

EDITORIAL

Impact of medical students on rural preceptors - it's time for better evidence

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Previous studies on the impacts of preceptorships on the preceptor have indicated a great burden on the preceptor. Despite this burden, preceptors continue to accept students. As a practical matter this does not make sense. Why would overburdened physicians volunteer for more duties. The Financial Impacts article breaks new ground to enable us to explore the positive aspects of preceptorships in financial and other categories¹.

The financial area is obviously of critical interest to not only preceptors, but also those who increasingly employ preceptors. Jack Verby, creator and director of Minnesota's Rural Physician Associate Program (RPAP) for 20 years, noted the positive financial impacts of long term preceptorships in his presentations to rural faculty at the Rural Minifellowship Program at East Tennessee State University. He stated that having a third year medical student in a rural practice for 12 months was worth an additional \$40,000 to \$70,000 in billings when compared to

years when the site had no RPAP student. (Rural Minifellowship Proceedings, East Tennessee State Department of Family Medicine, 1990)

The article hints at even greater financial impacts to explore such as improved practitioner efficiency and retention of market share in rural health systems. The ultimate savings may be in practices where long term students come back to practice. Again the RPAP program is an example of this. Some 60 RPAP students (out of over 800 graduates) have located practices in Minnesota towns where they did their RPAP preceptorship. These graduates come into town prepared to work. They have been in a community, they need little orientation, and they have been able to design their training to fit the needs of that community.

The potential impact to small practice settings is enormous. There is evidence that students participating in coordinated programs with rural selections and training tend to stay in



practice locations longer². Why train four physicians to practice for 5 years each in an underserved area when you can train 1 that would stay in practice 20 years or more, know the patients and community, and help retain community market share that is reduced by a constant turnover of practitioners?

On a more cautious note, there are dangers inherent in preceptorships, particularly those where there is little supervision of rural faculty. Preceptors are busy and patient demands are high. There is a tendency for students to do perhaps more than they are able to do. Some students are more capable and others are not. Also some students are able to realize their limitations and others are not able. Although rural preceptors in long term preceptorships are in a better position to evaluate students because of the length of exposure, there is the potential for mistakes to be made in patient care and in billing. Billing for a patient should only be done when the physician actually cares for the patient. Obviously patient care quality is a concern, but physicians can face governmental audits and fraud charges. If news of a preceptor audit spread widely, this could reduce or eliminate preceptorships in many areas.

The article also points out other positive impacts of preceptorships to explore. These include the potential for improved quality of care, physician education, and improved practitioner efficiency. During a visit to Minnesota, I had a chance to interview rural physicians and nurses and clinic personnel at RPAP sites. The comments of the nurses were revealing. They worked closely with the students to help them with phone calls, screening patients, and paperwork. These efforts could improve the efficiency of the practitioner and result in more and better patient care.

We need to take a more global approach when evaluating rural medical education studies. Health care is complex and short term thinking can actually cost more in the long run. There is no reason to doubt that rural medical education would be just as complex. While it is easier to measure markers such as preceptor time over a few months, it is harder with more students over a longer period of time. It is

even more difficult to do more detailed multi-method studies combining qualitative and quantitative approaches. A global approach may help us understand why practitioners continue to accept students, despite studies showing the extra burden. This approach is more expensive, but will yield more generalisable answers and suggest more relevant questions to explore. By continuing with simplistic, sitespecific studies, we may inadvertently be doing more harm than good.

Much is at stake in rural health. We need better information. We do not have the luxury of resources to waste in rural medical education. More importantly, we cannot afford to risk harm to rural patients and fragile rural health systems.

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References

1. Rabinowitz HK. Recruitment, Retention, and Follow-up of Graduates of a Program to Increase the Number of Family Physicians in Rural and Underserved Areas. *New England Journal of Medicine* 1993; **328**: 934-939.
2. Worley P, Kitto P. A hypothetical model of the financial impact of student attachments on rural general practices. *Journal of Rural and Remote Health* 1 (on-line), 2001. Available from: <http://rrh.deakin.edu.au> (accessed 7 March 2001).