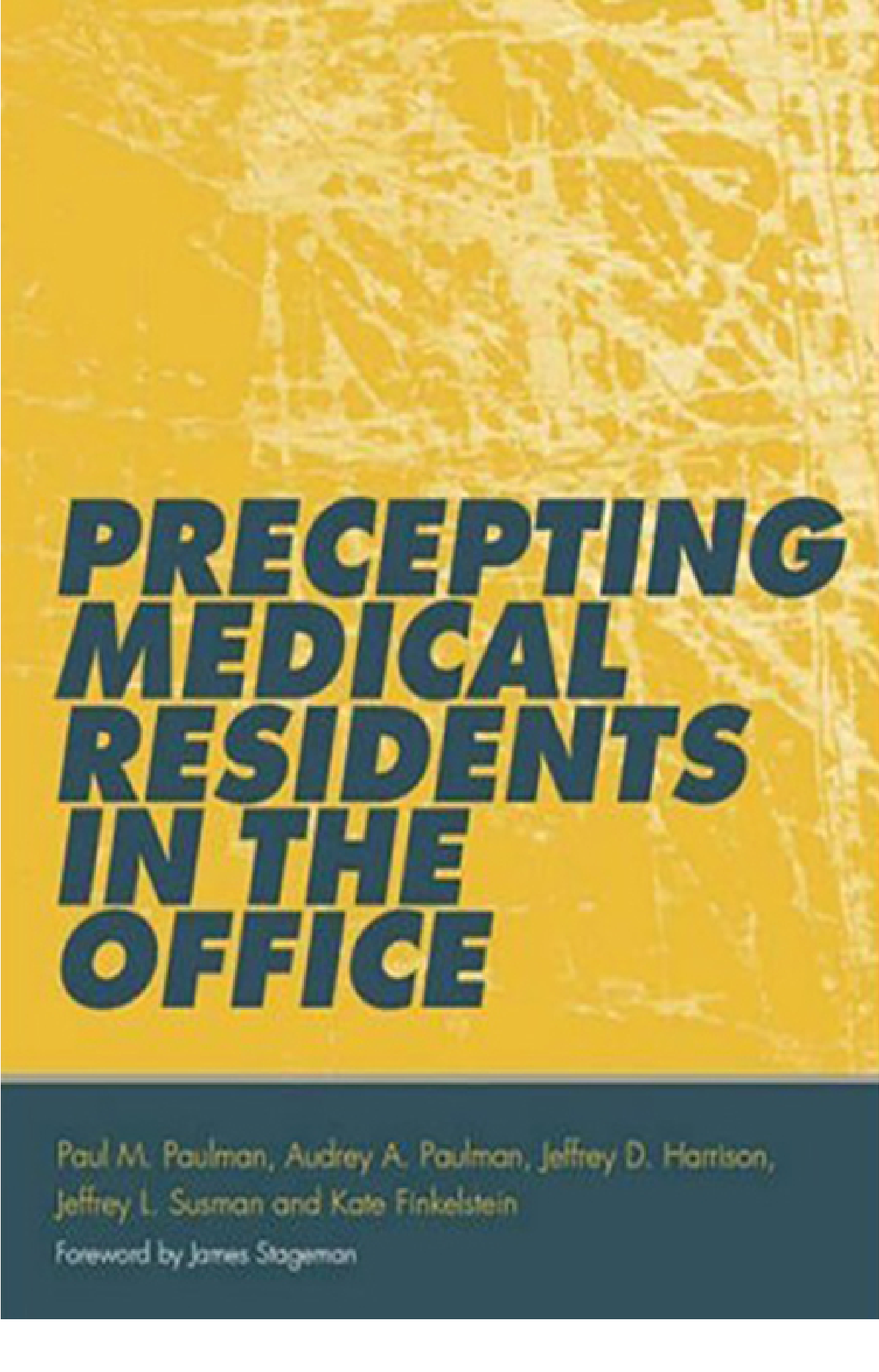
PRECEPTING MEDICAL RESIDENTS IN THE OFFICE
Paul M. Paulman, Audrey A. Paulman, Jeffrey D. Harrison, Jeffrey L. Susman and Kate Finkelstein
Foreword by James Stageman

Precepting Medical Residents in the Office

Edited by

Paul M Paulman, MD
Professor and Predoctoral Director
Department of Family Medicine
University of Nebraska College of Medicine

Audrey A Paulman, MD, MMM
Clinical Assistant Professor
Department of Family Medicine
University of Nebraska College of Medicine

Jeffrey D Harrison, MD
Associate Professor and Residency Director
Department of Family Medicine
University of Nebraska College of Medicine

Jeffrey L Susman, MD
Professor and Chair
Department of Family Medicine
University of Cincinnati

and

Kate Finkelstein, MLIS
Government Relations Senior Associate
DeBrunner & Associates

Radcliffe Publishing
Oxford • Seattle

CRC Press
Taylor & Francis Group
6000 Broken Sound Parkway NW, Suite 300
Boca Raton, FL 33487-2742

Version Date: 20160525

International Standard Book Number-13: 978-1-4987-9993-5 (eBook - PDF)

Contents

Foreword

Most readers are familiar with the phrase 'the secret of the care of the patient is in caring for the patient', the final line of Peabody's seminal article on patient care published in the *Journal of the American Medical Association* (19 March 1927).

However, some of his other observations, on medical trainees, earlier in the same article have been mostly forgotten.

> *The most common criticism made at present by older practitioners is that young graduates have been taught a great deal about the mechanism of disease, but very little about the practice of medicine – or, to put it more bluntly, they are too 'scientific' and do not know how to take care of patients.*
>
> *recent graduates, who find that in the actual practice of medicine they encounter many situations which they had not been led to anticipate and which they are not prepared to meet effectively.*
>
> *And while they have been absorbed in the difficult task of digesting and correlating new knowledge, it has been easy to overlook the fact that the application of the principles of science to the diagnosis and treatment of disease is only one limited aspect of medical practice. The practice of medicine in its broadest sense includes the whole relationship of the physician with his patient. It is an art, based to an increasing extent on the medical sciences, but comprising much that still remains outside the realm of any science ...*

Interesting, isn't it? Another example of the more things change, the more they stay the same.

Today we talk about imparting knowledge, skills and attitude and, for most people, this represents a continual learning process for both trainer and trainee. In his first book, *Precepting Medical Students in the Office*, Dr Paulman and his fellow authors did a commendable job in producing a comprehensive handbook for community preceptors with medical students in the office-based setting. In this, the second book, he lends his knowledge and skills to the issues of precepting medical residents in the ambulatory setting, again producing a comprehensive handbook for precepting residents.

Although modern technology can change the way in which students acquire knowledge and, in some cases, skills, there is no substitute for a true mentor. In Greek mythology, Mentor was the friend of Odysseus who was entrusted with the education of Odysseus' son, Telemachus. Webster's dictionary defines a mentor as 'a trusted counselor or guide.' In medicine, perhaps more than in any other profession, our mentors have always enjoyed a special place in our hearts and minds. In reciting the Hippocratic oath, new physicians pledge to 'keep this,

my oath and covenant, to regard him who teaches this art equally with my parents.' Although some professional athletes may contend that 'I am not a role model', there is no doubt where you and I, as preceptors, stand on this issue. We *are* role models. We *are* mentors and upon us falls the responsibility to prepare tomorrow's physicians for careers in public service that we can only begin to comprehend.

James Stageman, MD
Associate Professor, Department of Family Medicine
University of Nebraska College of Medicine
Assistant Dean, University of Nebraska College of Medicine
May 2006

Preface

This book has been produced to serve as a resource for community physicians who bring medical residents into their practices and train them in their offices. As hospital stays decrease in length and as more patient care is moved to the ambulatory setting, there is an increasing need for community-based training for medical residents in a variety of specialties.

The contributors have been recruited from the ranks of community teaching physicians and community- and university-based residency educators in family medicine, internal medicine and pediatrics. This book has been designed with the busy community physician in mind, and each chapter is intended to serve as a practical, concise, easily read, stand-alone resource on the topic covered. Those who read the entire volume will note differences in the writing styles in the various chapters and a certain redundancy with regard to key topics and issues. These are both inevitable in this type of educational manual.

The editors would like to dedicate this book to all of the community physicians who give of their time, talents and resources to train medical residents in their offices.

Paul M Paulman
Audrey A Paulman
Jeffrey D Harrison
Jeffrey L Susman
Kate Finkelstein
May 2006

About the Editors

Paul M Paulman, MD
Professor and Predoctoral Director
Department of Family Medicine
University of Nebraska College of Medicine, Omaha, NE

Audrey A Paulman, MD, MMM
Clinical Assistant Professor
Department of Family Medicine
University of Nebraska College of Medicine, Omaha, NE

Jeffrey D Harrison, MD
Associate Professor and Residency Director
Department of Family Medicine
University of Nebraska College of Medicine, Omaha, NE

Jeffrey L Susman, MD
Professor and Chair
Department of Family Medicine
University of Cincinnati, Cincinnati, OH

Kate Finkelstein, MLIS
Government Relations Senior Associate
DeBrunner & Associates, Sterling, VA

List of Contributors

Dale R Agner, MD
Commander 42nd Medical Operations Squadron
US Air Force – Maxwell Air Force Base

Dennis Baker, PhD
Assistant Dean for Faculty Development
Florida State University College of Medicine, Tallahassee, FL

Dan Benzie, MD
President
Gateway Family Health Clinic, Moose Lake, MN

Kaye Carstens, MD
Associate Professor
Nebraska Medical Center, Omaha, NE

Alexander W Chessman, MD
Professor
Department of Family Medicine, University of South Carolina, Charleston, SC

Deborah S Clements, MD, FAAFP
Associate Program Director
University of Kansas Medical Center, Kansas City, KS

Brian Finley, MD
Associate Professor
Nebraska Medical Center, Omaha, NE

Richard Fruehling, MD
Assistant Professor
Nebraska Medical Center, Grand Island, NE

Michael R Gloor, FACHE
President and CEO
Saint Francis Medical Center, Grand Island, NE

Karla Hemesath, PhD
Director of Curriculum and Evaluation
Aurora Health Care, Madison Fam Prac Res, Milwaukee, WI

Jeffrey W Hill, MD
Associate Professor
Nebraska Medical Center, Omaha, NE

Michael Horn, MD
Vice President for Medical Affairs
Saint Francis Medical Center, Grand Island, NE

Stanley M Kozakowski, MD
Director
Family Medicine Residency Program, Hunterdon Medical Center, Flemington, NJ

Alan Lembitz, MD
Vice President
COPIC Companies, Denver, CO

Amy L Longo, JD
Adjunct Asst Professor, Preventive and Societal Medicine
University of Nebraska College of Medicine, Omaha, NE

Mary Ann Manners, MSPH
Instructor
Nebraska Medical Center, Omaha, NE

Fred McCurdy, MD
Professor and Regional Chairman
Department of Pediatrics, Texas Tech Medical Center, Amarillo, TX

David V O'Dell, MD
Associate Professor and Director of Primary Care
Nebraska Medical Center, Omaha, NE

Kenneth G Reinert, MD
US Air Force – Scott Air Force Base

Edward Shahady, MD
Director, Diabetes Master Clinician Program
Florida Academy of Family Physicians Foundation, Jacksonville, FL

Kent Sheets, PhD
Associate Professor and Director of Educational Development
Department of Family Medicine, University of Michigan, Ann Arbor, MI

Eric Skye, MD
Assistant Professor
Department of Family Medicine, University of Michigan, Ann Arbor, MI

Jeffrey A Stearns, MD
Associate Dean
University of Wisconsin Medical School, Milwaukee, WI

David Steele, PhD
Professor of Family Medicine and Rural Health
Florida State University College of Medicine, Tallahassee, FL

Marian R Stuart, PhD
Clinical Professor of Family Medicine and Director of Behavioral Science
Department of Family Medicine, Robert Wood Johnson Medical School,
New Brunswick, NJ

Section I

The Resident and Teaching Techniques

Chapter 1

Value of Office-Based Teaching

Deborah S Clements, MD, FAAFP

Key Points

- Office-based teaching of medical residents offers residents invaluable learning experiences.
- The knowledge and skills acquired by medical residents in the community preceptor's office cannot be acquired in other venues.

The importance of community training of medical residents cannot be overemphasized. During the late 1890s, Osler anticipated the eventual separation of traditional hospital-based teaching and the realities of community-based practice and ambulatory models of care.

In his book, *Time to Heal*, Kenneth Ludmerer states, 'Community-based teaching of medicine provides every student with an opportunity to learn and know clinical medicine as it is practiced today and to meet and learn about patients, their lives, their communities and their doctors.' Nowhere is this more evident than in community-based residency training of physicians. The contributions of thousands of community physicians to the education of medical residents are critical in introducing useful practice models in an environment that closely approximates the typical practice of medicine, and in encouraging residents to develop their own practice style, to seek the setting most appropriate for their personal and professional fulfillment, and to provide role models and mentors for young physicians. Through sustained interactions with community faculty, residents gain an appreciation of the vital relationships among physicians across specialties, patients and their communities.

Academic health centers affiliated with community faculty realize many benefits as a direct result of their combined efforts, including closer ties with physicians in the community, increased opportunities to collaborate in practice-based research, more comprehensive faculty development, and revenue generated from patient referrals.

Undeniably, changes in the provision of medical care in the US over the past decade have presented some challenges to all medical educators. Scientific knowledge, diagnostic tools and treatment modalities have expanded dramatically, resulting in a far more extensive curriculum for residency training. As payment systems moved from fee-for-service to third-party administration models, the measurement of successful clinical education began to focus

increasingly on profitability and penetration of the market. Improvements in treatment combined with economic pressures resulted in shorter inpatient stays, and a shift of patient care to the ambulatory clinic. Increased regulatory pressures have shifted attention to the business of medicine, sometimes at the expense of the art and science of medicine. Finally, electronic access to information has changed the landscape of the patient–physician interaction, placing a renewed emphasis on the need for community physicians to manage relationships and knowledge in addition to providing medical skills.

Despite these challenges, community physicians remain satisfied with their career choice and continue their commitment to their patients and communities. Physician preceptors appreciate the adage that teaching is learning twice, using their interactions with residents both to improve their own understanding and to impart to their learners a full appreciation of longitudinal care, exacerbation of chronic conditions, the importance of a therapeutic alliance and the impact of the patient's family, work and community on the patient's health.

Through their work with community physicians, residents also develop the ability to effectively and safely manage uncertainty, to function as a member of a healthcare team and to integrate community resources into the optimal care of their patients.

According to Ludmerer, the power of medical education in the academic health center is limited, particularly with regard to its ability to produce doctors who are caring, socially responsible, and capable of behaving as patient advocates in all practice environments. It is important to recognize that the caliber of doctors we have represents a negotiation between medical education and society. That negotiation is successful in large part because of the efforts of community physician educators.

Chapter 2

Identifying Learning Needs of Residents

Mary Ann Manners, MSPH

Key Points

- Residency is the *application* and, most importantly, *problem-solving* part of previous undergraduate medical learning.
- Adjusting your teaching to the resident's learning needs can enhance the educational experience for the resident and preceptor.
- The preceptor's office offers unique learning opportunities for residents at all stages of training and from all backgrounds.

Introduction

Each medical graduate comes into residency with different knowledge bases, clinical experiences, fears, attitudes and, most obviously, strengths and weaknesses. A primary emphasis of undergraduate medical education is on mountains of memorization: anatomy and physiology, pharmacology, signs, symptoms and diagnoses, along with manual techniques of physical and laboratory examinations. Although problem-based learning (PBL) and clinical rotations offer some hands-on application, students have little primary responsibility. Residency provides the opportunity to fine-tune the graduate's knowledge and techniques within the context of a variety of patient care possibilities. Thus, in educational terms, residency is the *application*, and most importantly, the *problem-solving* part of previous undergraduate medical learning. Perhaps the prime benefit of residency is the guided tour that experienced physicians provide in the application of medical knowledge during the numerous rotations – when, where, why and how with the young and old, male and female, a variety of presentations, differing circumstances and concurrent diseases. Specifically, learning the 'in-the-trenches' techniques that experienced physicians offer of the knowledge, application and problem solving in your specialty is the goal for residents rotating through your office.

Keeping this cumulative progression of medical education in mind, the experiences and needs of residents rotating to your office will be more apparent. Even with advances in technology, physicians are more than technicians. More

than the textbook descriptions, residents need to learn how to apply the vast amounts of knowledge that they possess – which symptom or test is more valuable in certain circumstances, how to prioritize problems, the 'red flags' of the rare versus the common, and what laboratory tests provide the most fruitful results. In addition, they face the huge area of patient interactions, continuity, interview skills, prevention and patient education, along with behavior changes. Moreover, each specialty has manual techniques and procedures that can be honed beyond what is learned in undergraduate training. You are uniquely able to provide the application and problem-solving parts of medicine. Since residents are not usually competing with another student or resident for patients, the one-to-one time is maximized.

This chapter cannot address all the various content areas of each specialty. It will specifically address the types of exposures and processes needed by residents in the private office settings, by the year of residency. Although there is overlap from year to year, and specific residents may be ahead or behind in their personal level of education, the benefit *and* the challenge of individualizing your educational efforts are limitless in a private practice setting.

A Word About Non-Traditional Residents

Each year there are a few more non-traditional medical students, who then advance to residency. The non-traditional residents are older, have changed careers, or may have military experience. These residents bring a lot to the table, and are generally a wonderful influence on cohorts. They are commonly grounded in real-world experiences, more mature, more confident, and can see the big picture. They have positive attitudes, are able to put things in perspective, are serious about responsibilities, and 'look the part' of a physician, so are easily accepted by patients. Often they have had some experience of the healthcare system, either personally or through their family, which is a reference point for what kind of physician they want to become, and they are willing to work hard to get there. Educationally, they are self-motivated and eager to learn as much as they can. Frequently they are more comfortable in their own skin, and find it easier to admit what they don't know, to ask for help, or even to request additional resources, and extra clinical learning opportunities.

However, *some* of these non-traditional residents have difficulty in other areas, which aren't quite as apparent in the traditional residents. They may have experienced a drastic change and sacrifice in their lifestyle in order to enter medical school. Balancing the time demands of a spouse and children with hours on call, weekend duties, etc., may be more difficult. Worries about decreased income and mounting debt may increase excess moonlighting. They may struggle with the extended lack of autonomy and independence. Some don't like activities that they perceive as 'a waste of time' – they want to be finished and get their ticket stamped. In a few instances, these residents may appear rigid, try to cover up deficiencies, convey an attitude of already knowing everything, and thus are not very 'teachable.' As attendings and faculty, it is also easy to accept non-traditional residents who appear and act in a more mature manner as a colleague, to assume that they know more than they have proven, and to ignore behavior that would not be accepted in a younger resident.

The majority of the time, non-traditional residents are eager learners, a delight to have in a practice, and contribute much. However, educators need to keep alert for any problematic situations. Medical education in a private office has a great ability to individualize the one-on-one time spent with resident physicians, and to take all of these factors into consideration, if watched carefully. Subtle changes in teaching approaches can usually address these differences.

First-Year Residents/Interns

The internship year is primarily the *application* phase of their undergraduate education – learning what to do with all that memorized information. Since each medical school curriculum is slightly different, each graduate has a unique foundation of strengths, skills, attitudes and weaknesses or gaps in education and experience. One's natural inclination is to assume a certain breadth of knowledge based on personal experiences, or on preceding residents who have been on a rotation. Although tempting, this sets up a first-year resident for expectations that may or may not be realistic, often through no fault of the resident.

First-year residents are in a unique situation. They are excited about jumping in and learning, but their anxiety is high because of the increased responsibility for patient care. They are working with other residents who have come from various different medical schools, and they worry about how they will measure up. Like medical school, each month brings a different rotation – just when they feel comfortable with one team, the whole process starts again. And they are well aware that each attending physician has his or her own style, office procedures, staff preference and attitudes, etc.

You may not see first-year residents in your private offices, as most of the internship year is spent in hospital-based rotations. This formative year is important for laying the groundwork for the following years.

Questions and Needs

Orientation to Your Practice (see *Chapter 6)*

Relieving some anxiety early on can set the stage for residents to maximize learning. This includes introductions to personnel, administrative practices, community, special opportunities, expectations, call schedule, and internal and outside resources. Questions may include the following. Are there any patients they may not see? Are they expected to cover for emergencies? For nursing homes? For school sports physicals or classroom or presentations? For phone triage?

Resident Supervision in Your Practice (see *Chapter 7)*

Will they observe? Will they interview and present? Will they see as a team? Will they interview and examine? Will you see all patients with residents? If so, for how long? Or do you have residents present cases only for approval before the patient leaves the office? Do you supervise prescriptions? Laboratory orders? Billing?