

Letters to the Editor

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Editor, Letters to the Editor Section

Editor's Note: Send letters to the editor to karl.miller@erlanger.org or to my attention at *Family Medicine* Letters to the Editor Section, University of Tennessee, Chattanooga Unit, Department of Family Medicine, 1100 East Third Street, Chattanooga, TN 37402. 423-778-2957. Fax: 423-778-2959. Electronic submissions (e-mail or on disk) are preferred. We publish Letters to the Editor under three categories: "In Response" (letters in response to recently published articles), "New Research" (letters reporting original research), or "Comment" (comments from readers).

In Response

An "Uneventful" Pregnancy

To the Editor:

I was particularly interested in the "Lessons From Our Learners" article, "An 'Uneventful' Pregnancy," by Kalantari and Zamudio.¹ In my role as a "shadow," I teach family medicine residents in their clinics and frequently observe their interactions with Spanish-speaking monolingual patients.² Although we strongly recommend use of non-family member interpreters, I have on occasion observed encounters where one spouse interpreted for another and have seen several instances where problems resulted.³ In one case I observed, a bilingual husband controlled his wife's entire visit for low back pain, willfully misinterpreting her answers to obtain disability insurance. The patient was of course as oblivious as was the resident. Had I not been in the room observing, all parties would have reached an unwarranted diagnosis and response. The patient's facial expressions did not offer any helpful information in this case.

I was pleased to see that a home visit revealed a new depth of information to this woman's family

physician. I think that home visits and Kleenex are two of the most underappreciated tools in family medicine. To these I would add interpreters. I would like to ask Dr Kalantari how she ascertained on the first visit that her patient did not want an interpreter. Perhaps the husband had concerns that information about his wife's undocumented status might be shared and cause problems; this would not be an unusual concern.

Congratulations and thank you for writing this encounter up and sharing it.

*John Blossom, MD
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REFERENCES

1. Kalantari G, Zamudio A. An "uneventful" pregnancy. *Fam Med* 2006;38(10):700-1.
2. Blossom HJ. What the shadow knows. *Fam Med* 2003;35(10):742-4.
3. Blossom HJ. A physician's view on the role of interpreters. *California Healthcare Interpreting Association Newsletter* 2003;5(2).

Authors' Reply:

Dr Blossom's letter highlights important cautionary points when family members are used as interpreters, as was the case with Dr Kalantari using Louisa's husband, Rogelio, as an interpreter during their initial OB visit. In addition to family members intentional misinterpreting for the secondary

gains (ie, work disability and/or financial assistance) or for concern over undocumented residency status, my experience precepting domestic violence patients can often present with husbands insisting on interpreting to control and impede the information revealed in the medical visit.

To clarify Dr Blossom's question on how Dr Kalantari ascertained that her patient did not want an interpreter, Dr Kalantari directly offered to bring into the session a clinic interpreter, but Louisa declined and explicitly requested that her husband interpret. Dr Kalantari wanted to show respect for Rogelio's English capabilities, so she acquiesced. Dr Kalantari has some Spanish comprehension, which gave her added reassurance that Rogelio's interpreting was done with some accuracy. Follow-up OB visits included clinic interpreters especially when technical medical and laboratory results were reviewed.

Dr Blossom notes that the home visit, Kleenex, and the interpreter are the most "underappreciated tools" in family medicine. If we could add to this family medicine "tool chest," the family genogram as an instrument of helping to better listen to "what is often not said" of our patients regardless of where

the session is conducted and if an interpreter is needed. For it was the construction of Louisa's genogram during the home visit that revealed an X symbol (ie, signifying death) over her beloved brother-in-law's name that brought forth her unspoken grief and the need for Kleenex for the patient and her providers.

Thank you very much for your letter and excellent points.

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New Research

Faculty Development as a Strategy for Retaining Family Physicians in Academic Medicine

To the Editor:

Evidence over the past 3 decades suggests that insufficient training in research, scientific writing, cultural competency, and communication is strongly associated with the low retention rates of family physicians in academic medicine.¹⁻³ In this letter, we report on preliminary outcomes from a formative evaluation of a combined faculty development program designed to address these faculty needs^{3,4} at two US medical schools, one of them a historically black medical college.

Program Description

Using funding from a multi-institutional Bureau of Primary Health Care (BPHC) grant from the Health Resources and Services Administration, the two family medicine departments at the Charles R. Drew University of Medicine and Science (Drew) and the University of California, Los Angeles (UCLA) collectively established a combined faculty development program to address the recent decline in faculty promotion of family physicians. At the time of program inception in 2003, only five family physicians at UCLA were senior faculty (out

of approximately 18) and none at Drew (out of nine).

The Drew-UCLA Faculty Development Program (DFDP) was developed and implemented as a 3-year demonstration project comprising two program tracks (Track 1 and Track 2). Track 1 was a rotating 12-month series of workshops on medical education, patient-centered care, practice-based research, cultural competency, and skills for academic advancement (eg, scientific writing, grant writing). An interactive Web-based educational resource (WebCT) was implemented as an adjunctive tool for self learning and self-assessment. Speakers for the didactic workshops were drawn from a pool of senior faculty representing both primary care and specialty disciplines at both universities. Track 2 was designed to be a more-rigorous curriculum that involved quality mentorship of interested junior faculty by senior professors at Drew and UCLA.

The DFDP was structured and designed to include features known to be essential elements of outstanding faculty development: senior leadership and mentorship, ongoing input from relevant stakeholders, program emphasis on participative governance, effective communication and networking, and a built-in plan for evaluating program fidelity.^{2,4} The latter included a baseline faculty needs assessment (n=27) and focus group (n=10), an organizational readiness-to-change survey of clinical staff (n = 61), and periodic reviews of faculty activities at both institutions.

Results

The program achieved 80% of its first-, second-, and third-year objectives (eg, establishment of the Track 1 core workshops, good attendance of program activities, establishment of the WebCT as a self-learning tool). However, indicators of progress such as attainment of extramural funding, improved publication record, and number of academic promotions among eligible junior

faculty were equivocal. Analysis of the program data suggests that the lack of protected time and the growing demands on family physicians to provide clinical services contributed to lapses in the commitment by faculty interested in the Track 2 curriculum.

Comments

Like many faculty development programs in family medicine, the financial sustainability of our program is dependent on ongoing support from BPHC grants, with limited alternative sources. We encountered several institutional barriers that also limited the impact of our program on academic advancement of family physician faculty. Some of these barriers included a limited number of senior faculty with experience mentoring family physicians, a lack of protected time for junior faculty to pursue meaningful scholarly activities (eg, peer-reviewed publications or pursuit of a public health degree), and an academic rank that remains below other disciplines at each university. Targeted adjustments⁴ in the future, including identifying alternative funding sources and mentorship opportunities, may help improve the quality of our program, but advocating to university leadership to protect the time of junior faculty in family medicine will also be critical for increasing scholarly productivity—ultimately, the primary criterion for academic promotion.

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Acknowledgments: This project was supported by a grant from the Bureau of Primary Health Care, HRSA grant no. 1 D72C504179-01-00.

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