Faculty Profile: DO in clinical department who primarily works with medical students and possibly residents in a clinical setting.

Personal Statement	
Goals	Develop the knowledge base and thinking skills of various levels of medical students and residents with expectations outlined according to their level of training. Recognize weaknesses in knowledge base and design individual programs to remediate deficits. Impress upon students and residents the value of a holistic approach to patient care, and show by example how OMT can be incorporated into a busy schedule. Create an atmosphere of continual learning while promoting patient autonomy and safety.
Preparation:	Remain current regarding standards of care in my specialty; maintain board certification in my area. Attend faculty development seminars/lectures dealing with students and residents as learners.
Reflection/ Improvement:	Collect data from participants and colleagues regarding my effectiveness as clinician and educator, and use information obtained to better my clinical and teaching skills. Use a post-rotation written examination and computer-based presentations to evaluate student and resident learning, with end-of-rotation feedback obtained from participants Review lecture material annually to remain current on standards of care and changing clinical guidelines

Descriptions of Quantity		**Evidence of Quality**—methods and results
Attending Physician (one-on-one and interactive group teaching)		
Y1-Y5 (present)	Patient teaching rounds with residents, fellows, and students: 2 hrs/day for 5 days/week for 2 months/year	Student ratings since Y1: average 6.0 on a 7-point scale. (10-15 ratings per year) (see Table 1 in Appendix A) Resident ratings since Y1: average 6.3 on 7-point scale. (20 ratings per year) (see Table 2 in Appendix A) Department teaching award multiple times (see CV)
	Inpatient subspecialty consultation service with residents, fellows and elective students: 2 half days/week for 4 weeks per month for 3 months/year	
	Outpatient clinic (5 residents) ½ day/week for 7 months/year	
	Outpatient clinic – 1 student per 4 week rotation for 12 months of the year	
Small Group Teaching		
Y3-Y5	Small group facilitator for Ethics course (requires 8 half days)	Positive verbal comments from students on end-of-course evaluation (see summary in Appendix B)
Lecturer		
Y3-Y5	15 one-hr lectures to medical students in single preclinical course/year (average class size=220); because I try to keep my content current, I spend ~ 2-4 hrs prep time / lecture / year	Student ratings consistently about 6.0 on 7-point scale (over 150 ratings/year) (see Table 3 in Appendix A) Observed by course director; received positive, constructive feedback (see Appendix B)
	12 one-hr lectures to residents/year (average group=30)	Invited to do additional resident lectures grand rounds, CME courses due to positive ratings, comments from participants Cited by students as best lecturer (see letter
	3 grand rounds /year (3-4 hrs preparation time / session)	

	6 two-hr lectures for CME/Review courses/year	from course director)
	12 one-hr lectures to medical students in clerkship/year (same 2 lectures given each rotation; requires 4 hr preparation time once a year to freshen content)	See solicited letters from resident, medical student, and CME program director and clerkship director in Appendix C.
Discussion of Breadth		
Contributions reflect involvement in teaching at medical student, resident, fellow, and physician levels in multiple clinical settings and in the lecture hall.		

Personal Statement.

The first preceptor I had as a medical student was an older family physician who was in solo practice in a middle-sized community. Both he and his nurse took time to calm my anxieties and to reassure me that I wasn't expected to know everything by third year, but that I needed to be open-minded to the idea of continuous learning. I vowed then to give back to other physicians-in-training when I became a practicing clinician in order to "pay-it-forward"; to pay homage to those who have taught me my art, and to not limit my precepting to a certain group. They all are rewarding in their own way. I see the excitement and enthusiasm of third-year medical students as they leave the classroom for real patient encounters; I watch students who near graduation with their history-taking and physical exam skills finely tuned; I witness the maturation of residents as they become true healers during the time spent in residency. Each phase has its own anxieties and rewards, and keeps me invigorated as a preceptor.

I am an osteopathic family physician working with three partners in a busy private practice. We train both residents and medical students, and I also lecture at Des Moines University to first and second-year students. It is my personal goal to encourage students to consider primary care as a specialty and to be a positive role model for students that I mentor in the office or that I came contact with through ACOFP. I sit on a panel every year and discuss what it is like to be a physician educator; the fact that students and residents keep you current on practice guidelines by asking questions. I attend both CME conferences to obtain updates and I seek out faculty development opportunities at the medical school and at AACOM to help me become a better teacher – both to my trainees and to my patients. I mentor students and residents in the office, at the hospital, at the nursing home, and during home visits. I have them to my home for dinner at least once during their rotation so they can see the family side of my life – that one can truly "have it all" – a rich family and home life as well as a rewarding career as a family medicine provider.

This way of life has been influenced by what I consider a true foundation of osteopathic medicine – the holistic approach to providing patient care. The desire to show students that a clinician can be more than just a writer of prescriptions is what initially prompted me to take students on rotation. I wanted to demonstrate that, as osteopathic physicians, we touch patients with our hearts as well as with our hands. In my work with hospice patients, I show students by example how to help family members navigate through the trials of a death of a loved one. I teach students that family members won't always remember the details when being initially informed of a cancer diagnosis, but they never forget that you were there for them at the time of their loved one's death. I strongly believe that this empathy, this compassion for the dying and for those left behind, these labors of love for my patients and my profession are what makes me unique and distinctive. I educate my students by lecture, by assigning readings, and by allowing them to experience all facets of my life, thus providing a much wider scope of medical education than can ever be obtained in a classroom.

Although research has not been a strong focus in my career, I encourage students and residents to pursue ideas that are generated during their time with me. One such project involved the use of manipulation to shorten the time off work by nursing assistants employed at the local nursing home. Through the work done and the submission of a potential publication, it has proven to me that I can still experience professional growth and development even after 30 years of practice!

I hold mid-semester and mid-rotation evaluation conferences with each resident and student respectively. I feel my comments are constructive and delivered with honesty and tactfulness. I use feedback to make changes in my own teaching style, and at student request, have put aside one lunch hour a week to allow students to present a case of interest to my partners and staff. It is extremely rewarding to have a first-year student come up to me after lecture and express their interest in family medicine, then to be given the opportunity to mold them and guide them as interns, and even as residents. It reassures me that I may be improving the health of these students' future patients just by teaching and being a positive role model. That is an awesome responsibility but humbling at the same time. This is the priceless reward that refreshes itself with each eager student that joins our clinic family.

Appendices/Documentation

Documentation in appendices to support statements of quantity and quality in the structured summary is not provided for this example (see description of contents of the appendices below). However, you should include such documentation in your mini-portfolio, keeping within the limit of 25 pages (13 pages front and back).

Be sure to make clear reference to the documentation on your summary page by number or name (e.g., "See Appendix A"). If you refer to learner assessments, you should include a **summary** of the forms you received giving you those assessments. The documentation you provide will enable the primary and secondary reviewers to "audit" the quality information you include on your summary page.

Table of Appendices

The following table lists the elements that would have been included in this portfolio had it been from an actual faculty submission for the award.	
Appendix A	☑ Table 1: Average of student ratings of attending with norm group comparisons by course by year ☑ Table 2: Average resident ratings of attending with norm group comparisons by year\ ☑ Summary of verbal comments from end of course evaluations ☑ Table 3: average student ratings of lectures with norm group comparison by year
Appendix B	☑ Report of in-class observation by course director
Appendix C	Solicited Letters from: ☑ resident, ☑ medical student, ☑ CME program director ☑ clerkship director

Curriculum Vitae

A curriculum vitae is not included in this example, but would be if it were an actual portfolio. The CV, in standard Baylor format, allows primary and secondary reviewers to "audit" statements in the structured summary.