“What the Shadow Knows”

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In 2000, after an 8-year hiatus from clinical practice while I served as associate dean of the University of California, San Francisco Medical Education Program in Fresno, the Fresno Family Practice Residency program director offered to fund a portion of my time to join his behavioral science team, to do what is locally referred to as “shadowing.” “Shadows” spend one half day with each resident several times a year, performing one-on-one observations and giving feedback to the resident. This behavioral science activity implements sections of the curriculum on doctor-patient interaction, interviewing, ambulatory practice, the behavioral sciences, and will help teach and document core competencies. This paper shares some insights I have gathered from my 2 years in the role of shadow.

When shadowing, I arrive at clinic on time and introduce myself to the resident, nurses, and other attending faculty. I explain to the resident what I will be doing and ask to be introduced as someone who is “working with me today.” This avoids, “He is just following me,” “He is evaluating me,” or “They want to make sure I am doing a good job.” These toss-away comments demean the process and the resident.

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the e-mails because I have better perspective on what happened in patient encounters after a night’s sleep, and I also am more confident about which teaching points are most relevant. It is sometimes a challenge for me to decide which topics among many to discuss.

This is a portion of one of my e-mails:

Thank you for sharing your clinic with me on the above date. I enjoyed working with you. I share some general comments below followed by some patient-by-patient comments. This e-mail will go into your residency file; if you have any comments, questions, or corrections, please give me a call or e-mail me.

Dr X participated actively in the observation feedback session. She has been working on improving efficiency in the clinic. Dr X is a kind and committed family physician. She is not easily discouraged by the little frustrations that are a daily part of clinical practice. She is effective with staff and patients and pleasant with attending physicians. She is nondefensive about areas in which she is still learning.

Dr X handles introductions and structure of the clinic visit with ease. She encourages open communication with verbal and nonverbal cues. She clarifies and retraces ground in the interview effectively. She is warm and empathetic. Patients clearly respond to her interpersonal manner. She is generally thorough. She avoids jargon. She practices good hand hygiene. She protects patient modesty. She practices patient education.

Patient #1: Postpartum mother and infant with maternal grandmother. Question of retained products versus gonorrhea. Nice job relating to all in the room. (Patient’s mother was very outspoken about the fine job she felt Dr X had done in the delivery.)

Good introductions. Nice job explaining what your clinical considerations were. Good job with staff . . . tracking down old Pap smear results. You actually had to chase this family down in the parking lot to complete the visit! What excellent persistence! This patient will need HIV testing and counseling.

The responses to the presence of a family physician in the role of shadow have been most interesting. Early on, attending physicians were as nervous as the residents. This quickly passed. I make it clear that I am a learner and a teacher. I am always courteous to faculty and make it a point to give them appropriate, positive feedback. Nurses have been positive about the presence of another faculty member in the clinic setting, in part because I also give them feedback as well. In our settings, nursing assistants are frequently called on to translate for Spanish-speaking patients and nonbilingual residents. Only a few faculty, and no behavioral scientists, speak Spanish. I am able to speak and understand sufficient medical Spanish to understand and observe both interpreters and Spanish-speaking residents working with patients; this has been especially revealing.

After the first year of conducting these sessions, I was asked to write letters of recommendation and serve as a reference for residents. My notes were helpful to those evaluating residents for positions; they were especially interested in resident abilities to get along with nursing staff and colleagues, work as a team member, inspire patient confidence, relate to patients from multiple cultural backgrounds, and respond constructively to criticism.

I have made presentations of my observations, which I title “What the Shadow Knows and You Don’t,” referencing the 1950s radio show called “The Shadow,” to the attending physicians, nurses, and residents in our program. I am careful in these presentations to protect confidentiality. Audiences enjoy hearing about dedication, competency, commitment to good care, and other indicators of provision of good health care. Although it is not surprising that skill levels of physicians improve as they progress in training, this is a well-received observation. My presentations have provided rare opportunities to share an overview of the collected performances of our residents in ambulatory settings.

These points are some that have stimulated discussion:

• Resident physician behavior is shaped by size, equipment, and layout of the exam room. Doctors do not write in exam rooms with a small or absent desk and as a result have less face-to-face time with patients. Absence of reflex hammers in the exam room correlates with use of the head of the stethoscope as a percussive instrument. More residents and faculty than I would have expected listen to the heart and lungs through clothing.

• Residents may do unexpected and surprising things while interviewing patients. One resident chewed gum during visits. Another, a Vietnamese physician, had been taught that it is respectful to stand while interviewing a patient. Previously unknown to faculty, he stood throughout each of his visits.

• Residents can be bewildered or thrown off balance by the unusual. A new patient, accompanied by his wife, related to a resident that he had just been discharged from neurology clinic with a diagnosis of Huntington’s disease “because there was no treatment.” The resident response was to do a neurological exam (interrupted and redirected by the shadow).

• Residents may avoid commenting on the obvious or asking interesting questions. Noteworthy tattoos, deformities, clothing, jewelry, or facial expressions may not receive attention.
Residents underuse the problem-oriented medical record as a tool for patient education.

Residents can present only what they have seen or heard. A resident who had never seen a ruptured biceps tendon (old) did not describe it to his attending physician.

Second-language strengths and weaknesses are mostly unknown to attendings.

Hand washing and protection of patient modesty are variably done.

Untrained and/or volunteer interpreters can misinterpret; sometimes this is intentional.

Psychologists do not recognize some medical oversights or errors.

Physicians, or other health care workers, from different cultures are not necessarily skilled at cross-cultural medical practice.

Teaching is constrained by the “presentation” format. It is as hard for residents to present ambiguous clinical problems as it is for faculty to teach about them.

Clinical uncertainty elicits a “flight” to lab or X ray.

Nurses may recognize weak residents and performance issues before faculty does.

Observation and feedback are valuable to residents and to the training program. There is no better way of determining how residents behave in the exam room. In contrast to videotape reviews, residents can use synchronous observations to modify and improve their own repertoire of behaviors in real time. The unfolding of the patient’s narrative creates a shared experience unavailable to attendings not present in the room. The training and experiences I have had as a family physician, husband, and father all help me open up the richness of the ambulatory visit for younger and less-experienced residents. In-the-room interventions are not teaching options for faculty not present during the clinical encounter.

I recommend that faculty shadow residents for both teaching and pleasure and that they observe one another in their teaching activities too. I also suggest that residents observe one another and pick faculty members whom they respect and shadow them. Ambulatory practice comprises the majority of our graduates’ professional commitments; they deserve to be observed and taught the skills central to this area of medicine. Family physician observation of residents’ interviews of their patients is rewarding to residents, the residency program, and the shadow!

Acknowledgments: I thank Sean Shafer, MD, for his advice on this essay, John Zweifler, MD, for his support of this project, Gaines Thomas, MD, and the residents at the UCSF Fresno Family Practice Program for their participation and dedication, and Andrea Porter for her assistance in preparation of the manuscript.

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