Family Practice Forum

To Teach or Not To Teach

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The emergence of family medicine as a recognized specialty has led to an almost insatiable need for qualified instructors in medical schools, in residency programs, and as preceptors in private offices throughout the country.

Other specialists and subspecialists have long been the principle teachers of medical students and residents; however, the medicine practiced by family physicians has many aspects that cannot be taught by other specialists. Role models are needed in medical schools and family practice residency programs. The prevalence of self-limited diseases, psychosomatic problems, and long-term care of chronic illness cannot be adequately appreciated by most academicians or hospital-based subspecialists. Subspecialists tend not to be as acutely aware of the long-term advantages of preventive medicine and cost containment, of family and social relationships, and of subtle changes in appearance and personality that the family physician learns to observe and add to his/her data base and treatment regimen.

Perhaps the reflections of one who has made the recent transition from private practice to full-time teaching in a residency will be helpful to those of you who have given some thought to teaching full or part-time.

Teaching was thrust upon me. It began in 1973 when a Clinical Clerkship Unit was established on Whidbey Island in Washington State. Other members of the medical community had arranged with the Department of Family Medicine at the University of Washington to have medical students, and later residents, come to our small hospital for a six-week rotation during their junior and senior

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years. The students were assigned in sequence to the offices of the local physicians.

I enjoyed teaching students. Nearly everything was new and exciting to them. Their questions were stimulating, and my ability to give them answers provided ample material for gratification. I could share experiences and attitudes gained in 22 years of practice in a rural setting. Some of the friendships established during this experience are still kept alive today by occasional letters.

At age 49 I made the move. This may be a later than usual time of decision, but I truly enjoyed my life-style and practice. The main positive motivation came from a desire to expand my experience, to try something new in a new setting with new challenges. A significant part of my decision was the fact that my partner of five years decided to practice in Seattle. I did not look with pleasure at the prospect of returning to solo practice, nor did I want to go through the problem of seeking a new partner and working through that process again. Alternatives were the military, emergency medicine, or teaching. I elected teaching.

I had taken education courses in college and had served on the local school board. I truly believed that education could make the world a better place in which to live. I answered an ad in *JAMA* and soon found myself visiting a residency program in Macon, Georgia.

What I found was a struggling program in its third year of existence and a group of overworked residents who were undertaught and disheartened. The challenge and opportunity to make a contribution to needy residents in a medically needy state proved to be a big enticement.

To my surprise, my wife and our two children remaining at home were eager to move. They wanted the adventure of a new life in new surroundings. They have flourished in the new environment far better than I have.

Leaving practice was difficult. The last month it was necessary to do a lot of explaining to patients who felt abandoned. There was disbelief and a few tears especially among some of my elderly, chronically ill patients. Again I was surprised by the general feeling that people expressed. They felt, by and large, that I had earned a rest after 22 years and that it would be good for me to get away from the night work and constant pressure of practice.

For the final two months of practice and the first six months of teaching I was hypomanic. I slept about four hours nightly, awakening early with plans, protocols, ideas, and fantasies. Two weeks after I joined the faculty of the residency program, the Director announced his resignation to return to private practice. With only three months on-the-job training, I became Director.

A teacher learns as much or more than he teaches. Perhaps that learning is the greatest reward. There are few compliments and these probably are only perfunctory. While clinical ability is probably of less importance than some other capabilities, it is in this area that you are judged and judged severely by residents. Residents have an excellent olfactory sense and can detect the slightest odor of horse spoor. There is a steady diet of humble pie, such as admitting to your lack of knowledge in latest immune system information or cardiovascular physiology. A strict sense of honesty is needed; teaching is no place for an ego needing constant support.

Patience is a requirement for teaching. Budgetary requests and changes in protocol need to go to committees, department heads, and other administrative personnel. A need recognized today may not be satisfied for six months or a year. Foresight and planning are essential in reducing this very real source of frustration. Results of teaching are slow in coming. There may be long periods of time between changes in attitude or gains in skills in the residents. It is often difficult to keep from stepping in to complete a procedure when the resident is struggling to gain expertise.

Good teaching requires a willingness to listen, to interrupt any activity in order to hear a problem or grievance. Residents are struggling in one of the most difficult periods of their professional lives. The opportunity to consult with someone who has been there, made the adjustment, and survived the trauma is important to residents. Being that someone who is trusted is also quite an honor.

The teaching of family medicine is in its infancy. Much is to be learned about the goals, the process, and the evaluation of such teaching. There is ample opportunity to be creative. Passing information to young physicians and instilling workable attitudes may be a legitimate claim to immortality. The impact on medical care could be profound. Could it be a new career for you?