The Need for Office-Based Precepting

Editorial

For much of the past hundred years, residency training in internal medicine has aspired to achieve patient-centered principles championed by the education reformer William Osler—who in 1903 declared, "There should be no teaching without a patient for a text." By the 1920s, his ideas had been largely assimilated: The reformation of American medical education from didactic instruction in proprietary medical schools to Oslerian patient-centered teaching on medical services in hospitals was essentially complete. Since then, the size and scope of medical education have changed, but not its fundamental shape.

During the same interval, however, the nature of medical care has metamorphosed so profoundly that the hospital-based educational model is now severely threatened. Economic, technologic, and demographic pressures have created a patient mix on hospital medical services that is no longer representative of the general domain of internal medicine practice. Hospital patients are sicker, lengths of stay are shorter, procedures and critical care beds are more numerous, and management of many disease states has shifted exclusively to outpatient settings.

These changes have moved the focus of hospital-based training from Osler's intent of patient-centered diagnosis and teaching to the treatment of acutely ill in-patients. For such patients, history taking is highly disease- and physician-centered, employing an interviewing technique that is demonstrably counterproductive in the nonhospital care of patients. Other basic clinical abilities, such as interpersonal skills and competence in physical examination, selection of diagnostic tests, diagnostic problem solving, and ensuring continuity of care, also are underemphasized, while procedural skills and technology are correspondingly overemphasized.

Recent time-motion studies confirm that residents on medical services in hospitals actually spend little time in direct patient assessment. One study reported that in a 34-hour period, interns averaged only 5.6 hours at the bedside, with only 57 minutes of that time supervised by a resident or attending physician. In another study, interns and residents spent only 87 to 175 minutes of a 36-hour on-call period in direct patient assessment.

Four large surveys of practicing subspecialty and general internists suggest the consequence of this educational deficiency. The graduates of our training programs consistently report being well prepared in many in-patient procedural skills but ill prepared in the skills necessary for the practice of internal medicine. Among the skills most often named as underemphasized are the ability to deal with the psychosocial aspects of illness and the ability to perform the focused history and physical examination necessary for diagnostic assessment of the ambulatory patient.

How can this situation be remedied? Office-based precepting is unique in its provision of what J. O. Woolliscroft describes as the "educational intimacy" of one teacher,

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one learner, and one patient. Such intimacy, essential in maximizing patient-centered teaching, attending role modelling, and resident feedback and evaluation, has been lacking in traditional ambulatory training sites. Accordingly, a model for the educational activities of office-based precepting has been developed for the American College of Physicians' Community Office Residency Education Project. In the model, office-based precepting is defined as "the patient-centered teaching of house staff by an attending physician, who is the primary physician for the patients seen. Its central educational activities are attending role modelling and attending-resident interactions, focusing on clinical problem identification and clinical decision making." The model may be implemented in such settings as a general internal medicine teaching group practice, a community physician's private office, or a managed health care organization.

The model's design has multiple features to facilitate experiential learning. These include the intimacy of one teacher, one learner, and one patient; pre-session assessment of resident-specific goals for learning, with corresponding assignment of patients; frequent interactions between an attending physician and resident to refine basic clinical practice skills; and end-of-session feedback based on observable resident behaviors and chart review. Frequent occasions on which one teacher and one learner together encounter patients provide a richness of educational interactions not reproducible elsewhere.

In such encounters, patients with histories or physical findings that are hard to elicit, complex, or atypical present special challenges to the learning resident. The attending physician gives strong assistance by observing the resident's data-gathering and interpersonal skills, demonstrating advanced techniques, and offering feedback. The attending's commitment of time and attention to each patient introduces an element of humanism by highlighting for the resident the individuality and importance of each patient. All of the facilitating features are designed to encourage the resident to engage in self-directed learning and self-examination of his or her experience.

A number of reports describe the experiences of internal medicine residency training programs that have successfully introduced high quality office-based teaching. The first lesson is the obvious one that high quality teaching takes time. The question of cost is more complex. Several studies indicate that the actual cost to the practice depends on the professional development of the resident. In general, introducing an intern into practice results in a loss of revenue, whereas the introduction of a third-year resident results in a gain.

Most programs offer teaching credit for office-based precepting (just as they would for in-patient attending responsibilities). Malpractice insurance for residents is covered by the programs (as it would be for any recognized rotation). The factor mentioned most often by attending preceptors as having the biggest impact on the practice, aside from their own personal satisfaction and growth, is the cachet of the practice being seen by patients as a "teaching office." Residents report much greater frequencies of patient-centered attending-resident interactions, attending role modelling, and feedback and evaluation than those reported for traditional ambulatory clinics and for the general internal medicine teaching group practices developed in the early 1980s. They also note that the rotation is valuable because of its content and because it helps

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provide a balanced view of internal medicine and substantively influences career decisions.

Despite these and other supporting data, office-based precepting is an underutilized educational resource. The most recent report of the National Study of Internal Medicine Manpower reveals that the proportion of training time spent by residents in physicians' offices is only 0.6% in the first year, 1.9% in the second, and 3.1% in the third. There are compelling reasons to change this situation.

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