Letters to the Editor

The Journal welcomes Letters to the Editor; if found suitable, they will be published as space allows. Letters should be typed double-spaced, should not exceed 400 words, and are subject to abridgment and other editorial changes in accordance with journal style.

Telephone Management Training

To the Editor:

A pilot study evaluating the effectiveness of a training exercise for medical students in telephone management of medical problems has previously been published in this journal.[1] That study indicated that formal training improved the students' proficiency. However, the small number of cases studied required cautious interpretation. An interesting finding in that study showed that while proficiency increased, efficiency decreased, though not to a statistically significant degree. This letter summarizes a two-year follow-up of the initial pilot study studying the effectiveness of a telephone management training exercise for medical students, with emphasis both on process and outcome criteria.

Scripts are written for one adult and one pediatric case (abdominal pain in a 52-year-old woman and fever in a 3-year-old child). Actors pose as the simulated callers. The medical students are informed of the exercise and know the encounter is being tape recorded.

The first call is placed to each student during the first three weeks of a required community health/family medicine clerkship. The tapes are reviewed by a faculty member and scored according to standard criteria derived through a Delphi concensus technique.

A one-hour teaching session is conducted during the fourth week of the clerkship for all students. Feedback is given to the students on their performance, and concepts of decision making for telephone medical problems are discussed. Each student then receives a second telephone call during the last two weeks of the clerkship which is scored in the same manner.

A total of 72 students was eligible to participate in this exercise between August 1979 and July 1981. At least one telephone call was placed to 71 of these students. Thirty-five students received both telephone calls, had the calls recorded, and participated in the teaching session. These 35 students served as the basis for the analysis below. Inability to record both telephone calls for each student resulted from technical malfunctions, unavailability of the student, or unavailability of the simulated caller. The scores of those students who did not receive a second call did not differ significantly from the scores on the first call of those students who did receive the second call.

The overall total number of questions asked, total time of the interview, and proficiency all increased after the teaching session. These results agree with the findings of the initial pilot study. The overall increase in the number of questions was due to the large increase in the pediatric case, since this parameter did not significantly change in the adult case. In contrast to the pilot study, this larger

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study shows a small increase in efficiency, though again, it is not statistically significant.

Correct disposition was used as the outcome criterion. This did not change significantly after the teaching session (8/35 incorrect pretest, 10/35 incorrect posttest). The absence of statistically significant improvements in outcome may be due to the nature of the cases utilized and the level of training of the subjects. Many students were reluctant to rely simply on the telephone generated medical history and forego the option of seeing the patient.

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Career Satisfaction

To the Editor:

I was quite interested in the observations on the career satisfaction of family physicians in several of the articles of the October issue of *The Journal (J Fam Pract Vol. 11, No. 5)*. The high level of career satisfaction and appropriateness of training are in contrast to what I have seen in many practicing internists. These physicians were trained in tertiary care hospitals largely on inpatient services. In practice, they find their skills as consultants are rarely utilized and they are poorly equipped to handle many of the problems which patients present with. Many of them are quite discouraged by the content of their practice.

My sample is small and based largely on personal observation since I was trained in a traditional internal medicine residency but have subsequently become board certified in family practice and have practiced as a family physician. It would be interesting to see if my observations hold up in a study using a better sample of the two specialties.

Karl Singer, MD
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Home Visits as Curriculum

To the Editor:

Rediscovering the home visit has been a continuing challenge for faculty and residents for seven years in this residency program. At the end of this summer (1981), if all goes well, we will have supervised over 100 entering first year residents in conducting over 1,000 *planned* home visits as part of their initial orientation period.[1] Although research and service uses of the home visit are assumed, the educational value is at times questioned.

Acknowledging the widely emulated Case-Western Reserve Model of the early 1950s (four-year assignment of one family to each freshman medical student),[2] the Charleston home visit program has developed a number of its own special features for family medicine.

1. *The get-acquainted, contractual nature* of a new resident's first home visit is emphasized. This resembles the impact of the first office visit and initial history and physical examination, but there are features of intimacy and caring that go beyond the question of the physician's "turf" (the office) and that of the patient (the home). Also, the beginning of a three-year, tenured physician-family relationship is sealed by such a visit.

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2. *The timing of the visit* must be separate from acute episodes of illness in order to fulfill basic learning objectives. The interim between-illness house call allows family and physician to concentrate on non-urgent aspects of the encounter. Admittedly, the home may be an inferior place for many needed diagnostic and treatment services, but it is a superior place for teaching the expanded "bedside manner."[3]

3. *The cross-cultural aspects* of systematically visiting 10 to 12 households in one's first family practice provide an introduction to the cultural variations in the community and a background for the coming three years of health events that resident and family will experience together.

4. *The sharpening of observational skills* is enhanced. The creative use of eye and mind in the home setting is as important as it is in the office or hospital. No matter how knowledgeable the first year resident may be, he or she can still learn and practice the art of systematic data gathering. As teachers experienced in field social work and "shoe leather epidemiology," we try to focus on the essential strengths of the tool. A checklist form helps the resident note interior, exterior, and neighborhood characteristics as well as personal and social ones.

With regard to home visits in the curriculum, we have found that one or two home visits will not suffice. Only a series of supervised and planned experiences with appropriate faculty participation will do the job. Such teaching cannot be delegated or routinized; it must be an active preceptor experience. The home visit offers a unique opportutunity for ecologic observation. Whatever the particular family crisis, diagnostic dilemma, or breakdown in physician-patient communication, there is hardly a household visit that will not yield improved understanding.

Building on such experiences over the years, we have seen home visits grow as a healthy part of our curriculum. Not without cost in terms of faculty, resident, and patient time, the end product of home visits—a family physician who is fairly adept at making an efficient and humane home visit—is worth it. A survey of our alumni practicing in their communities revealed that over 80 percent regularly and voluntarily make home visits, but only for selected conditions.

English and American journals are currently discussing the merits of house calls. The debate centers on who should make them, who will pay for them, and who will decide on their necessity.[4,5] The debate will go on. In the meantime, in much of the United States, individual family physicians will continue to choose to make home visits at their own discretion and volition.

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