

## Evaluating Perceptions of Community-based Physicians From a High-retention Clerkship

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**Objective:** This study's objective was to ascertain factors contributing to high retention of community-based sites and their physicians in a 3-decade-old family medicine clerkship. **Methods:** Focus groups were conducted with community-based physicians from the Medical College of Georgia's family medicine clerkship. Transcripts were analyzed using an iterative process regarding physicians' initial and ongoing motivations for participating in the clerkship. **Results:** Thirteen physicians participated. Six themes were generated: family medicine promotion, valued role of teaching, leadership style, clerkship ownership, resources, and challenges. **Conclusions:** In addition to intrinsic motivators such as valuing the role of teaching the next generation of physicians and promoting the family medicine specialty, the participative leadership style of a clerkship may be an important factor in physicians' decision to teach in a clerkship. The physicians in this study described having collegial working relationships with the clerkship leaders and receiving consistent support in implementing objectives. Physicians attributed their high level of involvement and investment as a product of being respected partners in defining the clerkship. Financial support and teaching resources were also considered salient. A follow-up study with a larger population is warranted to support the importance of leadership style and other external motivating factors toward a clerkship's physician retention.

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Retaining community physicians in clerkships is a challenge for clerkship directors. Recruiting and retaining community-based physicians and meeting educational requirements are common difficulties for clerkships that teach in the community, beyond the traditional boundaries of an academic center. These topics have been discussed in the literature<sup>1,2</sup> and also informally at conferences of clerkship preceptors, directors, and department chairs.

Many factors motivate physicians to precept. Preceptors' personal satisfaction and professional growth have consistently been cited as major motivators to precept.<sup>1,3-5</sup> Recognition and faculty appointments have also been considered important.<sup>2,5,6</sup> Relatedly, incentives such as CME credits, faculty development, access to technology, or other resources are involved.<sup>1,2,5,7</sup> Monetary compensation has been considered a less important factor in some studies<sup>1-3,5,8</sup> but a valued factor in other studies.<sup>6,9</sup> Finally, attracting students to preceptors' specialty has been noted as a motivator to teach.<sup>5,10</sup>

With family medicine in its third decade and approximately 127 family medicine departments across the United States, we wanted to evaluate a long-running (more than 20 years) clerkship that has had minimal site and physician attrition. In particular, what aspects of this clerkship initially interested physicians to participate and what maintained their ongoing participation needed to be ascertained.

### Methods

#### Subjects

All physicians present at the Medical College of Georgia's (MCG) family medicine 2002 annual clerkship conference were eligible to participate. They were informed that participation was voluntary, and declining to participate would not affect standing in the clerkship. Sixteen physicians attended the conference and represented 15 of the 18 clerkship sites. Thirteen (80%) of these 16 physicians participated in the study and represented 12 sites. Participant demographics are summarized in Table 1.

#### Setting

MCG has provided its students a primarily community-based family medicine clerkship for 21 years and

Table 1

## Demographics of the Community-based Physicians in the Focus Groups (n=13)

Age	Mean=46.7 years (range 32–67), (SD=11.5)
Race	African American: 23% (n=3) Caucasian: 77% (n=10)
Gender	Women: 15% (n=2) Men: 85% (n=11)
# of years in practice	Mean=14.8 years (range 1–41) (SD=13.1)
# of years in clerkship	Mean=9.85 years (range 1–19) (SD=7.4)

SD—standard deviation

has formal faculty arrangements with 100 physicians at 18 practice sites (private practices, residency training sites, military site, and academic center). To date, only two sites have ended their relationship with the clerkship. The family medicine department provides an initial 2-day orientation and a final exam for each rotation. Community physicians are responsible for all other aspects of training, including clinical experiences, procedures, documentation, and lectures. Most sites have students 48 weeks of the year in 6-week rotations. Community physicians receive a teaching incentive, a student housing allowance, and a clinical appointment.

*Procedure*

We used a facilitated focus group format during the clerkship's annual conference. We formed two focus groups and randomly assigned physicians to groups. MCG's institutional review board approved the study. There were no sources of funding for this research.

The primary prompt questions were what initially interested the community physicians to teach in the clerkship and what contributes to their ongoing participation. Additional questions about their influence within the clerkship, importance of incentives, and receptivity to research endeavors were asked. Table 2 provides a complete list of the topic questions. Two psychologists facilitated the groups (one facilitator per group) and recorded responses from the groups with audiotapes and written notes. The facilitators reviewed transcriptions for accuracy.

*Data Analysis*

The first two authors and two additional subinvestigators independently reviewed the transcripts, independently generated a list of preliminary themes, and then examined the preliminary themes for commonality among the reviewers. When a reviewer noted a theme

Table 2

## Probe Questions for Focus Groups

1. What initially made you decide to teach medical students?
2. What are some of the reasons you have continued to teach medical students?
3. What level of influence do you have within the family medicine clerkship?
4. What alterations would you like to see within the clerkship?
5. How well have your concerns been addressed by the family medicine clerkship directors?
6. What are your thoughts regarding the overall educational programs at the Medical College of Georgia?
7. How important are monetary benefits to your decision to participate in the clerkship? (eg, payments, books, computers)
8. What are your thoughts on conducting research as an optional part of the clerkship?

that was not identified by other reviewers, all reviewers reconsidered the evidence for the theme to determine its appropriateness. Themes that received consensus by all reviewers were kept as final themes.

**Results**

Sufficient evidence was found for 19 minor themes that could be further grouped into six major themes (Table 3). The major themes were (1) promotion of family medicine, (2) intrinsic value of the role of teaching, (3) structure provided by clerkship leadership, (4) community physicians' ownership of clerkship, (5) resources provided by leadership, and (6) challenges and opportunities.

*Promotion of Family Medicine*

The community physicians considered teaching an opportunity to demonstrate to students the breadth and depth of family medicine. Participants expressed their passion for the family medicine specialty. As one participant stated, "I have a passion for teaching and I've sort of fallen in the 'true believer' category of family medicine educators, but I really have an interest in sort of 'evangelizing' our specialty." Physicians practicing at the inception of family medicine as a discipline joined the clerkship as a means to improve the status of family medicine with their colleagues. They wanted to counter negative labels (eg, "family medicine as second-choice profession"). One of the founding clerkship physicians said, "We wanted to elevate the status of GPs to being a quality specialty . . . we are not secondary to anybody." Community physicians also recognized that teaching could be a means to attract students to family medicine and perhaps eventually to their practices. A rural physician noted, "It's been a recruitment tool for us . . . they see that practicing in a rural area is not undesirable, like a lot of them think."

Table 3

## Themes From Clerkship Focus Groups

1. **Family Medicine Promotion**  
*"I really have an interest in sort of 'evangelizing' our specialty."*  
 a. Demonstrate breadth and depth of family medicine specialty  
 b. Attract to family medicine in general and to specific practice sites
2. **Valued Role of Teaching**  
*"Once I say it and connect the dots for them, it's like 'Oh yeah!'"*  
*"I found that it keeps me motivated to keep learning."*  
 a. Professional responsibility  
 b. Enjoy teaching  
 c. Teaching applied clinical skills as a primary role  
 d. Means to stay informed about the medical field (ie, clinical knowledge and practice management knowledge)
3. **Clerkship Leadership**  
*"... as long as they're [students] meeting the mark with the numbers, common diagnoses... you can structure however you want."*  
*"I know that it's [help from leadership] a phone call away, and I immediately have access to someone on the other end to tell me what to do or solve the problem for me."*  
 a. Provide flexibility in implementing the clerkship objectives  
 b. Maintain consistency in clerkship leadership (ie, minimal turnover, similar style)  
 c. Maintain consistent liaison person (ie, clerkship coordinator)  
 d. Proactive with clerkship issues (eg, administrative and educational)
4. **Preceptor Ownership**  
*"We are the clerkship!"*  
*"... they [clerkship leaders] brought us along and thought our opinion was worth something and asked our opinion, as these things were implemented."*  
*"It's always fun and helpful at these meetings [annual conferences] to find out what other people are doing..."*  
 a. Adopt "ownership" approach to the clerkship  
 b. Consensus building is an important role of the clerkship leadership  
 c. Develop procedural monitoring tools (eg, student logbook, procedures card, responsibility checklist, evaluation form)  
 d. "Personal feel" of the clerkship
5. **Clerkship Resources**  
*"I had a contractual relationship with the Medical College, and they provided me funds that help offset the cost of that apartment and so the student from MCG had first dibs..."*  
*"... they've always made sure that the students out at the private sites had access to almost everything the students at the residency center had..."*  
 a. Appreciate teaching resources (eg, reference books, computer, Internet access) provided by the clerkship leadership  
 b. Consider financial assistance to be important in offsetting housing costs for students  
 c. Consider financial assistance to be important in offsetting likely revenue loss while teaching students but do not consider it a sufficient reason to be involved with teaching
6. **Challenges**  
*"If it [research] requires more time, I can't do it."*  
*"I would say I'd give it [research] a shot and see how it would happen, as long as I'm not married to it..."*  
 a. Cautiously receptive to incorporating research endeavors into the clerkship  
 b. Interested in obtaining additional faculty development training (eg, teaching and technology skills)

*Valued Role of Teaching*

Community physicians consider teaching a professional responsibility to teach the next generation of physicians (eg, sense of "owing something back" to the profession), an enjoyable activity, and an important task for helping students' transition from "book learning to clinical application." It also serves as a stimulus to stay informed of advances in medicine.

Physicians liked the one-on-one interactions and being there "when the light went on" as a student grasped a concept and enjoyed helping "brain prepared" students translate readings into real-world practice. "I'm always surprised at how the students don't do well in connecting their first 2 years to their clinical [rotations]. . . . they'll struggle with that [reading EKGs], but once I say it and connect the dots for them, it's like 'Oh yeah!'"

Finally, the community physicians used teaching to stay informed about the medical field. They noted that "staying on their toes" regarding medical advances was imperative to being good teachers and clinicians. Comments such as "I found that it keeps me motivated to keep learning. I don't want them showing me up," or "They are somewhat educating to you because they come up with wanting to know why something is done, and you know you've always done it that way, but you can't give them an answer, so you've got to go figure out how you're going to answer," were common.

*Clerkship Leadership*

The community physicians described the clerkship director's role as guiding physicians but also providing flexibility in implementing objectives. Despite the clerkship's detailed monitoring system for patient encounters, procedures, and teaching experiences, the physicians perceived the leaders as flexible. "They [leadership] take the 'hands off' approach once the student is released to the site. However, you have to set up as long as they're [students] meeting the mark with the numbers, common diagnoses, the procedures . . . you can structure however you want."

Consistent leadership was noted as important. The community physicians agreed that having just two directors in 21 years with similar styles has created a predictable pattern for working together. The physicians also emphasized the importance of having a consistent liaison person. The clerkship coordinator has been in the position since the clerkship's inception and was described as a vital organizer and problem solver. Rapid responses and familiarity with the physicians and their staff were cited as strengths. "They've [clerkship leadership] always been very supportive of any problems we have, either with the program or with the students. I know that it's a phone call away, and I immediately have access to someone on the other end to tell me what to do or solve the problem for me."

### *Community Physicians' Ownership of Clerkship*

When asked about the community physicians' influence on the clerkship, they emphasized, "We are the clerkship!" Their "ownership" was illustrated in comments such as "We basically, sort of, run the show," and "We kind of put it [student daily schedule] together ourselves and work it out, and I think that's probably the real benefit." A consensus-building style has been typically used. "When we had a change in venue and people, they [clerkship leaders] brought us along and thought our opinion was worth something and asked our opinion, as these things were implemented. They do not come in with an agenda that says, 'Now fellas, here's how we're going to do it.'" Finally, the community physicians described the congeniality expressed within the clerkship. They noted developing professional relationships with one another due to long-term connections and unified commitment to the clerkship. Feeling comfortable with one another professionally was considered important. "It's always fun and helpful at these meetings [annual conferences] to find out what other people are doing . . ."

### *Clerkship Resources*

The community physicians appreciated a variety of provided resources and considered them important in the stability of the clerkship. These resources were characterized as teaching aids (eg, computers, Internet access, library references), housing assistance, and teaching incentives. "We didn't have access to these things, but they've always made sure that the students out at the private sites had access to almost everything the students at the residency center had . . ."

The community physicians considered financial assistance important in offsetting student housing costs. The clerkship has been able to offer state funds of approximately \$300 per week per student for teaching and \$20 per day per student for housing costs. A physician described a situation in which he was scheduled to receive two students from different institutions: "I had a contractual relationship with the Medical College, and they provided me funds that help offset the cost of that apartment and so the student from MCG had first dibs . . ." Similarly, the community physicians considered their teaching stipend important in offsetting any potential revenue loss while teaching students but did not consider it a sufficient reason to teach.

### *Challenges*

The final theme, challenges, may be interpreted as challenges to meet growth areas in family medicine and teaching. Physicians recognized that time constraints were a barrier to further developing their skills in teaching (eg, addressing problematic students), technology (eg, using personal digital assistants, searching the Internet for articles), and research. A range of responses was offered regarding participating in the

department's practice-based research network. "If it [research] requires more time, I can't do it." "Make the students do it." "I would say I'd give it a shot and see how it would happen, as long as I'm not married to it, to make a commitment forever." The physicians expressed interest and cautious receptivity to incorporating these new endeavors into their practices.

### **Discussion**

The findings from this study provide additional support for the intrinsic motivating factors described previously,<sup>1-5,8,10</sup> as well as highlight a partnership model for structuring a clerkship. Community physicians emphasized the valued role of teaching and wanted to promote family medicine to the next generation. Flexibility in implementing teaching objectives and provision of teaching resources were important. In contrast to an earlier study<sup>11</sup> citing minimal financial concerns for teaching students, the physicians in this study considered financial assistance an important consideration. They appreciated assistance with offsetting housing costs and the perceived reduction in patient volume resulting from teaching. The teaching incentive may also serve as an overt demonstration by the clerkship that community physicians are valued and may remind physicians of their formal departmental relationship.

Perhaps the most intriguing finding from the focus groups is the community physicians' sense of "ownership" of this clerkship. Participants have assumed an active role in shaping the clerkship objectives and their implementation. The annual conference has been used as an avenue for sharing information and soliciting input on needed changes. The clerkship leaders establish specific goals and requirements for student education (ie, diagnoses, procedures, patient volume) and provide immediate access for problem solving as well as teaching resources such as computers, books, and Internet access. The community physicians then assume the responsibility for implementing these objectives in ways that work at their sites.

Based on the perceptions of the community physicians, examples of the leaders' behaviors can be examined for a leadership pattern. According to the path-goal theory of leadership, leadership behavior tends to be directive, supportive, participative, or achievement oriented.<sup>12-15</sup> The majority of comments about the clerkship leaders were about participative or consultative interactions. This style appears to have been present at the inception of the clerkship and continues today. However, the community physicians noted the leaders were directive regarding "getting the numbers" or meeting educational requirements for the students. Once the leaders make these objectives clear, they offered support in assisting the community physicians in meeting them.

Two other aspects of path-goal theory, the self-perceived ability of the workers and their perceived importance of the task, help to explain why a less-directive approach has worked well with these physicians. According to the theory, workers who perceive themselves high in ability or perceive the task to be essentially important to them do not like directive leadership.<sup>14</sup> The physicians know their practices, have experience with implementing objectives with students, and believe they have something important to give back to the profession. Leadership that provides support and solicits participation is more likely to succeed in this environment. Overall, the leadership seems to be initially directive about the requirements but both participative and supportive in implementing them.

### Limitations

First, only a subset of the clerkship's physicians participated in the focus groups. The physicians who attended the annual conference may be more invested in teaching or in the clerkship's stability overall than non-attending physicians. Second, the time constraints of the sessions may have impeded additional themes from developing. Additional time for conducting the groups as well as a larger number of physicians could prove fruitful. Third, the MCG family medicine clerkship provides monetary support to its community physicians, and generalizations to clerkships without compensation may find a different set of participation factors. Finally, community physicians at different points in their careers may differ in what motivates them to participate. In this study, the later career physicians (ie, those practicing at the inception of family medicine as a specialty) tended to emphasize improving the status of family medicine as a primary reason for initial interest in teaching more than the early career physicians. Additional research is warranted to determine if these motivations apply similarly to new community educators.

### Recommendations

In addition to the intrinsic motivators that most community physicians have for teaching, such as passion for teaching, professional responsibility, and continuing development of own medical knowledge, physicians may continue to participate in a clerkship that promotes a partnership between leaders and community preceptors. A partnership enhances the physicians' "ownership" of the clerkship and perhaps its stability, as evidenced by high retention.

Leaders must strive for a balance between providing the infrastructure and providing the flexibility to

determine how the objectives can be achieved. Further, having a consistent leadership style in which a close working relationship can be developed with community physicians over time is beneficial. Having consistency in a coordinator position allows for broader relationship building and appears salient to the daily functioning. Regular contacts and annual meetings foster the professional connection. We believe additional discussion and research is warranted to determine how the mechanisms that enhance the clerkship in this study may be generalized to other clerkships.

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