Journal of Contemporary Medical Education
www.scopemed.org
DOI: 10.5455/jcme.20170612092633

Original Research

An assessment of reward and faculty development opportunities provided to pediatric community faculty

Jerold M. Stirling

Department of Pediatrics, Stritch School of Medicine, Loyola University Medical Center, USA

Address for correspondence: Jerold M. Stirling, Stritch School of Medicine, Loyola University Medical Center, USA. E-mail: jstirli@lumc.edu

Received: January 26, 2017
Accepted: April 26, 2017
Published: June 20, 2017

ABSTRACT

Objective: Many medical schools in the US are experiencing difficulty maintaining sufficient ambulatory pediatric training sites for their students. The goals of this study were to assess the incentives, reward, and faculty development (FD) opportunities provided for pediatricians serving as community faculty (CF) teaching in pediatric clerkships in the US. **Materials and Methods:** A 10-question prospective survey of the membership of the Council on Medical Student Education in Pediatrics incorporated into the organization's 2014 annual survey. **Results:** Representatives from 92% (111/121) of U.S. medical schools responded to the study. 79% of medical schools utilize CF to teach pediatrics. 82% of respondents were having difficulty recruiting and retaining pediatricians to teach students. 39% of medical schools provided monetary stipends for teaching. 68% of schools provided FD for their CF. **Conclusion:** The majority of schools rely on non-monetary incentives to recruit and retain their CF. As compared to previous studies, more medical schools are offering financial stipends. Most schools, but not all, offer some form of FD training for their CF. There is a wide variation in the scope of FD training provided to community physicians that teach medical students.

KEY WORDS: Education medical, education medical undergraduate, pediatrics, physician's role, preceptorship

INTRODUCTION

Over the past few decades, as medical care has migrated from the inpatient to the ambulatory setting, the education of medical students has followed. A substantial proportion of outpatient teaching now occurs in the offices of primary care physicians. This follows a long-established tradition of physicians volunteering to teach medical students in their offices [1].

Community-based training offers numerous benefits for both the learner and the clinical preceptor. Medical education experts emphasize that working in the community enables students to learn from a larger and more diverse patient population than they might experience rotating through a campus-based office. This educational experience provides the students with the opportunity to learn specifically about the relationships between pediatricians and the communities in which they practice [2,3].

Pediatricians that serve as community faculty (CF) also benefit and are motivated to teach students in their offices for a myriad of reasons. For example, these practitioners are giving back to the medical profession, while serving as role models and enjoying the intellectual stimulation of having learners in their offices [4].

Unfortunately, several recent studies show that many medical schools are now struggling to recruit and retain CF [5,6]. This is particularly disconcerting, as few medical schools employ sufficient faculty to address all clinical teaching needs [7]. Numerous forces have collided to create this shortage.

Pediatricians, like all primary care physicians, have been faced with increased patient workloads and additional administrative requirements. Many have implemented electronic health records, which although an excellent patient care tool, add additional time to their day. Studies have also shown that teaching medical students significantly slows down patient throughput. Those dedicated CF who chooses to teach students often adapt by seeing fewer patients, thereby sacrificing clinical revenue, or work additional hours needed to maintain their income [8]. These factors are a significant strain for community physicians and prevent practitioners from accommodating students [9].

There is also competition from other professional training programs seeking to place their students in the primary care offices. Teaching programs for advanced practice nurses, nurse practitioners, physician assistants, as well as foreign medical schools, are all vying for teaching sites [5,8]. In metropolitan areas such as Chicago and New York City, entrepreneurs are serving as brokers recruiting primary physicians and offering generous financial stipends for placement of foreign medical students [9]. It is likely that the shortage of CF will increase with the opening of new medical schools and the expansion in class size of existing schools.

The majority of studies of CF have been limited in scope and focused primarily on the benefits that they value for teaching [4,7,10]. Our study, however, was designed to better understanding this valuable group of educators by (1) defining the current status of the CF shortage, (2) determining what incentives medical schools offer to recruit and retain CF, and (3) determining the scope of faculty development (FD) provided by medical schools to CF.

MATERIALS AND METHODS

Survey Development

This was a prospective survey of pediatric clerkship directors, their assistant directors, and other academic pediatricians and staff involved in medical student education. To meet the goals of this study, the author collaborated with the Council on Medical Student Education in Pediatrics (COMSEP) to identify three specific constructs that guided the development of items for this survey: (1) The use of CF during students' third year clerkship, (2) the offering of incentives to recruit and retain CF, and (3) the availability of FD training for CF members.

Additional question was included to capture relevant demographic information for all respondents and their institutions. Survey questions focused on FD were developed from review of educational materials provided for CF [11-13]. The study was designed in conjunction with University of Illinois Survey Research Laboratory. Importantly, the study design and all research materials were reviewed by the Loyola University Health System Institutional Review Board.

Recruitment and Data Management

COMSEP surveys their membership annually on topics related to pediatric medical education, and the survey for this study was appended as one of six topics in their 2014 annual survey. With COMSEP's approval, an email invitation was sent to individuals registered as members and reminder emails were sent to non-responders at 3-week intervals for a maximum of 60 days. Survey responses were de-identified using a unique ID system.

Statistical Analyses

To minimize the influence of multiple responses from the same institution, an *a-priori* decision was made to include only one response per institution. When multiple responses from the same institution were detected, a hierarchical decision was made to retain only one record. That is, survey responses from clerkship directors were retained first, followed by those submitted by assistant clerkship directors, chairpersons, assistant or associate deans, teaching faculty, or clerkship coordinators.

The data were initially screened for missing and incomplete responses. Subsequently, respondent demographics were tabled as valid counts and proportions, and a Wilcoxon rank-sum test was used to compare urban institutions against non-urban institutions on the number of students receiving ambulatory training by CF, the number of CF who receive monetary support for training medical students, and the amount of monetary support provided to CF (if any). For the purposes of this analysis, urban was defined as an institution in a city with at least 500,000 residents. Wilcoxon rank sum tests were also used to make similar comparisons between institutions with >75 students versus those with 75 or fewer students. Kruskal–Wallis tests were used to compare responses among institutions located in the Midwest, Northeast, South, and West. When significant overall variability was detected in these models, all possible pairwise comparisons among the four regions were compared as a *post-hoc* analysis. These *post-hoc* tests applied a conservative Bonferroni correction to control the Type I error rate. Finally, a binary logistic regression model was used to determine the odds being unable to recruit and retain community preceptors as a function of providing monetary and non-monetary support. All analyses were completed using SAS version 9.4 (Cary, NC).

RESULTS

Survey Response

Email invitations and surveys were sent to 423 COMSEP members with 179 members answering at least one survey question (a 42% response rate). Among the responses, 63 records were censored as duplicates, and five records representing non-US medical schools were excluded from the study. Accordingly, the total number of responses available for this analysis was 111 surveys which represented 92% (111) of U.S. medical schools.

Demographics and FD

As anticipated, clerkship directors represented the largest proportion of survey respondents, followed by assistant or associate clerkship directors and clerkship coordinators. Schools from all geographic regions of the United States were represented in the response set, with approximately 40% of responses originating from the South, 28% from the Northeast, 21% from the Midwest, and only 11% from the West [Table 1]. Regarding class size, the vast majority of respondents (85%) said their program had more than 75 students [Table 1], while 73% of respondents indicated that they rely on CF for their training program [Table 1].

Overall, there were no significant differences in the number of students who receive training from CF between: Urban versus non-urban schools [$P \sim 0.56$, Table 2]; institutions with large versus small class sizes [$P \sim 0.15$, Table 3], or among schools located in different geographical regions [$P \sim 0.08$, Table 4].

A significant number of respondents (43%) indicated that they provided FD opportunities to CF. Representation of those topics included in these respective FD programs is offered [Figure 1].

Training and Monetary Support

Approximately, 82% of respondents ($n \sim 92$) indicated that they had difficulty recruiting and retaining community preceptors

Table 1: Characteristics of survey respondents and medical school

Characteristics	*N* (%)
Respondents' educational role*	104 (94)
Clerkship director	76 (73)
Assistant/associate clerkship director	11 (11)
PGY-4 director/assistant director	3 (2.9)
Medical education staff	3 (2.9)
Teaching faculty	2 (1.9)
Clerkship coordinator	7 (6.7)
Another educational role	2 (1.9)
Location of medical school	
Midwest	20 (21)
Northeast	27 (28)
South	39 (40)
West	11 (11)
None	19 (22)
Number of students currently enrolled in PGY-3	89 (80)
75 or fewer	13 (15)
76 or more	76 (85)

N: The number of valid respondents who answered the survey question. *Indicates a check-all-that-apply format was used and, as such, only percentages are reported at the item level. Other educational role comprises one respondent who was both a clerkship director and PGY-4 director as well as another respondent who split his/her time evenly between serving as a clerkship director and associate dean for medical education

Table 2: Training and monetary support for community faculty at urban versus non-urban institutions

	N	Urban (%)	Non-urban (%)	*P*
Proportion of students who receive training by CF	73	37 (51)	36 (49)	
None	15	7 (19)	8 (22)	0.56
5% or less	7	3 (8.1)	4 (11)	
>5-30%	17	9 (24)	8 (22)	
>30-50%	9	4 (11)	5 (14)	
>50-99%	16	9 (24)	7 (19)	
100%	9	5 (14)	4 (11)	
Proportion of CF who receive a monetary stipend	60	33 (55)	27 (45)	
None	47	30 (91)	17 (63)	0.02
>0-25%	4	0	4 (15)	
>25-99%	3	0	3 (11)	
100%	6	3 (9.1)	3 (11)	
Amount provided to CF (per week)	26	12 (46)	14 (54)	
None	20	12 (100)	8 (57)	0.02
$51-100	3	0	3 (21)	
>$100	3	0	3 (21)	
Amount provided to CF (per student)	26	13 (50)	13 (50)	
None	17	11 (85)	6 (46)	0.047
>$0-100.00	2	0	2 (15)	
>$100.00-500.00	4	2 (15)	2 (15)	
>$500.00	3	0	3 (23)	

N: Number of valid respondents who answered the survey question. CF: Community faculty. Urban is defined as an institution in a city with at least 500,000 residents. Significance (*P*) is based on the Wilcoxon rank-sum test

to teach 3rd year students. However, binary logistic regression models revealed no statistically significant association between receipt of monetary or non-monetary benefits and difficulty recruiting and retaining CF.

Despite a comparable number of students who receive training from community-based faculty in urban versus non-urban areas ($P \sim 0.56$), schools in non-urban areas were more likely to offer CF a monetary stipend when compared to schools in urban areas ($P \sim 0.02$). Further, the amount provided to such faculty per week and per student was significantly higher among non-urban schools than urban schools ($P \sim 0.02$ and 0.047, respectively) [Table 3]. No such trends were discovered when comparing responses from institutions with more than 75 students against those with 75 or fewer students [Table 3]. However, northeastern schools provided significantly higher stipends to community-based faculty when compared to Southern institutions (overall $P \sim 0.04$, adjusted *post hoc* $P \sim 0.03$) [Table 4].

DISCUSSION

Recruitment and Retainment of CF

Our study demonstrates that a large percentage of schools use CF in their pediatric clerkship programs [Table 2]. We also found that the percentage of schools struggling to recruit and retain CF had increased between 2013 and 2014 from approximately 50-75%, respectively [5].

Reward and Incentives

Many previous studies have examined the incentives and reward valued by CF. The majority concluded that community preceptors place the highest value on non-monetary rewards. However, several recent studies have found that financial stipends may be growing as important incentive for these community physicians [14-16].

We found that the location of a school may influence the likelihood that it would offer monetary rewards to CF. Schools located in non-urban areas were more likely to provide stipends, and in larger amounts, than schools in urban areas. A simple hypothesis for this finding may be due to supply and demand, with fewer pediatricians available to teach in non-urban areas. Medical schools in the Northeast provided significantly higher stipends to CF when compared to those in the South. It is possible that the greater number and higher concentration of medical schools (and other health-care professional training programs) competing for clinical sites are driving the need to provide stipends to CF in the Northeast.

Providing financial compensation to CF for their time may not be the complete answer to the shortage. Our study found that there did not appear to be a strong relationship between those schools that provided stipends and the ability to recruit and retain CF. It is possible that the financial compensation alone offered to community physicians was not sufficient to incentivize them to teach students in their offices.

Our study attempted to illuminate the range of financial stipends that schools provide to CF. The results that are reported may not be an accurate representation due to a low response

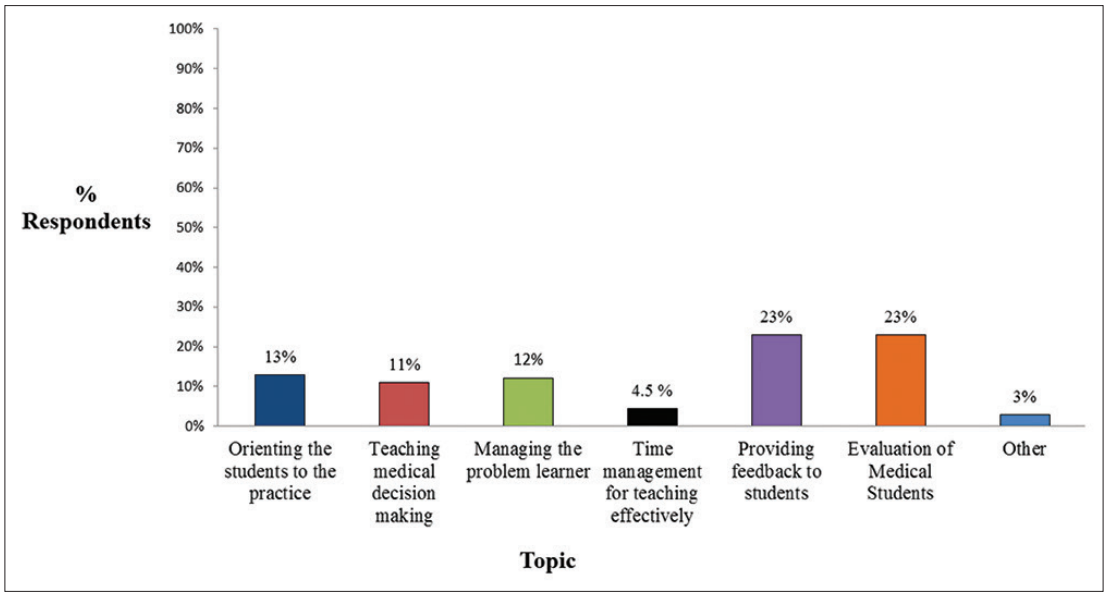

Figure 1: Topics included in faculty development programs (n = 48)

Table 3: Training and monetary support for community faculty by school size

	N	Number of students (%)		*P*
		75 or fewer	76 or more	
Proportion of students who receive training by CF	78	13 (17)	65 (83)	
None	18	5 (39)	13 (20)	0.15
5% or less	8	3 (23)	5 (7.7)	
>5-30%	18	2 (15)	16 (25)	
>30-50%	8	0	8 (12)	
>50-99%	17	0	17 (26)	
100%	9	3 (23)	6 (9.2)	
Proportion of CF who receive a monetary stipend	59	10 (17)	49 (83)	
None	47	7 (70)	40 (82)	0.60
>0-25%	3	2 (20)	1 (2.0)	
>25-99%	3	1 (10)	2 (4.1)	
100%	6	0	6 (12)	
Amount provided to CF (per week)	26	6 (23)	20 (77)	
None	21	4 (67)	17 (85)	0.48
$51-100	3	1 (17)	2 (10)	
>$100	2	1 (17)	1 (5.0)	
Amount provided to CF (per student)	26	4 (15)	22 (85)	
None	17	2 (50)	15 (68)	0.91
>$0-100.00	3	2 (50)	1 (4.5)	
>$100.00-500.00	4	0	4 (18)	
>$500.00	2	0	2 (9.1)	

N: Number of valid respondents who answered the survey question. CF: Community faculty. Significance (*P*) is based on the Wilcoxon rank-sum test

rate to these particular survey questions. It appears that our respondents may have reluctant to disclose this information or were unaware of the amount of stipend provided by their schools.

Monetary stipends may not be an option or necessary for all medical schools to recruit or retain preceptors. There may be other lower cost options such as offering practitioners continuing medical education (CME) for teaching or for attending FD programs. Another incentive that may be low cost and feasible for Pediatric Departments is developing and including CF in educational quality improvement projects to obtain Part 4 maintenance of certification (MOC) credit [17]. Another tactic recently recommended by the task force of the alliance for clinical education is to reframe the relationship between the medical student and the pediatric office by having students assist in office tasks relevant to their education, such as rooming patients or conducting developmental screenings [18]. The students thereby add value to the practice in exchange for the education that is provided.

FD

To be effective clinical educators, physicians that serve as medical school faculty require formal instruction in educational methods and medical student assessment [19]. To understand the scope of FD offered by medical schools, we queried the survey group regarding the content and the amount of training provided to CF. We found that many schools did not offer FD to their CF. Of the schools that provided FD, there was variability in both the extent offered as well as the topics included in the training.

Providing FD is not always an easy task for medical institutions given that in many regions, there are distance/geographical barriers, which make traveling to the school a hardship for CF. However, a variety of models have been used by schools to provide this instruction remotely including in office training sessions or via electronic means such as teleconferencing or online training courses [20-22]. In addition, a number of organizations, including the Council of Medical School Education in Pediatrics (COMSEP), the

Table 4: Training by and monetary support for community faculty by school location

	N	Midwest (%)	Northeast (%)	South (%)	West (%)	*P*
Proportion of students who receive training by CF	74	15 (20)	17 (23)	32 (43)	10 (14)	
None	18	1 (6.7)	2 (12)	12 (38)	3 (30)	0.08
5% or less	8	3 (20)	2 (12)	3 (9.4)	0	
>5-30%	17	1 (6.7)	6 (35)	5 (16)	5 (50)	
>30-50%	8	1 (6.7)	3 (18)	4 (13)	0	
>50-99%	16	5 (33)	4 (24)	5 (16)	2 (20)	
100%	7	4 (27)	0	3 (9.4)	0	
Proportion of CF who receive a monetary stipend	57	14 (25)	16 (28)	21 (37)	6 (11)	
None	46	12 (86)	11 (69)	18 (86)	5 (83)	0.54
>0-25%	3	0	1 (6.3)	1 (4.8)	1 (17)	
>25-99%	3	1 (7.1)	1 (6.3)	1 (4.8)	0	
100%	5	1 (7.1)	3 (19)	1 (4.8)	0	
Amount provided to CF (per week)	26	5 (19)	6 (23)	11 (42)	4 (15)	
None	20	4 (80)	4 (67)	9 (82)	3 (75)	0.88
$51-100	3	1 (20)	1 (17)	1 (9.1)	0	
>$100	3	0	1 (17)	1 (9.1)	1 (25)	
Amount provided to CF (per student)	24	5 (21)	8 (33)	8 (33)	3 (13)	
None	16	3 (60)	3 (38)	8 (100)	2 (67)	0.04
>$0-100.00	2	1 (20)	0	0	1 (33)	
>$100.00-500.00	4	1 (20)	3 (38)	0	0	
>$500.00	2	0	2 (25)	0	0	

N: Number of valid respondents who answered the survey question. CF: Community faculty. Significance (*P*) is based on the Kruskal–Wallis test

Society of Teachers of Family Medicine, medical schools and other groups, have developed online FD materials and lectures [11-13].

Limitations

This study design has several limitations. First, the data gathered was self-reported and may be imprecise or biased as a result of the interpretation of the respondents. In addition, as several of the survey questions were open-ended, the data and results reported were dependent on coding of the responses by our data analysts. Finally, the study may have been limited by under sampling of other administrators who interact with CF, including assistant or associate clerkship directors. However, clerkship directors generally serve as the principal liaison with CF at most US medical schools, and these individuals were well represented in our sample (73%). As such, this survey may be viewed as an initial understanding of how medical schools are recruiting, retaining, and providing FD.

CONCLUSION

The crisis in the availability of ambulatory sites for training continues to deepen. Fortunately, several medical educational organizations including COMSEP, the Association of Medical School Pediatric Department Chairs (AMSPDC), and the Alliance for Clinical Education have all turned their attention to this issue. These organizations are currently developing recommendations to assist medical schools with this problem. A combined AMPSDC and COMSEP task force are following up with an additional CF survey in the upcoming year that will serve to monitor this problem. However, it is likely that medical schools will need to customize or expand the types of incentives they offer to CF based on the needs of community physicians in their regions.

The scope and comprehensiveness of FD training offered by medical schools for CF vary widely among medical schools. FD has the potential of improving not only the quality of teaching but may be utilized as an incentive for CF if linked to CME or MOC credit.

ACKNOWLEDGMENTS

The author acknowledges Sowmya Anand Ph.D. for assistance with survey design and William Adams for assistance with statistical support.

COMSEP Community Faculty Survey

1. With which medical school are you affiliated?_____
2. On average, how many clerkship students are you administratively responsible for each year?
   (a) 1-50
   (b) 51-75
   (c) 76-100
   (d) 101-125
   (e) 126-150
   (f) 151-175
   (g) 176-200
   (h) 201-250
   (i) >250
3. Which one of the following best describes the location of the medical school in which you work?
   (a) In a city with a population of 500,000 or more
   (b) In a city with a population between 50,000 and 500,000
   (c) In a suburban county around a metropolitan area
   (d) In a rural or non-metropolitan area
4. How many students are currently enrolled in the third-year

class at your medical school? _____

5. What percentage of these students receive ambulatory training during the pediatric clerkship by community faculty not employed by your medical school? _____
6. Of the community faculty or clinical sites not employed by your school providing clinical experiences for students rotating in third-year pediatrics at your medical school, what percentage are given a monetary stipend by your medical school for teaching?_____
7. If your medical school provides a monetary stipend, on average, what is the amount given by your medical school to community faculty or clinical sites for the training they provide?
   Per Week _____
   Per Student _____
8. What types of non-monetary benefits, if any, does your medical school offer to community faculty for the training they provide?
   (a) None
   (b) Plaque or certificate acknowledging the service provided by the faculty
   (c) Parking privileges at your medical school location(s)
   (d) Library privileges at your medical school location(s)
   (e) An email account carrying your medical school's domain name
   (f) Discounted access to fitness facilities at your medical school location(s)
   (g) Discounted or free CME
   (h) Gifts during holidays
   (i) Invitations to retreats/conferences
   (j) Other _____
9. Does your program offer any faculty development opportunities to community-based faculty, or does it not offer any faculty development opportunities?
   (a) Offers
   (b) Does not offer
10. How does your program provide faculty development training?
    (a) Faculty development handbooks
    (b) On-site training of preceptors
    (c) Web-based training
    (d) Faculty development retreats
    (e) Other_____
11. What topics are included in your faculty development program for community-based preceptors? (Check as many that apply.)
    (a) Orienting students to the practice
    (b) How to teach students to become effective clinical decision-makers
    (c) How to manage the problem learner
    (d) How preceptors can manage their teaching time effectively
    (e) How to evaluate medical students
    (f) Providing feedback to students
    (g) Other _____
12. As a clerkship director, are you having difficulty recruiting and retaining community preceptors to teach third-year students?
    (a) Yes_____
    (b) No_____

REFERENCES

1. Ludmerer KM. Learning to Heal: The Development of American Medical Education. Baltimore, MD: Oxford University Press; 1996. p. 5.
2. Johnson RL, Charney E, Cheng TL, Kittredge D, Nazarian LF, Chesney RW, *et al.* Final report of the Fope II education of the pediatrician workgroup. Pediatrics 2000;106:178.
3. Scheiner A. Guidelines for medical student education in community-based offices. Pediatrics 1994;93:957.
4. Latessa R, Beaty N, Landis S, Colvin G, Janes C. The satisfaction, motivation, and future of community preceptors: The North Carolina experience. Acad Med 2007;82:698-703.
5. Erikson C, Hamann R, Levitan T, Pankow S, Stanley J, Whatley M. Recruiting and Maintaining U.S. Clinical Training Sites: Joint Report of the Multi-Discipline Clerkship/Clinical Training Site Survey; 2013. Available from: https://www.members.aamc.org/eweb/upload/13-225%20WC%20Report%202%20update.pdf. [Last accessed on 2017 Jan 02].
6. Irby DM. Where have all the preceptors gone? Erosion of the volunteer clinical faculty. West J Med 2001;174:246.
7. Denton GD, Griffin R, Cazabon P, Monks SR, Deichmann R. Recruiting primary care physicians to teach medical students in the ambulatory setting: A model of protected time, allocated money, and faculty development. Acad Med 2015;90:1532-5.
8. Denton GD, Durning SJ, Hemmer PA, Pangaro LN. A time and motions study of the effect of ambulatory medical students on the general internal medicine clinics. Teach Learn Med 2005;17:285-9.
9. Chicago Clerkships. Available from: http://www.chicagoclerkships.com/about.php. [Last accessed on 2016 Nov 01].
10. Vath BE, Schneeweiss R, Scott CS. Volunteer physician faculty and the changing face of medicine. West J Med 2001;174:242-6.
11. Faculty Development, Council on Medical Student Education in Pediatrics Website. Available from: https://www.comsep.org/educationalresources/FacDev.cfm. [Last accessed on 2017 Mar 01].
12. Teaching Physician, Society of Teachers of Family Medicine Website. Available from: https://www.teachingphysician.org. [Last accessed on 2017 Mar 01].
13. Effective Preceptor Series, the Association of Professors of Gynecology and Obstetrics Website. Available from: https://www.apgo.org/online-resources/128.html. [Last accessed on 2017 Mar 01].
14. Baldor R, Brooks W, Warfield M, O'Shea. A survey of primary care physicians perceptions and needs regarding the precepting of medical students in their offices. Med Educ 2001;35:789-95.
15. Ryan M, Vanderbilt A, Lewis T, Madden M. Benefits and barriers among volunteer teaching faculty: Comparison between those who precept and those who do not in the core pediatrics clerkship. Med Educ Online 2013;18:10. Available from: http://www.med-ed-online.net/index.php/meo/article/view/20733 [Last accessed on 2017 Mar 01].
16. Anthony D, Jerpbak CM, Margo KL, Power DV, Slatt LM, Tarn DM. Do we pay our community preceptors? Results from a CERA clerkship directors' survey. Fam Med 2014;46:167-73.
17. Earning ABP MOC Credit for ACGME Program Evaluation and Improvement on the American Board of Pediatrics Web Site. Available from: https://www.abp.org/news/abp-moc-credit-acgme-program-evaluation. [Last accessed 2017 Jan 10].
18. Christner JG, Dallaghan GB, Briscoe G, Casey P, Fincher RM, Manfred LM, *et al.* The community preceptor crisis: Recruiting and retaining community-based faculty to teach medical students-a shared perspective from the alliance for clinical education. Teach Learn Med 2016;28:329-36.
19. Functions and Structure of a Medical School, Liaison Committee on Medical Education: Standards for Accreditation of Medical Education Programs Leading to the M.D. Degree. Standard 4.5. p. 34. Available from: https://www.members.aamc.org//LCME%20Standards%20May%202012.pdf. [Last accessed on 2017 Jan 02].

20. Steinert Y, McLeod M, Boillat M. Faculty development: A "field of dreams". Med Educ 2009;43:42-8.
21. Lanagois J, Thatch S. Bringing faculty development to community-based preceptors. Acad Med 2003;8:150.
22. Bramson R, Vanlandingham A, Heads A, Paulman P, Mygdal W. Reaching and teaching preceptors: Limited success from a multifaceted faculty development program. Innov Fam Med Educ 2007;39:387.

Source of Support: Nil, Conflict of Interest: None declared.