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President's Column

The Invisible Faculty

Joseph Hobbs, MD

I had departed the medical school much too late to reach this small Georgia town before dark. Most of the 175-mile drive south was in daylight on interstate highways, but traveling the final 57 miles after nightfall on unfamiliar secondary roads was a challenge to my sense of direction. I arrived safely at my motel at nearly 9:30 p.m., fatigued from a long day of clinical work and meetings and my decision to fit this daily medicine clerkship teaching site visit into an already over booked schedule. After a brief review of the next day's meeting itinerary, I got some much-needed sleep.

The trips to community working sites, although a necessary part of the maintenance of a decentralized teaching network, had always been somewhat problematic. The importance of these visits was not usually understood by medical school faculty beyond the department of family medicine. Too often, the community physician faculty were faceless names on a list) an invisible part of the medical school's faculty, whose contributions far exceeded their recognition. But, tomorrow, things would change.

The next morning, I traveled the short distance to the office of this group of three family physicians who had participated in the family medicine clerkship since its inception 10 years earlier. The courteous staff escorted me to a large office library, where I awaited my 9:30 a.m. appointment to discuss the activities in this teaching site over the last six months. I was informed that only two of the physicians were to meet with me, once they completed evaluating a few early morning appointments. The senior partner was not available until midmorning because of extended hospital rounds caused by a busy night on call. A third-year family medicine clerkship student, who had been on call with the senior physician, was also participating in morning hospital rounds.

The office was spacious with an ample waiting area and, I was pleased to see a plaque on the wall that identified the facility as an official teaching site of the Medical College of

Georgia. There was a small laboratory with a staff member already performing a myriad of studies for patients whose appointments started at 8 a.m. The library was well supplied with the standard textbooks and the expected journal collection. In a corner of the library sat a computer station stamped with the medical school's identification tags. On the screen was the Internet home page of the medical school, which gave students and physicians access to our institution's medical informatics system. A set of standard texts, provided by the medical school, were arranged neatly in the same area, and abstracts from library searches were scattered at the end of the table.

When the two physicians were ready to meet, they suggested that we use one of their offices for more privacy. The office was large and neatly appointed, except for a desktop littered with opened texts and journals. I noticed a blackboard on the wall that had a partially erased pathway of the renin-angiotensin system with the sites of action for ACE inhibitors and aldosterone blocking agents indicated. The more recent use of the blackboard appeared to be notes on a patient with mental status changes and abnormal electrolyte and blood gas data. The chalked scribbling had a differential diagnosis of mental status changes, as well as comments about adult immunizations, health maintenance appraisals, and an attempt to construct a genogram of this patient's family.

My official purpose that morning was to review with these physicians the performance of the four students they had taught over the last four 6-week rotations of the family medicine clerkship. I was particularly interested in the documentation of appropriate types and numbers of clinical encounters provided to the students, the consistency of objective test performance, student evaluations, and essential elements of the clerkship curriculum that were not consistently addressed throughout the teaching network. Although this site had no difficulty providing the appropriate number of patient encounters and distribution of diagnoses to meet the required clinical content of the clerkship, as usual, they intently studied the data, especially their performance when compared with the other 12 family medicine group practice teaching sites in the clerkship. One of the physicians, noting low student encounters with patients who had an anemia, offered a plausible reason for the students' low reporting of this problem and suggested a strategy to increase student recognition of this common problem. That strategy was subsequently suggested to all teaching sites in the family medicine clerkship.

I listened to these community physicians' self-assessments of teaching effectiveness, which was always far too critical, and marveled at the seriousness with which they took their teaching responsibilities. They were pleased that they had the responsibility of grading the mid-term and final family medicine clerkship modified essay exams, because it provided additional insight into the students' approaches to clinical problem solving. This exam assessment helped define specific feedback and strengthened their confidence in the validity of their assessments of student performance. Their confidence as effective teachers had also been heightened by data that showed no statistical differences in end-of-rotation objective exam performance when community practice teaching sites were compared with the formal teaching venues of the university and community residency programs.

After about 40 minutes, the senior partner joined the meeting. This was the physician who most frequently represented the group at the annual family medicine clerkship review, planning, and faculty development sessions. He was also responsible for implementing any new curricular elements of the clerkship and ensuring that student evaluation and feedback occurred in a timely fashion. The student I had met previously in the orientation session at the beginning of the rotation also joined us. The student was jubilant because he had participated in the delivery of a baby for the first time earlier that morning. What I did not realize was that this would be one of five such experiences for him during the family medicine clerkship and would ultimately comprise the majority of his obstetrical experiences for his third year, which included his experiences on the OB-GYN clerkship.

The student apparently had been clinically busy, as evidenced by two dog-eared patient encounter log books in his coat pocket, each of which had space for the documentation of at least 48 ambulatory and 10 hospital patients. Since this was the middle of the third week of the 6-week clerkship, it was obvious that at that pace, he would evaluate a sufficient number of patients to appropriately prepare for the clerkship final exam. The student, who had already been featured in the small town weekly newspaper, had been to a Rotary with one of the physicians several days earlier and was scheduled to attend the first home game of the county's high school football team to assist the senior member of the group, who was the team physician. He related later that, to his surprise, the majority of his time was used to assist in the treatment of heat-related illnesses in the band members, who were performing in full uniform on an unexpectedly hot and humid evening.

The student, as one would expect, praised the quality of his clinical experiences, especially as it related to the quantity, relevancy, and the degree of direct student involvement. However, these same sentiments were also expressed at the end-of-the-clerkship student debriefing session, where no faculty were present, as well as in his subsequent explanation for his change of career goals from med/peds to family practice.

Had my advocacy for community- based education been strong enough? Was I requesting institutional support for the community teaching sites while not providing the necessary departmental support?

The final piece of business was to introduce the group to a curricular evolution to ensure that all community- based faculty taught elements of population and evidence- based medicine. Although I had originally thought that this level of instruction would be difficult to demand of these community-based teachers, I underestimated their willingness to continue a process of critical self- education based on evidence, as opposed to convention. We had already determined that it was the community faculty, not the students, in most teaching sites who were the most frequent users of the medical informatics system. This suggested that, although not formalized, these busy practitioners were already seeking evidence as the basis of their clinical practice.

So, why did these physicians teach? Certainly not for the small reimbursements they receive from the medical school for teaching and for housing costs. Most community physician faculty related the fun and personal satisfaction provided by teaching. They also realized that teaching kept them in a mode of constant learning, since students were continually seeking understanding of fundamental issues related to patient care. These student inquiries caused physicians to frequently reassess the reasons they did the things they did.

As our session ended about 11:40 a.m., I recognized that once again this group of family physicians had given much more than I had expected. With the exception of some early morning office visits and absence of one of the partners toward the end of the session, our meeting had been scheduled in lieu of a full morning of clinical office activity, which certainly affected their economic bottom line. One member of the group also spent his lunch hour with me discussing the status of a former student who had been discovered by him and his colleagues to have a learning disorder that was seriously impacting his clinical performance. This problem, which was not picked up on at any of the student's previous clerkship experiences, became evident to this group of family physicians because of the continuous contact that they had with the student each day of the clerkship rotation. I was able to report that his prognosis was good, although his program of study would require some modification.

As I departed at 2 p.m., I had an opportunity to see the third-year clerkship student once again. I joked with him about his upcoming required patient home visit with a family who also invited him to stay for dinner as being an unfair reward. Although I would not return to this site for another 12-18 months barring any emergencies, I felt comfortable that the flow of information to and from this site would continue. The department staff had already scheduled two other visits to this site to install and upgrade computer hardware, and the usual mail and phone contact with the faculty of this teaching site during every student rotation would continue.

This visit was typical of the group practice teaching sites in the family medicine clerkship, which comprises 74% of all teaching sites and are assigned 59% of the 180 third-year students from the Medical College of Georgia. The group practice structure made it possible for students to be assigned frequently to these community-based teaching sites at rates ranging from 80%-100% of the time. All of these community physician faculty felt that the instruction of third-year medical students extended their day but did not cause any real financial loss, especially where the offices were large enough to allocate an exam room for the students' patient encounters. These flexible resources were more likely found in group practice settings. The constant teaching experience resulted in a more consistent delivery of the required content of the clerkship, as well as more consistent and reliable student evaluations. Although the group practices had more resources to implement required clinical course responsibilities, many solo practitioners, for reasons of personal commitment to community-based clinical education in family medicine, have also been able to sustain substantial teaching commitments on a frequent basis.

Why did these physicians teach disproportionately to their recognition as credible partners in the academic health center's educational enterprise? The complete answer continued to elude me, but I nonetheless was grateful for the phenomenon. These community physician faculty substantially impact the quality of general ambulatory medical training, increase the choice of family practice as a career, provide credibility and relevancy to all generalist medical disciplines, and enhance the general development of the physicians of the future as they serve as mentors, role models, and advisors. In fact, the physicians in these group private practices have substantially more direct student teaching hours in the clinical setting than many faculty in traditional teaching venues (i.e., university and community residency programs) and yet they teach year after year without loss of enthusiasm.

During the trip home, I wondered if the less-than-appropriate appreciation for the efforts provided by all of the community-based family medicine faculty who taught in the clerkship was in part a failure on my part. Had my advocacy for community-based education been strong enough? Was I requesting institutional support for the community teaching sites while not providing the necessary departmental support? Had I truly made the issue of appropriate support for community faculty not only to the dean but to my department chair as well? Even the term preceptor did not fully describe this valuable community faculty resource and permitted them to appear as an amorphous mass with no individual significance, easily ignored and undervalued.

If I could only get others to see what I had seen that day in a family medicine group practice in south Georgia, the concerns about lack of educational consistency and rigor of community-based teaching would rapidly fade. It must be recognized that these community physician teachers provide much more than the content of a clinical course or the appropriate evaluation of a student; they provide a learning experience that is totally immersed into the lives of these physicians and the activities of their communities. These lessons are needed elements in the general medical education of future physicians, so we don't lose sight of the humanity of what we do and what we expect of our students in the future. When the teaching potential of academic center-community physician educational partnerships is fully realized, then perhaps community physicians will move from the invisible septum of the faculty to a place of influence that is consistent with the quality of their contributions. And maybe the debate over the support for their efforts will wane. Until then, my advocacy must not wane.