(8) Scholars workshop research ideas. We discussed and posted our various research projects or areas of interest so that interested residents could get involved during their required scholars’ workshop rotation.

So, what are you doing next Tuesday night? Pizza OK?
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Patient Ownership: Should Language Be a Barrier?

To the Editor:

There are two statements that the residents often make when presenting their cases to the preceptors during office hours. In fact, I almost had come to expect that they would begin their presentation by these two or at least one of these statements. The first is “This is not my patient” and the second is “This patient does not speak any English.” I have at times wondered if these statements affect the other faculty physicians in the same way as they affect me, and then there are times when I start questioning my own sensitivity in this regard. Do I overreact, or is it truly inappropriate for us as family physicians to state that the “patient is not ours” or to be biased by the fact that the patient may not be fluent in English?

I can only imagine that it is not just the residents and it is not just the family medicine residents who make these statements. Why do physicians often make these statements? Do they not want to take ownership? Do they want to blame the PCP (primary care physician) for the treatment plan? Do they think they can get away with not dealing with the acute problem and not address the other issues like psychosocial issues and other time-consuming problems if they simply deny that the patient belongs to them?

In recent months, however, some family medicine residents have pleasantly surprised me by saying “The patient’s PCP had started him on . . .” rather than stating “This is not my patient,” which makes it clear that although the patient has another physician as his/her PCP, the resident seeing him/her today is still taking ownership of the patient. It gives me the immediate feeling that the group of physicians works together as a team and although the patient has an assigned PCP for continuity of care, the entire group works cohesively to provide quality care to the patient.

As family physicians who are responsible for the teaching of medical students and residents, it is important that we role model this behavior and also instill in our learners the sense of ownership of the patients. In fact, they should be made aware of the fact that in this age of growing multi-physician practices, they will be cross-covering their associates. Therefore, it will be beneficial to them to regard every patient as one belonging to the practice and therefore to all the physicians.

As for the second statement, “The patient does not speak any English,” my question to the resident or the medical student often is: “Why are you conveying this information to me? Did you use the language line or the translator? If so, it would suffice to say ‘I used the Spanish language line/interpreter for this patient.’” Somehow, the statement “This patient does not speak English” immediately implies that the physician has a negative impression of the patient. Even if patients do not speak the English language, they have similar complaints and similar diagnoses and therefore deserve similar work-up and treatment as any other patient. It is true that sometimes the statement about patients’ lack of knowledge is presented first and foremost to caution regarding any possible misinterpretation of history/chief complaints, etc, secondary to language barrier. However, in this day and age, it is expected that a large patient population in many or all practices may speak a language other than English and, therefore, physicians should start developing ways in their practices to assist them in taking care of these patients rather than getting frustrated at the inability of the patient to speak a common language.

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New Research

Faculty Academic Boot Camp

To the Editor:

Family physicians transitioning into faculty positions from residency training, fellowships, private practice, and elsewhere often lack academic skills training, familiarity with academic environments, career planning goals, and peer support. Lack of these attributes may adversely impact faculty satisfaction, career progression, and retention. Faculty satisfaction and retention are important, not least because the cost of recruiting and training a primary care faculty member may exceed $200,000.

We present a brief, intense faculty development model that successfully oriented three new faculty in a US academic department of family medicine. From September to November 2006, three physicians transitioning from residency, private practice, and the military participated in a 3-month “Academic Boot Camp” aimed at fostering faculty success, satisfaction, retention, and advancement.

Methods

In their first month as faculty, participants completed an academic needs assessment concerning their teaching, research/scholarship,
and administrative skills. Over 3 months, senior medical school faculty conducted 24 biweekly skills-based sessions targeted at participants’ self-reported educational, research, and career needs. Sessions lasted 45–90 minutes. Administrative topics included Departmental Mission and Vision, University Travel and Reimbursement, Time Management, Running Meetings, an Overview of the Medical School Curriculum and Teaching Opportunities, and an orientation to the university’s promotion and tenure process. Teaching skills topics included Preparing and Giving Lectures, Teaching and Learning Theory, Small- and Large-group Teaching, Dealing With Problem Learners, and sessions on aspects of clinical teaching, including evaluation. Academic/scholarly skills sessions included Searching the Literature, Essentials of Scientific Writing, Writing a Conference Abstract, Writing a Family Physicians Inquiries Network (FPIN) Article, and Creating a Curriculum. Career development topics included Starting an Academic CV and Educator’s Portfolio and the Role of National Organizations and Meetings. In addition, participants identified a focus area for their future scholarly activity, and all acquired local and national mentors in that field.

Between sessions, participants completed exercises and conducted peer coaching in clinical teaching and academic skills. Participants knew at the time of recruitment that they would experience this academic orientation. They had protected time to complete all activities and, because they were building new clinical practices, patient care duties were not yet overwhelming.

**Results**

Within 6 months, the three participants formed a peer support group, acquired academic skills, and gained familiarity with the university environment. To date, they have delivered more than 20 peer-reviewed lectures, published three manuscripts (with three more under review), submitted three successful national abstracts and one international conference abstract, compiled their academic portfolios/CVs, and identified local and national mentors in their areas of scholarly focus. Two have adopted administrative responsibilities, and the third has undertaken a Master’s in Public Health degree and been named Co-I on an National Institutes of Health-funded research study (RO1). All express high career satisfaction. We estimate the costs in senior faculty time in preparing and delivering the sessions at around $5,000.

**Discussion**

Our brief intense immersion program provided new faculty with a structured orientation, career guidance, and early academic success. Since participants were in the early stages of building their practices, the department suffered minimal loss of clinical income. We do not yet know if this early confidence and success will positively impact participants’ long-term career satisfaction, academic advancement, and retention. However, the Academic Boot Camp was practical, enjoyable, and productive. We recommend our brief immersion model to other institutions transitioning faculty into academics and will submit the teaching materials to the Family Medicine Digital Resources Library (FMDRL) for general use.

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**Reference**