

Discussion

The role of pharmaceutical support in medical education has come under increased scrutiny in the past several years.² Despite the often ubiquitous presence of pharmaceutical representatives in many hospitals, residents feel they are immune to the influence of pharmaceutical detailing on actual prescribing habits.³ Our pilot work argues differently and adds several other important findings to this body of literature. First, it suggests that physicians are more likely to preferentially use trade names when prescribing common medications as they progress through training. This preferential use of trade names provides a subtle element of complimentary corporate “advertising” within the clinical environment. The fact that this trend only increases with clinical experience is concerning. Our respondents were also largely unaware of the cost of the medications they most commonly prescribe.

Our findings highlight the need for ongoing physician education to eliminate pharmaceutical bias. While a small sample size and federal physician status limit the generalizability of our findings, our results suggest an important semantic bias in the use of common primary care medications, one that worsens over time.

Mark B. Stephens, MD, MS

Uniformed Services University
of the Health Sciences

Amelita Maslach, MD

Malcolm Grow Medical Center
Andrews AFB, Md

Marc Childress, MD

Uniformed Services University
Bethesda, Md

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Correspondence: Address correspondence to Dr Stephens, CDR MC USN, Uniformed Services University of the Health Sciences, Department of Family Medicine, 4301 Jones Bridge Road, Bethesda, MD 20814-4799. 301.295.3632. Fax: 301-295-3100. mstephens@usuhs.mil.

REFERENCES

1. Steinman MA, Shlipak MG, McPhee SJ. Of principles and pens: attitudes and practices of medicine housestaff toward pharmaceutical industry promotions. *Am J Med* 2001;110:551-7.
2. Montague BT, Fortin AH, Rosenbaum J. A systematic review of curricula on relationships between residents and the pharmaceutical industry. *Med Educ* 2008;42:301-8.
3. Adair RF, Holmgren LR. Do drug samples influence resident prescribing behavior? A randomized trial. *Am J Med* 2005;118(8):881-4.

Attitude Change Following a Homeless Clinic Experience

To the Editor:

It has been proposed that the care of medically underserved patients is more likely to fall to primary care physicians than to specialty care physicians.¹ More family physicians are needed, and engaging physicians in work with the underserved can be difficult.

The Family Medicine Residency program at West Virginia University initiated a multidisciplinary Homeless Care Clinic in April 2006. Family medicine residents and faculty, as well as psychology, nursing, and social work trainees, were involved in comprehensive patient-centered assessment and treatment. Second-year family medicine residents spent three to four afternoons in the Homeless Care Clinic, totaling 16 to 20 hours of service. Residents also had the opportunity to participate in a Street Rounds program mentored by a family physician faculty member.

Residents completed two measures before and after the Homeless Care Clinic experience: the Attitudes Toward Homelessness Inventory (ATHI)² and the Health Professionals' Attitudes Toward the Homeless Inventory (HPATHI).³ Higher scores on the ATHI and HPATHI indicated more positive attitudes toward homelessness.

Demographic information was collected on each patient, along with type of care received. Since

initiation of the clinic, there have been a total of 552 encounters with 210 different patients. Patient ages ranged from 18 to 69, with male patients comprising 77% of the patient population. About 50% of the patients lived at the local homeless shelter, while 10% slept on the streets at the time of their visit. More than half of the patients demonstrated symptoms of serious mental illness. Clinicians estimated that patients in 13% of visits had such significant health problems that they were at risk for death. Family medicine residents participated in 93 visits, along with nursing students (seven visits), social work students (75 visits), and doctoral students in psychology (152 visits).

Following the clinic experience, responses on the HPATHI to the statement “Homelessness is a major problem in our society” reflected a statistically significant increase, along with responses to the statement “I feel comfortable being part of a team when providing care to the homeless.” It is notable that none of the 27 items on the ATHI demonstrated a significant change, and that only two of the 23 items on the HPATHI demonstrated a significant change. Out of the 27 items on the ATHI, responses post-clinic experience increased on 15 items, decreased on 11 items, and stayed the same on two items. Out of the 23 items on the HPATHI, responses post-clinic experience increased on 10 items, decreased on 11 items, and stayed the same on two items.

It is puzzling why attitude change was not more positive, since other residency programs with a homeless clinic experience have noted attitude improvement, as measured by the ATHI, following a 2-week intervention.^{4,5} In the cited curriculum, the training intervention was multifaceted. Residents were asked to participate in lectures, see homeless patients in a variety of settings beyond the clinic, par-

ticipate in journaling, and follow individuals who were advocates for homeless individuals. It is possible that including residents in a clinic experience without the additional experiences may have fostered less positive attitude change, since the patients were often complex and lacked adherence with medical regimens. Attitudes might change more noticeably in the positive direction if we expanded the clinic experience to include more didactics and personal experiences with the homeless population. Nonetheless, we believe that a homeless clinic experience is an important addition to a primary care residency to enhance health care advocacy efforts and volunteerism. We encourage other residencies to develop such experiences and share efforts at measuring learning outcomes.

Erin L. Woodhead, MS

Jeannie A. Sperry, PhD

Emily H. Bower, MS

Karen M. Fitzpatrick, MD

West Virginia University

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The Institutional Review Board of West Virginia University approved the research presented in this paper.

Corresponding Author: Address correspondence to Dr Sperry, West Virginia University, Department of Family Medicine, PO Box 9152, Morgantown, WV 26506-9152. 304-598-6900. Fax: 304-598-6905. sperryj@wvu.com.

REFERENCES

1. Forrest CB. Strengthening primary care to bolster the health care safety net. *JAMA* 2006;295(9):1062-4.
2. Kingree JB, Daves WF. Preliminary validation of the attitudes toward homelessness inventory. *J Community Psychol* 1997; 25(3):265-88.
3. Buck DS, Monteiro FM, Kneuper S, et al. Design and validation of the health professionals' attitudes toward the homeless inventory. *BMC Med Educ* 2005;5(1):2.
4. Buchanan D, Rohr L, Kehoe L, Glick SB, Jain S. Changing attitudes toward homeless people: a curriculum evaluation. *J Gen Intern Med* 2004;19(2):566-8.

5. Buchanan D, Rohr L, Stevak L, Sai T. Documenting attitude changes toward homeless people: comparing two standardized surveys. *Med Educ* 2007;41:346-8.

Comment

Dealing With Loss in the Journey of Mentoring

To the Editor:

Pamela, a first-year resident, presented a case to me (ASW) as part of a reflective learning session. Cases are selected by residents sometime after regular staffing. These sessions are designed for the residents to think about, reflect, and discuss with the mentor their emotional experiences during the patient encounter in order to utilize them in a more mindful manner in patient-centered care. She presented a young woman who had a miscarriage about a month ago and she was seeing her for an acute care appointment.

Pamela related that she was troubled by this woman's loss but gave reassurance that this feeling did not interfere with her workup or care. I asked her to tell me about her interview, her workup, and how she detailed the experience of the management plan. Reviewing the whole encounter gave her the opportunity to think about and reflect on the situation in a deeper way than a more-routine preceptor encounter.

Pamela indicated that she had assessed the patient's coping with the miscarriage, including using the Beck Depression Scale, and discussed both the woman's support system and her partner's ongoing adaptation to the loss.

When I asked Pamela if she would share what it was like for her to see this woman, she became teary eyed. She told me that as a student, she saw a woman who lost a baby at birth, and her advisor told her then that the sadness she felt was unnecessary. "Pamela, this is not your pain. It is the patient's loss and the patient's pain, not yours!"

She then said that she has continued to struggle, often unsuccessfully, with her own sense of loss and pain as her patients who suffer with loss and pain. She wondered if she was meant to be a physician if she had such problems with her own feelings and emotional responses.

As faculty and medical educators, we frequently miss helping a troubled learner. The desire to be helpful, understanding, and wise is a commendable and expected value. However, this miss begins with the perception that the learner is "troubled" and the response is to offer "help." Assumptions are made and the resulting conversation can interfere in a learner's ability to cope successfully with the emotional trials of being a physician. The ability to cope in medicine may be about many things, but certainly it is about seeking balance, focus, and "sense making" to one's experiences. The medical student advisor meant well but in reality hampered the coping strategies of this learner. It truly was Pamela's pain. It was her emotional response to a patient's loss; they traveled the same road of experience. Trying to make people deny their human responses to others is not only inappropriate, it is confusing and can lead to the questions Pamela posed about her ability to be a competent and effective physician.

There is yet no closure to this situation with Pamela. I asked her to reflect on why the advisor's words meant so much to her, had such an influential impact on her thoughts and self concept, and why she hasn't made an effort to struggle with what was said. Pamela's answers came out as I expected. Earlier school experiences outside of medicine in which she was "called out for sharing the pain and loss of others" had found a new credibility in her training.

Pamela and I created an action plan. Pamela was instructed to use guided imagery to place these earlier messages into a box and close