi process, we have identified five community preceptor competency domains and 21 associated competencies for use in preceptor needs assessment, development, and evaluation activities.

Getting consensus on an issue is not easy. Commonly used consensus methods include brainstorming, nominal group technique, consensus development conferences and the Delphi technique.27,28 We chose to utilize a modified Delphi technique as a rigorous, semiquantitative method to arrive at a consensus on this important question. While the Delphi process can lead to a “lowest common denominator”29 result rather than a robust product, the breadth of audiences, stakeholders, and rounds in our process supports the validity of our findings.

Still, this list of competencies is not without its limitations. While the resulting product is meant to be broadly applicable to community preceptors of medical students in the various disciplines that make up medicine, the final list of five competency domains and 21 associated competencies may be skewed to the needs of family medicine preceptors as data was obtained through stakeholder audiences predominantly associated with family medicine. Also, all of our participants who completed the two phases of the modified Delphi process were associated with one of three medical schools in Minnesota and Wisconsin. We endeavored to find broader consensus beyond our own medical schools by getting external validation from physicians and clerkship coordinators attending a national meeting on medical student education (the 2017 STFM MSE meeting in Anaheim, CA). Still, broader sampling in other parts of the country and in other primary care and medical specialties would need to occur for greater generalizability. Finally, while developing teaching competencies was the focus of this effort, the teaching competency of the community preceptor is not the only factor that affects students’ experiences. Medical scope of practice,30 patient population (eg, underserved, immigrant, etc),31 degree of patient autonomy,32 and length of the clerkship33 are also important variables that affect a student’s perception of the clerkship and influence a student’s interest in the specialty. These issues also need to be considered and addressed as we seek to give medical students the best possible training during their clerkships.

Conclusion
Education depends on having clearly defined target performance expectations. Well defined lists of competencies exist for various medical educators.21,22 Building on this work using a modified Delphi process, we have developed a list of five competency domains and 21 associated competencies to assess preceptor needs, support preceptor development, and evaluate progress toward teaching excellence.

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References


