Innovations in Family Medicine Education

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Editor’s Note: Send submissions to jfreeman3@kumc.edu. Articles should be between 500–1,000 words and clearly and concisely present the goal of the program, the design of the intervention and evaluation plan, the description of the program as implemented, results of evaluation, and conclusion. Each submission should be accompanied by a 100-word abstract. Please limit tables or figures to one each. You can also contact me at Department of Family Medicine, KUMC, Room 1130A Delp, Mail Code 4010, 3901 Rainbow Boulevard, Kansas City, KS 66160. 913-588-1944. Fax: 913-588-2496.

Your Life on Film: Teaching Continuity to Residents Through PowerPoint and Videotaped Interviews

Karen Gershman, MD; James L. Glazer, MD

Residents often lack the context they need to care for challenging patients. We developed a curriculum using videotapes of patient visits to teach (1) knowing the patient’s context, (2) time: the key to trust, (3) reciprocity in the patient-doctor relationship, and (4) overcoming resistance to care. This teaching was most effective when the patient was interviewed by his/her own resident physician, when a particular patient was shown over time, and when contrasting different methods of dealing with behaviors common to two patients was demonstrated. Residents rated conferences in the “excellent” range and demonstrated a deeper appreciation of the elements of continuity.

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Case Report

Helen wasn’t the kind of patient physicians warned to right away. Her reputation preceded her, and most residents were reluctant to assume her care. Helen was complicated both medically and emotionally. Although she was only in her 40s, she looked 60. Her body was ravaged by lupus that had led to her obesity, renal failure, and cardiac failure. Her chart was formidable, ballasted by notes attesting to a life spent in hospitals and doctors’ offices. Its tattered cover read “Chart 6 of 6.” In 2 more months she surely would have generated chart number 7.

Helen’s mistrust of doctors seemed to match the size of her medical record. Residents, in particular, drew a special kind of ire from her. She was obstinate and extremely critical of them. During one interview, she quipped that she chose to stay in a residency practice where her doctor changed every 3 years because “I like rubbing residents’ noses in their mistakes.”

Introduction

Residents frequently struggle to master the difficult interactions they face each day in the office. They are often perplexed at the response they get when they complain to their mentors. Many find that faculty do not share their frustrations but instead seem to revel in those kinds of patients. The same interactions that are a toxic astringent to residents represent a flavorful spice to faculty members. What accounts for this difference?

When assuming the care of challenging patients, it is sometimes difficult for residents to keep their actions in perspective. The insights gained from accompanying a patient across the years can help physicians understand them better and make us a meaningful part of their lives.
Studies have demonstrated that continuity experiences are lacking in traditional residency curricula; despite the fact that many medical schools have adopted the model. Part of this deficiency stems from the fact that studies have failed to show improvements in continuity of care among residency programs using longitudinal tracks.7

Teaching continuity in a residency program involves much more than encouraging simple follow-up. Three years is often not long enough to experience major life events such as a birth, a marriage, or a death with one patient. When we can share such markers of time with them, we may come to be counted among their close sources of support.8 Other educational systems have been much more successful in teaching continuity through a dedicated curriculum spanning 6 years.8 But, how can we expose residents to shared memories in our residencies over only 3 years? We have found that filmed interviews of patients over time provide residents with the context they lack, especially when these interviews include someReminiscence perspectives offered by the patient and clinician.

Methods

We developed a curriculum to complement the residency’s traditional approach involving follow-up and encouraging stable resident-patient bonding. Residents attended sessions dedicated to discussing continuity as a concept. They viewed videotaped interviews of routine patient visits as well as special interviews set up with willing patients, presented on PowerPoint to learn specific principles of continuity of care. We compiled segments of patient interviews over several years and extracted salient moments from them. Clips were integrated into a PowerPoint presentation to support an overall theme. The series of lectures gives residents a sense of their patients’ histories and an understanding of the subtle changes they undergo over years of life. Continuity topics included (1) knowing the patient’s context, (2) time: the key to trust, (3) reciprocity in the patient-doctor relationship, and (4) overcoming resistance to care.

Results

Resident response to this series of lectures has been very positive. Residents consistently rate conferences in the excellent range (4 to 5 out of 5). They commented particularly on the insights they gained after comparing an earlier interview of a patient with progressive dementia with one recorded more re-

Table 1

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<tr>
<th>Question</th>
<th>Pretest</th>
<th>Posttest</th>
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<td>• What does continuity mean to you?</td>
<td>• Ability to diagnose problems over long term; consistent follow-up by a group of health care workers</td>
<td>• Understanding patients’ motivations happens with continuity.</td>
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<tr>
<td>• What would help you be empathic with a difficult patient?</td>
<td>• Telling me about the patient • Model the behavior with the patient</td>
<td>• “Showing me a film over their lifetime brings out my emotions.”</td>
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Themes:
1. Continuity involves knowing patient’s context (95% of residents indicated context was important).
   • “A sense of the person, not the disease is important.”
   • “Learning about a patient’s past is key.”
   • “Understanding patients’ motivations happens with continuity.”
   • “We can help people in other ways besides just providing medical care when we provide continuity”

2. Trust depends on continuity over time (90% of residents indicated that relationships with patients depend on continuity over time)
   • “Can have continuity with a new patient by having time to explore their past.”
   • “Having time to listen with one’s heart is key to building a long-term relationship with patients.”

3. Continuity involves reciprocity between patient and physician (70% of residents mentioned themes of reciprocity).
   • “Physicians can gain insights from patients about the human condition.”
   • “I may walk the walk eventually.”
   • “It’s important to see how patients see us.”

4. Issues of compliance are aided by continuity (70% of residents mentioned this theme).
   • “Some patients are not too thrilled with me either.”
   • “It’s important to give patients more choice.”
   • “I could do better at listening to what the patient is really asking.”
cently. The technology allowed them to recognize what their brief experience could not: that this patient still possessed a complex personality despite the advancing cloak of her dementia.

Videotaped interviews on PowerPoint also gave teachers an opportunity to address themes of “annoying” patients. We found that our conferences generate insightful comments. One resident remarked tellingly, “I don’t mind taking care of my own crazy patients; it’s the other resident’s crazy patients I don’t like taking care of.” Subsequent discussion led to an appreciation of the fact that continuity leads to familiarity, which in turn fosters feelings of ownership, connection, and commitment to our patients (Table 1).

Discussion

The success of these modules hinges on several key components. Challenging patients make the most helpful subjects. They capture residents’ interest, and they frequently raise familiar issues.

We found that teaching is most effective if patients are interviewed by their resident providers rather than faculty. Past resident providers become part of their patient’s story. Residents viewing these interviews gain a sense that they are a part of a family of doctors that together provides care of a patient over his/her lifetime. It also instills in them a feeling of generativity. They learn that in time they too will pass on their patients to other residents.

PowerPoint is crucial to the effective presentation of videotaped material. Conferences are planned to involve a unifying theme such as patient conflicts or noncompliance, and interview clips must be kept consistent with that theme. Whenever possible we have presented contrasting approaches to similar challenges so that residents may appreciate differing styles of interaction. Music may be integrated into presentations to set a specific mood. Clips showing the same patient over different life stages, or in good and poor health, are particularly effective in communicating continuity messages.

Helen agreed to be interviewed for our program. She described hardships she had overcome in her life and offered insights regarding her own stubbornness. She laughed at herself for being such a “crabby” patient. Among the residents empathetically watching the interview presentation was Helen’s new physician, a resident who had just arrived at the program. She cited this early film introduction as the seed for her strong relationship with Helen, whom she saw in clinic every week through her residency. Early one Sunday morning 3 years later that same resident journeyed 1 hour south to a tertiary care medical center so that she could be at Helen’s bedside when she died.

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References