

other US schools. Requisite knowledge for working effectively with interpreters can be improved with this brief intervention. However, the Web module, even when added to practice in a standardized setting, is inadequate for improving skills. A more comprehensive and intensive approach may be needed that requires greater and more diverse curricular investment.

Désirée Lie, MD, MSEd

*Department of Family Medicine
University of California, Irvine*

Sylvia Bereknyei, MS

*Department of Medicine
Stanford University*

Adina Kalet, MD, MPH

*Department of Medicine
New York University*

Clarence Braddock III, MD, MPH

*Medical Education
Stanford University*

Corresponding Author: Address correspondence to Dr Lie, University of California, Irvine, Department of Family Medicine, 101 The City Drive South, Bldg 200, Suite 512, Orange, CA 92868. 714-456-5171. Fax: 714-456-7984. dalie@uci.edu.

REFERENCES

1. Karliner LS, Perez-Stable EJ, Gildengorin G. The language divide. The importance of training in the use of interpreters for outpatient practice. *J Gen Intern Med* 2004;19:175-83.
2. Lee KC, Winickoff JP, Kim MK, et al. Resident physicians' use of professional and nonprofessional interpreters: a national survey. *JAMA* 2006;296(9):1050-3.
3. Kalet AL, Mukherjee D, Felix K, et al. Can a Web-based curriculum improve students' knowledge of, and attitudes about, the interpreted medical interview? *J Gen Intern Med* 2005;20(10):929-34.
4. NYU School of Medicine. Working with interpreters module. <http://edinfo.med.nyu.edu/interpreter/>. Accessed December 11, 2008.
5. Boker J, Bereknyei S, Ahearn CS, Fesko C, Lenahan PM. Validating measures of third-year medical students' use of interpreters by standardized patients (SP) and faculty observers. *J Gen Intern Med* 2007;22(suppl 2):336-40.

Implementation of Handheld Procedure Tracking in a Family Medicine Residency

To the Editor:

Evaluation of procedural skills is a challenging aspect of training in family medicine. Using a personal

digital assistant (PDA) to track procedures could benefit family medicine residents if it contributes to evaluation of learning objectives. A dossier of logged procedures could help to identify gaps in training if procedures logged by residents were compared against a core procedure list. In Canada, a core procedure list has been defined as those procedures that family medicine residents should learn and be capable of performing following residency.¹

During a study of a PDA-assisted evidence-based medicine course, we implemented an electronic procedure tracking system. In 2003, all 44 incoming first-year McGill family medicine residents at four training sites were invited to participate and were offered a new PDA along with software training. All residents attended at least one training session to learn about Praxis procedure tracking software, version 2.5. Following this session, residents were asked to begin logging procedures and were told they would not be evaluated on the basis of their logged procedures. Midway through the project (April 2004), midterm reports were distributed to each resident, for feedback on the number of procedures they had logged in comparison to their peers.

Of 44 eligible first-year residents in July 2003, 37 consented and received a Dell Axim X5 PDA. From 2003–2005, four consenting residents withdrew from the project, four others went on maternity leave, and three went on leave of absence. By July 1, 2005, 5,428 procedures were documented, with a mean of 148 (range=6–746) per resident. Three hundred or more procedures were logged each month during the first 7 months of the study, with the highest number (n=640) in September 2003. There was a substantial decrease in number of procedures logged by January 2004 (n=360). The highest number of procedures logged throughout all clinical rota-

tions was reported in OB-GYN and family medicine, and the lowest was in surgery.

Our results indicate computerized procedure tracking is feasible in family medicine residency. The handheld procedure tracking system permitted collection of a large procedural dataset. From July–October 2003, we observed a novelty effect as reflected in a large number of procedures logged per month. However, beginning in January 2004, there was a substantial decrease in usage of Praxis software. This observed decrease in the number of logged procedures was likely related to low motivation, a problem that could be confirmed by interviews in future research. In addition, procedures such as venipuncture may have been considered so routine they were not logged. We do not know if the number of logged procedures was related to low motivation or a low number of procedures performed. Increasing resident usage of any procedure tracking system would likely result from integrating the findings of tracking in formative and summative evaluation. This would help to “close the feedback loop,” whereby data entered should provide residents with relevant feedback, thus encouraging further software use. However, procedure tracking is not sustainable when it is optional. Assuming preceptors guide residents to reflect on gaps in their training using a dossier of logged procedures, a mandatory system for procedure tracking should be implemented.

Navya Mohan Mysore

*Faculty of Medicine
McGill University*

*Roland Grad, MDCM, MSc
McGill University*

David Topps, MD

*Northern Ontario School of Medicine
Sudbury, Ontario*

Doug Hall, MSc

*Undergraduate Medical Education
University of Calgary*

Corresponding Author: Address correspondence to Dr Grad, McGill University, Herzl Family Practice Centre, 3755 Cote Ste Catherine Road, Montreal, Quebec H3T 1E2. 514-340-8222 ext. 5851. Fax: 514-340-8300. roland.grad@mcgill.ca.

REFERENCE

1. Wetmore SJ, Rivet C, Tepper J, Tatemichi S, Donoff M, Rainsberry P. Defining core procedure skills for Canadian family medicine training. *Can Fam Physician* 2005; 51:1364-5.

Comment

“Going Home” Strikes a Chord

To the Editor:

A recent heartfelt essay written by Seehusen, titled “Going Home”¹ resonated with me. Our connection to our past is an important issue to recognize among first-generation medical professionals and medical professionals at large. After hearing my classmates’ experiences over the holidays, I often feel like I am the only one in this unique situation—many of my classmates have a parent or two who are physicians, and it seems all of them have parents who have received higher education.

I differ from many of them because I grew up in a small town—technically speaking it is a village due to its size and governance—it has no stop lights or fast food, and the largest employer in town is the public school, K-12 in one building. It’s a farming community, and consequently I grew up watching milk

prices and working at an implement dealership for seven summers. My folks and family knew I would never be able to stay, and most of my older siblings encouraged me to move away when I got the chance. So when the time came to leave and go to college, despite my folks having never left their small village—except for a brief period when my father was in the army—I did. My mom told me, with tears in her eyes, the day I left for school, “I knew this day would come, and I will never hold you back.”

I worked hard in college, believing I had a special opportunity because I was able “to leave.” I encountered a tremendous growth in experience, knowledge, and wisdom and made good grades, being a well rounded small-town guy. I was fortunate enough to get into medical school knowing full well my family was proud of my accomplishments. Yet in all of the wonderful and grueling experiences I have had thus far—the remarkable personal and academic growth—I too find that these wonderful things have caused an impasse between my family and me. I want so badly to share my victories with them and equally often share my grievances. Yet the explanation necessary to appreciate the situation is often the limiting factor. I have had innumerable conversations with my wife discussing the exact same issues that Dr Seehusen discussed in his essay. The typical conversations I have with my father

are about the weather, the tractors, the farm, or work (ie, selling farm machinery)—the resemblance of my situation and Dr Seehusen’s is uncanny.

I think this predicament is common for first-generation professionals. It should be discussed more often in medical school curricula before one finds themselves in a situation wondering why he or she can no longer relate to family members despite having wonderful and meaningful interactions with patients behind the façade of being a great physician. I feel it is important to keep my small-town roots viable since they shape who I am and the interactions I have with patients in a positive manner. I keep a copy of Dr Seehusen’s essay in my white coat on the wards as a reminder to follow the “milk prices.” I have even had the opportunity to discuss with several patients, who probably assumed the medical team could never relate to their lives, about custom field work and the future of the small family dairy farmer. Being able to nurture this side of my interpersonal communication skill set keeps me close to my family and narrows the chasm when I come home and share these stories and topics in conversation.

Zachary J. Baeseman
University of Wisconsin

REFERENCE

1. Seehusen DA. Going home. *Fam Med* 2008;40(10):700-1.