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Between 2001 and 2004, the National Faculty Development Program for General Internal Medicine produced practical guidelines for outpatient preceptors to teach students and residents. This U.S. Public Health Service/Health Resources and Services Administration-sponsored program tried to reinforce learning in such key content areas as cost-effectiveness, end-of-life care, evidence-based medicine, geriatrics, prevention, and psychosocial aspects of care. The psychosocial TIPS produced was learner/patient centered when used selectively depending on trainee and patient needs. TIPS includes a mnemonic sequence called CAARE MORE that includes:

- **connect** with trainees and patients as persons.
- **assess** trainee’s and patient’s knowledge, thinking, attitudes, feelings, and skills, permitting care based on the trainee’s and patient’s needs.
- **ask** psychosocial questions determining trainee’s and patient’s feelings, concerns, stressors, patient’s health and spiritual beliefs, and family and social support.
- **role model** important behaviors including empathy, respect, self-disclosure, and social amenities that can be modeled during preceptor-trainee and preceptor-trainee-patient interaction.
- **environment** that is a role model for a safe, supportive, and enjoyable doctor-patient relationship.
- **manage** by integrating communication skills into ongoing care (i.e., impact of applying doctor-patient communication skills and psychosocial patient assessment).
- **observe** trainee’s affect and other non-verbal or verbal clues as a basis for accurate assessment, reflection, and feedback.
- **reflect**, discuss, and provide feedback on knowledge, attitudes, feelings, and performance to help reinforce and enhance humanistic behavior.
- **evidence/education** that provides information and cognitive support enabling cognitive, attitudinal, and behavioral change.

While recognizing the limitations of preceptorship education, it can also be very effective in teaching humanistic care. This is particularly true when it incorporates the application of knowledge to real patients, role modeling, practice, feedback, reflection, and discussion.

(Kern DE, Branch WT, Jackson JL, Brady DW, Feldman MD, Levinson W, Lipkin M. "Teaching the psychosocial aspects of care in the clinical setting: Practical recommendations." Academic Medicine. 80: 8-20; 2005.)
The Importance of Evidence-Based Medicine

Michael E. Whitcomb, M.D., editor of Academic Medicine, says that for the sake of future patients, evidence-based medicine must be taught to medical students, residents, and practicing physicians. For practicing physicians, for example, conducting clinical question exercises in practice settings is the best kind of continuing education in which doctors can participate. Residents should also be educated in programs in which they learn the importance of using an evidence-based medicine approach to decision-making in the provision of clinical care to patients.

When given the time to generate clinical questions in an outpatient clinic relevant to patients and provided with abundant online resources, for example, most of the time residents were successful in finding answers to almost all questions that affected their decision-making. Furthermore, it was found that it is possible to design an educational experience showing them the importance of incorporating the best available evidence into clinical practice. One of the major barriers, however, was the need for time to incorporate evidence-based decision-making into educational programs so that clinical questioning can take place.

Those who are responsible for designing and conducting medical education experiences in the curricula of medical students and residents must make such exercises part of all clinical rotations. Time for this must be included in both outpatient and inpatient settings with the guidance and support of faculty. Dr. Whitcomb concludes that such exercises will allow students and residents to learn the most current approach to care and management given to patients, which is a concept they will take into their practices. Future physicians must organize their practices in a way in which they can have the time and resources necessary to answer complex clinical questions encountered in daily clinical practice. There is a sense of urgency for the academic community to make the changes possible to provide such education.

(Whitcomb ME. "Why we must teach evidence-based medicine." Academic Medicine. 80:1-2; 2005.)

Fourth-Year Medical Student Assessment of the Value of Subinternship Training

Medical educators have emphasized the core third-year medical school clerkship but universally include the fourth-year acting internship or subinternship as an integral part of the course of study. A cross-sectional survey of 101 fourth-year Boston University School of Medicine students who completed a subinternship was recently conducted. Of the skills assessed in the survey, there were several in which less than 75 percent thought they were adequately prepared. Those skills were discussing end-of-life issues, delivering bad news, and assisting with patient or family grief management—each of which represents complex communication skills.

Other skills in which they believed they were not adequately prepared were the identification of adverse drug reactions and the ability to assess patient competency. Since the study was of only one class, the authors felt their results may not be generalizable. However, they believe it may provide enough information for them to challenge medical educators to enhance instruction in higher-level communication skills. They also concluded that it appeared that the subinternship is "an effective tool in preparing students for many of the challenges they will face in residency and beyond."

Increase in Enrolled Minority Students in Allopathic Medical Schools

There was a 2.5 percent increase of African American enrollees in U.S. allopathic medical schools in 2004 and an increase of 8 percent of Hispanics. Overall, 34,702 students applied to U.S. allopathic medical schools in 2004, and 16,419 of the 17,382 who were accepted enrolled. While slightly more than 50 percent were accepted, 47.3 percent enrolled. Of the applicants, 21,023 or 61.7 percent were white, 52.1 percent of whom were accepted. This compares to 41.4 percent of African American applicants who were accepted. Mexican Americans had 403 of 810 applicants accepted or a rate of 49.8 percent compared to a 58.3 percent acceptance rate for 144 Cuban American applicants and 57.4 percent of 505 Puerto Rican applicants. Of 106 Native American applicants, there was a 50 percent acceptance rate.


Applicants to Allopathic Medical Schools by Number and Percent Applied and Accepted in 2004

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Applicants</th>
<th>Accepted</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
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<tr>
<td>Total</td>
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<tr>
<td>White</td>
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<td>African American</td>
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<td>Native American</td>
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<td>Mexican American</td>
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<td>Cuban</td>
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<tr>
<td>Other Hispanic</td>
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<tr>
<td>Asian</td>
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How to Acquire Communication Skills

A discussion is provided as to the need for good physician communication skills, their effect on the outcomes in clinical practice, and the reasons why they are not used more often. Suggestions are provided for physician education and training in communication. It is suggested that good communication skills will identify patient problems more accurately. In addition, patients adjust psychologically and are more satisfied with their care. Doctors with good communication skills have greater job satisfaction and less work stress. Physicians have available to them training that can provide them with effective methods of communication skills. The opportunity to practice key skills and receive constructive feedback of performance is essential. Among the reasons that physicians may block the use of communication is by:

- offering advice and reassurance before the main problems have been identified
- explaining away distress as normal
- attending to physical complaints only
- switching the topic
- "jollying" the patient along

To enhance their communication skills, physicians are advised to seek out courses and workshops that include:

- cognitive input
- modeling
- practicing key communication skills

(Maguire P and Piteathly C. “Key communication skills and how to acquire them.” British Medical Journal. 325: 697-700. 2002.)
The authors, who qualified themselves as nodding at presentations (NAP) investigators at the University of Calgary and McMaster University, define a lecture as "a means of transferring notes from the pages of the speaker to the pages of the audience without going through the mind of either." They report on a study measuring how often physicians nodded off during a two-day lecture series. The quality of the lectures is classified as being entertaining and informative, to monotonous and repetitive, to rushed, to Felliniesque. The method of measurement used was nod-off episodes per lecture (NOEL). They did say that occasional overcounting might have occurred since some of the NOELs were actually vigorous nodding in agreement (NIA).

However, since they were experienced observers, they believed they could distinguish between many associated factors (e.g., drooling, snoring, gasping). This was qualified by the need to include narcolepsy in their differential diagnosis. A correlation was noted between lecturers who wore tweed and NOELs. The investigators concluded that nodding off is common and that it may cause a health risk to patients. To prevent nodding during lectures, they recommended studies be done to determine if interventions had an effect on the health of patients (e.g., public-speaking lessons, wardrobe makeovers, drama classes).

(Rockwood K, Hogan DB, Patterson CJ. "Incidence of and risk factors for nodding off at scientific sessions." Canadian Medical Association Journal. 171:1443-1445; 2004.)

Analyzing M.D./M.B.A. Career Choices

The rapid changes in health care delivery require physicians who have advanced skills in business. As a result, this has created the need for training programs such as the M.B.A. as a dual-degree program. A survey was done of medical students in dual M.D./M.B.A. programs at six medical schools to determine the factors that influence medical students to enter the program. Other areas assessed by the survey included determining when they decided to enter the dual-degree program, what influenced them to select the dual-degree program, their income expectations as a result of completing the program, and career and job plans.

Among the job preferences they indicated as a result of this additional training were: medical director-multispecialty group; medical director-major HMO; medical director-large insurance/managed care company; CEO-biotechnology company; medical director-single specialty group; chief of staff-large for-profit hospital; medical director-inner-city health clinic; and medical liaison of World Health Organization.

The mean expected annual income after 10 years of those who were enrolled in the dual-degree program ranged from $40,000 to $140,000 more than the medical students who were not in the dual program.

(Sherrill WW. MD/MBA students: "An analysis of medical students career choice." Med Educ Online. 9:14; 2004.)