Teaching in the Office

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Like all of medicine, the practice of gastroenterology has transitioned from a predominantly inpatient to an outpatient specialty, and so has a good deal of student, resident, and fellow teaching. Moreover, even the inpatient service has seen a marked compression of time for teaching, which could once be carried out in a leisurely fashion but now requires nearly surgical precision to accomplish. The pressures to begin the discharge process as soon as a patient is admitted, the growing bureaucratic requirement for documentation and charting, resident and student duty-hour limitations, and ever-shortening lengths of stay—coupled with the trend to admit only the most acutely ill patients (many of whom may not be able to provide a history themselves)—have altered the way medicine is taught and by whom. Hospitalists have supplanted other generalists and subspecialists as the principal inpatient teachers, and even they need to “teach on the run.”

Ironically, the changes on the inpatient service have fostered the need for more teaching in the clinic, which used to be considered more challenging than the inpatient setting for teaching due to the brief and episodic nature of outpatient visits combined with the growing emphasis placed on the volume of visits, efficiency, and compliance with ever-increasing documentation requirements [1, 2]. Nevertheless,

patients seen in an office generally can give a history and often have fresh complaints that require evaluation, diagnosis, and treatment or have a chronic disease with which a student or resident may not be familiar.

One of my career missions as a clinician educator has been to teach young colleagues how to be a doctor—how to engage patients, obtain an accurate and useful history, perform a competent and relevant physical examination, conduct necessary but not excessive diagnostic testing, formulate a management approach, connect with the patient as a person, and inspire adherence to the diagnostic and treatment plan. This is a tall order, but in an age of increasingly fragmented care, reliance on technology for diagnosis, patient dissatisfaction with physicians and with the medical system, and a medical knowledge base that is so seemingly limitless that no physician, let alone a novice, can hope to master it, I am convinced that the most important lessons I can impart to my young associates are the skills and attributes of an effective clinician [3].

For over 30 years, I have encouraged students and senior residents rotating on either the medical service or gastroenterology service to join me once a week in my office. I always use the term “office” rather than “clinic,” which has a somewhat pejorative connotation, to describe my private practice. I neither adjust my schedule to accommodate a student or resident nor alter the durations of visits or number of patients that I see. New patients are scheduled for 45 min and follow-up visits for 15 min. Before the session, I review the expectations of the session. Medical students evaluate one new patient and then present the case to me for discussion, whereas residents generally observe (“shadow”) me when I evaluate new patients, since observing an experienced subspecialist is particularly useful to postgraduate trainees. Students and residents both observe my care of follow-up patients.

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I instruct a student to spend 25 min with a new patient, take a fairly complete history, examine the patient as completely as possible, save for the neurologic examination. Having reviewed any available records prior to the visit, I share the highlights with the student, emphasizing key points ahead of time. When we introduce ourselves to the patient, I explain that the medical student is working with me, has reviewed some of the background information, and will see and examine the patient first. I further explain that since two minds are better than one, we will endeavor to understand the patient's concerns as completely as possible. I have rarely if ever had a patient decline the involvement of a student. While the student is evaluating the patient (usually in the examination room), I return to my office to catch up on documentation and, if possible, see a follow-up patient or two, to stay on schedule.

When the student emerges, I suggest that he or she have the patient dress while we discuss the case briefly. I do not ask for a formal presentation at this time but rather inquire of the student as to the essence of the problem and the top two or three diagnostic impressions. When the patient rejoins us in the office, I have the student, seated next to me and, like me, facing the patient, present the case. I prefer that the patient listen to the student's presentation for two reasons: (1) to ensure that the information is accurate (many patients interject clarifications during the presentation) and (2) to make it appear as if I too had obtained the history from the patient. This technique enables me to bond with the patient on the first visit, even though I myself did not actually take the history. While the student is presenting the case, I take notes, and afterward, I ask the patient questions to clarify the history. I then ask the patient (with the student) to step back into the examination room briefly so that I can check one or two principal findings. I do this in part to have an opportunity for "laying on of the hands."

We return to the office to discuss our impressions. Depending on the complexity of the case and the student's apparent understanding, I generally ask the student to provide his or her initial impression. Using the student's impression as a starting point, I then give my opinion to the patient while involving the student in the discussion. I initially indicate the elements of the student's impression with which I agree, adding my further, more detailed assessment. Students are naturally intimidated by having to commit themselves in front of a patient, but I try to relieve their anxiety quickly by taking over the discussion and validating information the student has provided. Once we come up with a plan and escort the patient to the front desk, the student and I debrief further. I provide feedback by identifying one or two points I liked about the student's evaluation and at least one opportunity for improvement. I

then dictate the consultation note in front of the student. In this way, while the student hears how I put the case together, he or she receives a mini-lecture on my assessment, basis for my primary diagnosis, and treatment plan, as I essentially think out loud. By dictating the note myself, I ensure that my documentation is sufficient for future patient visits. This approach, by absolving the student of the burden of writing a note, is appreciated by students and contributes to a positive learning environment.

My principal office teaching method is modeling. Since it is important for students and residents to observe an experienced clinician, I particularly want to demonstrate how to "connect" with a patient despite time constraints and documentation and teaching requirements. It is most important, particularly at the initial consultation, to listen to the patient's story. I never interrupt a patient's opening statement, pointing out the importance of listening to my young observers. As has been widely cited, if uninterrupted, the patient will generally speak for 150 s (in contrast to the average of 16 s until the first interruption by a physician) [4], a small investment of time to begin to elicit a patient's trust and confidence. I also initially try to ask open-ended questions and follow the patient's lead, even if elements of the history are obtained in a seemingly random fashion. Over the course of history taking, gaps can be filled in. Paradoxically, when a patient is given the opportunity to unburden him or herself, the history is more complete, making subsequent visits more efficient.

I nearly always examine a patient myself, even if only briefly and in settings where I am certain that the physical examination will be unrevealing, as in the follow-up of early-stage hepatitis C. I believe in the therapeutic power of touch, as has been described in the literature, and I want to be sure to demonstrate proper hand hygiene to my observers. Occasionally, of course, unexpected findings are discovered.

Since teaching gastroenterology is an important goal, for each patient encountered, I try to make one or two key points. For more complex situations, I may refer a resident to a paper or chapter that I have written. Having published across the spectrum of the field, I am able to extend my teaching reach with little expenditure of extra time during a busy practice session. I often ask medical students to look something up, particularly when they ask a specific question that can be readily answered by an appropriate search of online sources. Although endoscopy is central to the practice of gastroenterology, I am careful to teach young colleagues that acquisition of the excellent clinical skills that inform the judicious selection of endoscopic interventions is of equal or greater importance than acquisition of technical skills, since gastroenterology is not merely a technical specialty [5].

It is imperative that we keep the great traditions of humanistic patient care alive in an era in which the clinical

encounter is threatened by depersonalization. Every generation must understand the importance of treating the human being behind the disease, the essential qualities of integrity, kindness, compassion, trust, and empathy, and the value of enthusiasm, clear reasoning, and effective communication [6]. I am particularly fearful that as we transition to so-called population health management and use templated electronic data entry programs, we will forget about the patient's individual story in all its richness and the human emotions that govern behavior at times of illness and stress. I am concerned that our new electronic record systems were not designed with teaching the art of medicine in mind [7, 8]. Recently, I have been asked to stop dictating my patient notes and instead enter checklists into the health record to facilitate data analysis, not to mention billing compliance. (Thus far, I have resisted, at least partially!) An unintended consequence of such "progress" is a growing restriction on the use of methods that have served me well to teach students and residents how to effectively and humanistically care for patients. Preliminary work has, in fact, suggested that implementation of an electronic health record dampens the enthusiasm of faculty for teaching [9]. Conversely, I recognize that the electronic health record can be used as an effective and even innovative teaching tool [10]. Clearly, we must find ways to incorporate new technology while keeping the rich traditions of medicine alive in the "new world order" [11].

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