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Feussner to Lead National VA Research Program

Eric C. Westman, MD, MHS

Long-standing SGIM member and contributor, John R. Feussner, MD, MPH, has been chosen to be the new Chief Research and Development Officer for the Veterans Administration beginning August 1996. As Chief Research and Development officer, Dr. Feussner will oversee the $250 million VA research program, which includes Medical Research, Rehabilitation Research and Development, and Health Services Research and Development. He will report directly to Dr. Kenneth W. Kizer, the Under Secretary for Veterans Affairs. Dr. Feussner currently serves as Chief of the Division of General Internal Medicine at Duke University Medical Center and is director of the Center for Health Services Research in Primary Care at the Durham VA Medical Center.

Dr. Feussner will be the first health services researcher to lead the VA Research Program. Dr. Feussner's research interests include assessing the validity and predictive value of clinical measurements, health services research in ambulatory care, technology assessment of laboratory and radiographic studies, and chronic disease monitoring and management.

When asked about the implications of his selection for health services research, Dr. Feussner replied, "The funding for Health Services Research is projected to increase in Fiscal Year 1997 from the current level of approximately $33 million. My stated goal is to increase research funding for applied research including epidemiology, clinical epidemiology, health services research, and health policy research. Research will focus on priority areas that cross traditional research boundaries. Thus, research dealing with substance abuse that falls within Health Services Research or Medical Research will be combined to indicate that the re-

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The 20th Annual Meeting: A Look Ahead

Richard P. Lofgren, MD, MPH
Program Chair, 1997 National Meeting

The 19th Annual National Meeting was an enormous success. Drs. Lucey and Suchman and their committees, working in concert with Elnora Rhodes and her staff, are to be commended for "hosting" this exciting program (and party). The program had a special vitality due to new features such as the special research symposia, the focus on the clinical educator, and the additional awards. No wonder the attendance at our meetings continues to grow. We are still trying to digest the new knowledge we acquired.

Although the sights and sounds of the 19th Annual Meeting are fresh in our minds and the laughter from the Capitol Steps has barely died away, it is already time to turn our attention to the 1997 program. Trying to build on the successes of the previous meetings will be a pleasant but formidable task.

I often say that the role of the attending is to state the obvious (which can be important). The health care delivery system and thus our academic health centers are undergoing tremendous change. For the 1997

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Managed Care: A Fundamental Extension in Morality?

Matthew K. Wynia, MD

In his famous 1968 *Science* article, "The Tragedy Of The Commons," Garrett Hardin wrote that the problem of overpopulation "has no technical solution; it requires a fundamental extension in morality." He went on to describe what turns out to be an entire class of problems of "common goods" that may be modeled on "the tragedy of the commons." Focusing on the population problem, he recalled the overgrazing of town commons by herds of privately held cattle. Each herdsman could reason that adding one more cow to the common grazing area would contribute negligibly to overgrazing, but add substantially to his own holdings. Unfortunately, most herdsmen reasoned in this way, leading to the "inevitable, tragic, destruction of the commons." Hardin suggested that individuals would similarly continue to reproduce, to the ultimate detriment of all, in the absence of an extension of moral responsibility to encompass the group as a whole. In short, Hardin observed that individuals following their legitimate individual best interests will sometimes not do what is best for society, and ultimately themselves. What was good for the president of General Motors was not necessarily good for America, and following the profit motive was not always of net benefit to society.

"Might managed care provide the framework for such an extension of morality?"

In the 1950s this might have been a highly remarkable notion. Even in the midst of the collectivist culture of 1968 it made some waves. Unfortunately, this notion appears to have become frankly stunning today. Hardin's work directly refuted the over-simplification that Adam Smith's celebrated "invisible hand" of the marketplace would always assure the efficient distribution of resources. Hardin stated that the collective culture had to protect its common interests from what amounted to individual greed. In a sense this laid the groundwork for (even as it was spawned from) the Great Society's ideals. But Hardin's hope that the recognition of this phenomenon might lead to collective action to protect the "commons" may have been a sign of more optimistic times.

Today, the belief that Adam Smith's "invisible hand" is the inherent guardian of an efficient, and even equitable, market has become commonplace. Among those in positions

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Precepting in the Ambulatory Care Clinic

Geoffrey C. Lamb, MD

In keeping with national medical practice trends, the residents' continuity practice in the ambulatory care clinic is becoming an increasingly important component of the Internal Medicine residency training program. The ambulatory setting provides a unique opportunity for exposure to a range of issues and challenges that cannot be easily addressed in the traditional inpatient setting. The SGIM's Interest Group for Clinic Directors of General Internal Medicine Teaching Clinics has focused much of its efforts on addressing pragmatic approaches to dealing with these challenges. Over the five years of its existence, the group has collected and disseminated data on a range of issues facing the residents' continuity practice. This year the group sponsored a workshop at the SGIM National meeting entitled "Precepting in the Ambulatory Care Clinic." This paper represents the author's perception of some of the more important messages learned through these efforts.

"… the bulk of teaching opportunities occur during one-to-one interactions between resident and faculty"

Most academic general internists are familiar with the challenges of teaching in the ambulatory clinic. On any individual clinic day, time is short, the residents are operating on a tight schedule, and patients are waiting. Surveys in the literature suggest that the time attendings spend interacting with a resident on individual cases range from 4 to 10 minutes, with only a quarter of this time dedicated to teaching. Cases are unpredictable, so it is difficult to prepare or to anticipate what issues will arise. Complete information is frequently not available so decisions and advice

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President's Column

Focus

William M. Tierney, MD

When I first agreed to join the faculty of the Department of Medicine at the Indiana University, I was in the latter half of my chief residency at the county hospital I now call home. I had intended to go into practice as a general internist. When I agreed to stay, I had assumed that I would be a clinician-educator; this was the only role model of an academic general internist that I had been exposed to. My division chief, however, had other ideas.

At that time (1980), there was no clinical track at Indiana University. He was having trouble getting clinician-educators promoted and said that I would have to "do some research." I sat there slack-jawed, never having considered this possibility. But he had considered it and suggested that I speak with Clem McDonald.

Unbeknownst to me and most of the Medicine faculty, Clem, a general internist who had been my attending physician 18 months earlier, was one of the world's leaders in medical informatics. Among his unique qualities was his insistence that his informatics innovations be studied using rigorous, randomized, controlled clinical trials. Indeed, without even knowing it, I had been a subject in the study of computerized reminders that was his first great success.[1]

I met with Clem and immediately knew that he was sitting on a gold mine and that he could not possibly take full advantage of it. I intended to let him continue with the controlled trials and focus my efforts on mining the rich clinical data stored in his rapidly growing electronic medical record system. My first attempts (in retrospect, laughably inept ones) involved predicting laboratory abnormalities in patients treated with diuretics.[2] I performed this research while participating in a "fellowship" that had no curriculum and no faculty other than Clem and a statistician from Purdue (60 miles to the north) who visited one half-day per week. Most of my learning took place at their feet, supplemented by what I gleaned from textbooks and manuals.

During my two year "fellowship," my time was "protected" by my division chief. This meant that I attended on the inpatient general medicine

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SGIM Forum seeks to provide a forum for information and opinions of interest to SGIM members and to general internists and those engaged in the study, teaching, or operation for the practice of general internal medicine. Unless so indicated, articles do not represent official positions or endorsement by SGIM. Rather, articles are chosen for their potential to inform, expand, and challenge readers' opinions.

SGIM Forum welcomes submissions from its readers and others. Communication with the Editorial Coordinator will assist the author in directing a piece to the editor to whom its content is most appropriate.

Research Funding Corner

In August, 1996, there are several research opportunities of note for SGIM members:

Title: Research on the Homeless with Alcohol Problems

Funding Agency: National Institute on Alcohol Abuse & Alcoholism

Brief Description: Support is provided for research dealing with the identification, treatment, and rehabilitation of homeless people with alcohol problems. This area is supported by R01, R03, and R29 award mechanisms.

Application Due Date: October 1, 1996; February 1, 1997; June 1, 1997

Contact Person: Fulton Caldwell, PhD, Treatment Research Branch, Willco Building, Suite 505, 6000 Executive Boulevard, MSC 7003, Bethesda, MD 20892, Telephone (301) 443-0796, Fax (301) 443-8774

Title: Health Services Research on Alcohol-Related Problems

Funding Agency: National Institute on Alcohol Abuse & Alcoholism

Brief Description: Support is provided for research related to improving the availability, accessibility, delivery, quality, cost-effectiveness, impact, and outcomes of alcohol-related treatment and prevention services. This area is supported by R01 and R29 award mechanisms.

Application Due Date: October 1, 1996; February 1, 1997; June 1, 1997

Contact Person: Robert B. Huebner, PhD, Division of Clinical & Preventive Research, Willco Building, Suite 505, 6000 Executive Boulevard, MSC 7003, Bethesda, MD 20892, Telephone (301) 443-0796, Fax (301) 443-8774, e-mail: bhuebner@willco.niaaa.nih.gov

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Title: Small Business Innovation Research Program

Funding Agency: National Institutes of Health, Centers for Disease Control and Prevention, Food and Drug Administration

Application Due Dates: April 15, August 15, and December 15 of each calendar year

Brief Description: Innovative technologies and methodologies fuel progress in research and represent an increasingly important area of the economy. The Small Business Innovation Research (SBIR) program provides support for research and development of new technologies and methodologies for small business concerns as well as for scientists at research colleges and universities. The intent of the SBIR program is to increase private sector commercialization of innovations derived from federal R&D. Scientists at research institutions can play an important role in an SBIR project by serving as consultants and/or subcontractors to the small business concern. In this manner, a small business concern with limited expertise and/or research facilities may benefit from teaming with a scientist at a research institution; for the scientist at a research institution, this team effort provides support for R&D not otherwise obtained.

Contact Person: MTL, Inc., 13687 Baltimore Avenue, Laurel, MD 20707-5096, Telephone (301) 206-9385, Fax (301) 206-9722, e-mail: a2y@cu.nih.gov

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For early notification of grant opportunities, try these web sites:

Federal Grants:
http://www.nih.gov

American Cancer Society:
http://www.cancer.org

American Heart Association:
http://www.amhrt.org

Non-profit Organization Listing with hot links:
http://fdncenter.org
http://www.duke.edu/~ptavern/foundations.html

Please send research opportunities and WEB sites of interest to SGIM researchers to: Eric C. Westman, MD, MHS, Ambulatory Care (11-C), Durham VAMC, 508 Fulton Street, Durham, NC 27705, Telephone (919) 286-0411 x6257, Fax (919) 416-5881, e-mail: ewestman@acpub.duke.edu ■

Academic Calendar

September

The deadline, for submitting workshops, abstracts, and clinical vignettes to present at the Southern SGIM Regional Meeting is September 4, 1996

October

The deadline for submitting proposals for workshops to present at the National SGIM Meeting is October 18, 1996.

1997

The deadline for submitting abstracts to present at the National SGIM Meeting is January 6, 1997

The National SGIM Meeting is May 1–3, 1997, at the J.W. Marriott Hotel, Washington, DC

Feussner to Lead National VA Research Program

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search funding is for substance abuse. The overall funding line will remain intact largely for administrative purposes. In addition, a separate funding category, Cooperative Studies, will be created. This is the VA's clinical trials program."

Dr. Feussner agrees that his appointment indicates a change in direction of the VA. "The VA is changing its clinical focus from a hospital-based to an outpatient-based system with increasing emphasis on primary care. In that context, the VA has reorganized its clinical program as regional networks called VISNs (Veterans Integrated Service Networks). Similarly, residency training and research programs are being realigned to focus more effectively on problems unique to or especially prevalent among veterans, and to focus on research likely to be relevant or applicable in the near term. There is a pressing need for additional clinical research that will improve patient care and improve the functioning of the integrated networks."

Dr. Feussner will be recruiting for key leadership positions in Research Service including a Deputy to the Chief Research Officer, Director of the Medical Research Program, and Director of the Health Services Research Program. ■

Focus

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wards two months a year and had one half-day a week in the primary care clinic. Once my "fellowship" ended, my clinical demands expanded to well over 50% commitment: three to four months attending on the inpatient wards, three half-days in the clinic, and two months in the emergency room per year. I loved it. Despite the intense work hours and averaging four hours of sleep a night, the environment was unbelievably fertile for doing research, teaching, and providing care. I was reasonably good at each, and I threw myself into all three of these roles. I felt that I could indeed be a "triple threat."

"I felt that I could indeed be a 'triple threat' "

I was wrong. I had not anticipated three things. First, beginning in my second "fellowship" year, Clem took sabbatical leave to begin a journal ultimately known as *MD Computing.* However, he had been funded to perform a controlled trial of computer-generated preventive care reminders versus monthly feedback reports. He asked me if I would like to take over the trial, and of course, I agreed. It was substantially harder than fiddling with the database, but it was also more rewarding because it required creativity for designing the protocol and overcoming problems and it required interpersonal skills that I had refined during my chief residency. The trial went well, and the paper was accepted as a poster at a national AFCR meeting and was published by the first journal to which I submitted it. I was hooked on clinical trials.

Second, my familiarity with the database put me in the position of being the conduit to these data for all other investigators, administrators, and strategic planners. I became very popular and was asked to collaborate on numerous research and clinical projects. Third, our research operation grew larger, and I grew older. I became a mentor for junior faculty and was thus responsible for careers other than mine. And I became physically unable to survive on four hours of sleep a night. Ten years after joining the faculty I was a tenured full professor, yet still spending more than 50% of my time in clinical and teaching endeavors. It couldn't last.

I was faced with the first identity crisis of my career. Since I could not be a triple threat, what was I? How could I choose between three things I dearly loved? This was the most difficult struggle of my professional life. I decided that, despite the joy I got out of practicing and teaching, I was not a unique teacher or clinician. My unique contribution, and the one that my division needed the most, was my research skills. So, reluctantly, I asked to have my non-research commitments reduced to 25%. Although this was clearly the best decision for me and my colleagues, to this day I miss the intensity of clinical care and teaching as profoundly as an amputee misses the lost limb. It aches, and there is no equivalent of Tegretol to relieve the professional discomfort.

"I miss the intensity of clinical care and teaching as profoundly as an amputee misses the lost limb"

Now, as the "old man" mentoring budding generalist faculty members,

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News from the Regions

We are beginning to coordinate a variety of regional activities with the National SGIM office and council. The regional representatives are currently developing plans to enhance communication lines between regions and define a variety of regional priorities. This process will be discussed at the upcoming regional business meetings.

Please find below dates for meetings already scheduled for this current academic year. As more information becomes available, such as deadlines for abstract submission, etc., we will publish it in this column. The regional representatives will be contributing to this column on a regular basis.

Regions	Meeting Dates
Midwest	September 19–21, 1996
New England	October 4–5, 1996
Mountain West	February 2–4, 1997
Southern	February 6–7, 1997
Northwest	February 21, 1997
Southern California	February 21, 1997
Mid-Atlantic	March 1997

Gregory W. Rouan, MD
Coordinator for regional activities

The 20th Annual Meeting: A Look Ahead

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meeting, we would like to focus on the changing academic health center and explore the potential opportunities for us as faculty members and as a Society. These are dynamic, if not frightening, times. Many of us are required to shift our focus and adjust our daily operations and "job descriptions." Denial, resistance, and hand-wringing are common responses to change. The challenge is to be resilient and to recognize and seize the opportunities that emerge. As academic generalists, we are in the unique position to help shape and define the future. Hopefully we will continue and expand the dialogue at our next meeting.

The quality and uniqueness of our meeting is the final result of the selfless and enthusiastic contributions of our members. Throughout the summer, the Precourse Committee has been soliciting ideas and developing a tentative program. Your ideas, suggestions, and concerns about the 1997 meeting are welcomed. However, much of the program will be finalized by early fall.

I am fortunate that many wonderful individuals have accepted the invitation to serve on the Program Committee. Listed below are the Committee Chairs and Co-chairs and their e-mail addresses. If you have any specific questions or ideas, please let them know.

The 1997 meeting will be our 20th anniversary and will mark the end of an era. After this next year, the meeting will no longer be held in conjunction with the AFCR and the meeting location will rotate around the country. It will be a time to celebrate our past accomplishments as we tackle future challenges. Please mark the dates May 1–3, 1997, on your calendar. ■

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Managed Care: A Fundamental Extension in Morality?

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of public responsibility calling on the marketplace of individuals to address the problem of individual allocation of common goods is proclaimed as the responsible thing to do. Privatization of everything from public parks to highways and public hospitals is heralded as the panacea for resource allocation difficulties (read: budget problems). Unfortunately, a resurgent belief that individual or corporate motivations are synchronous to societal goals does not make it so. Despite our current fascination with the marketplace, it remains a poor solution to the allocation of society's common goods—among them, medical care.

But is medical care a common good? If medical care is merely a commodity, the equivalent of, say, toothpaste, computers, or paperclips, then the market can ensure continued innovation while maintaining maximal efficiency. For several reasons, I don't believe that it is so. Notably, physicians' ethical and legal obligations suggest that medical care is a common good that all citizens rightly expect to receive; just as they rightly expect to receive federal highways, park services, and military protection (not for free, mind you, but as a shared expense). In distinct contrast to medical care, no matter how urgently in need of a paperclip one may be, there is no ethical or legal obligation on the part of paperclip distributors to provide it.

If medical care is a common good, and an expensive one at that, then protecting the medical commons will also require a "fundamental extension in morality." That is, it will require an extension of public morality to encompass a concern for the well-being of one's community when making individual level decisions. In effect, the development of a capacity to make decisions that run counter to one's individual best interest, in serving the best interest of the community, is needed.

The intriguing next question is:

> *"If medical care is a commodity, the equivalent of, say, toothpaste … the market can ensure continued innovation while maintaining maximal efficiency"*

Might managed care provide the framework for such an extension of morality? This is not a question as to whether managed care can provide similar, or better, care than has fee-for-service medicine. It almost certainly can. This is a more far-reaching moral question that hinges on issues such as community values and trust and that stems from the inevitable use of managed care as a rationing tool. And the answer (as for most serious questions in economic and ethics) is: It depends. It depends on what the goals of managed care are, and on public acceptance of these goals. For example, if the public understands that the money saved by providing less than absolutely optimal care is to be redistributed to the community in the form of other goods and services, of which they may be the beneficiaries, then it just might work. If, conversely, the public understands that the money saved is going to Wall Street and CEOs while health care coverage itself becomes more sparing, judging by the current mood, I doubt they'll willingly play along.

The first step towards managed care fulfilling its potential as a means to enhance social responsibility is to recognize that managing care for profit will not ultimately perform in ways that are best for society. Garrett Hardin said as much in1968. Managing care for populations might, but, tactically, that means medical care administrated by not-for-profit organizations that take their responsibility to communities very seriously. More seriously, sometimes, than their fund balance. And it means exempting not-for-profits from the competitive pressures that the for-profits, with their faster capital acquisition capacities and inherent lesser responsibility to communities, drive. Making not-for-profit managed care compete with its for-profit cousin for the loyalty of (paying) patients, will eventually breed distrust of the entire system. I submit that we should argue fervently for the elimination of the profit motive in the allocation of common goods—medical care being no exception.

Finally, and most importantly, as residents and fellows entering the job market, we must carefully examine the goals of our prospective employers because as physicians we must be able to openly endorse these goals. If the organization offering the job has a fundamentally different objective than do we, then we should look elsewhere. Ultimately, it will be our relations with patients, with ourselves, and with our communities, that are risked when the needs of a community are subverted to the desires of stockholders. ■

Precepting in the Ambulatory Care Clinic

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are often based on partial data, especially as the attending's opportunity to directly interact with the patient can be limited with residents reluctant to staff patients due to time pressures and perceived loss of control. Nationally, only about 60% of patient cases are presented to attending staff, and in less than half of these are the patients actually seen by the attending.

These challenges don't negate the need for a strong emphasis on outpatient teaching but do help to explain why "clinic" has so often been one of the least popular of the residents' experiences. It is the recognition of these challenges that has led to the understanding that there must be a clear curriculum and a structured environment that maintains the emphasis on the teaching aspects of the clinic. All aspects of the time spent in the clinic should build upon one another if the opportunity for teaching is to be maximized. Too often the outpatient "curriculum" brings to mind only the clinic conference and ignores the rest of the teaching opportunities of the setting. Teachers and residents need to be aware of how the agenda and individual faculty/resident relations contribute to the whole. Administratively, the staffing of the clinic should be designed to facilitate this agenda as well as service the needs of the patients. Structured teaching interactions such as clinic conferences are very important, both formal and informal teaching processes complement and facilitate a comprehensive and effective clinical experience.

Curriculum

In any outpatient setting, the bulk of teaching opportunities occur during one-to-one interactions between resident and faculty. This demands that there be a clear curriculum for the outpatient setting that incorporates the goals and objectives of this component of the clinic experience. This is the ideal setting to work on skills such as history taking, physical examination, data synthesis, prioritization of issues, and communication. The educational goals should be reviewed with each resident prior to each year's outpatient experience. One of the advantages of the weekly continuity experience is that as the attending gets to know the resident, the teaching interaction can be tailored to the individual resident's needs. Each individual encounter is short, so it is nearly impossible to address more than one or two points during any single encounter. However, over the months there should be enough interactions with a given resident to allow the attending to work on most issues. This is most effective when the attending and resident work in concert, periodically taking the time to communicate perceived needs.

From the attending's point of view, the curriculum is merely a framework upon which to build. In any encounter, the attending has two tasks: First, what are the patient's immediate needs for care (diagnosing the patient)? Second, what are the resident's needs (diagnosing the learner)? The latter involves direct observation, addressing the resident's questions, questioning the resident, and simply asking the resident about his/her concerns. Depending on the nature of the needs and the personality of the learner, a wide range of techniques can be applied, such as minilectures, direct questioning, role modeling, demonstration, thinking out loud, feedback, and assignments for independent learning. A number of faculty development programs address teaching in the ambulatory setting and can be used to facilitate these techniques.

There are definite limits to what can be accomplished in the one-to-one teaching interaction. Limited time for discussion prevents an in-depth review of many aspects of a medical issue. The spectrum of problems in any one clinic may be so limited that a resident might never be exposed to certain outpatient issues in the course of a three-year experience. With this in mind, many institutions set aside a block of time for a clinic conference. This allows for the in-depth discussion of a range of topics ensuring that important ones are not neglected and that important issues within an individual topic are understood. It can also provide a vehicle for teaching aspects of medicine that do not lend themselves to the quick, focused discussion of a patient while in clinic.

Data from the Clinic Directors Interest Group show that 71% of residencies surveyed have a clinic conference. The majority (96%) have a topic-based curriculum focusing on common outpatient problems, typically taught by faculty general internists with residents periodically incorporated. Some sites also use this time for more innovative tasks such as reviewing qualitative analysis data, videotapes of interviews, and developing practice guideline.

Timing of the clinic conference is dependent upon the goals to achieve. Holding it at the beginning of the clinic session allows residents to congregate prior to the arrival of scheduled patients. This can be an advantage if residents are coming to the clinic from multiple locations. It permits one to set the tone for the day and to address administrative issues prior to clinic. Unfortunately, the preclinic conference can suffer when residents are late, and it is difficult to tie material to the patients who will

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be in clinic that day. Post-clinic conferences help to end the day in a timely fashion and permits the discussion of fresh cases. On the downside, residents who finish early are anxious to leave, while those with a time-consuming patient may be absent. A weekly conference on ambulatory topics can be more formal but, depending on the number of residents involved, less interactive. However, it permits a more in-depth discussion of an issue, diminishes the number of individuals who have to prepare conferences, and makes it easier to serve a meal as incentive for attendance.

Attendance at clinic conferences, as with most residency conferences, is variable at best. Spot quizzes and requiring that question answers be turned in on a regular basis help ensure that material is being looked at and what has been learned is continually being assessed. A clearly stated expectation that conferences will be attended is often enough to ensure participation, as long as it is followed up by attention to individual attendance.

Structure

The structure of the teaching clinic is an essential component to meeting curricular goals. The ratio of residents to faculty must be small enough to allow individual attention, yet large enough to make faculty time in the clinic cost effective. The clinic directors' database tells us that current faculty to resident ratios average 1 to 4.92. Residency Review Committee guidelines suggest that the ratio should be no more than 1 to 6. New HCFA billing guidelines effective July 1 should greatly impact these ratios as they require a maximum ratio of 1 to 4. Much of the learning in any resident setting is resident to resident as well as faculty to resident, so it is most effective if there is a mix of senior and junior residents in this milieu. Ideally, at least two faculty should be in clinic at any one time. This permits a faculty supervisor to spend extra time with a resident, whether it be working with a difficult patient or assisting with a procedure. When a faculty member is alone, there is pressure to not let other residents who need to staff get backed up, resulting in fewer procedures getting done and more cases being referred to specialists.

Continuity between faculty and resident is helpful in trying to achieve teaching objectives. A single preceptor is better able to diagnose the learner's needs and can build on previous experiences in subsequent case presentations. This is usually best achieved through faculty-resident teams that have developed a close working relationship over time. The potential downside is that individual residents limited in their exposure to only one or two faculty may lose some of the richness of diversity. This can be dealt with by implementing ambulatory block experiences and electives. It is important that the attending have a strong background in ambulatory general practice so as to have a facile command of ambulatory issues as they arise. Typically, this is best provided by the general internist but can be provided by a subspecialist who chooses to maintain a strong generalist background and perspective.

The patient panel size for the resident should be large enough to provide a spectrum of patient problems while small enough so as not to overwhelm the resident with service need. Average panel sizes for PG1s are 68, PG2s 96, and PG3s 125.2. Similarly, the number of patients should provide a balance between the service needs of the practice and the educational needs of the resident. In general, as residents become increasingly busy they become less available for teaching as the time a resident spends staffing with a preceptor is directly dependent on the patient load. This was elegantly demonstrated by Malone, et al., in an observational study of senior residents in a teaching clinic. Time spent staffing was maximized at 11.5 minutes per clinic session when a senior resident had 4 patients and dropped to 7.6 minutes when the number of patients was greater than 5. Currently the national averages for the number of patients seen by residents in a single clinic session are PG1s 3.7, PG2s 4.9 and PG3s 5.82.

External pressures for billing and documentation, as well as the desire to enhance teaching, raise the question of whether the clinic faculty should staff every patient that the resident sees. The current practice in most institutions is that interns are staffed on every patient while PG2 and PG3 residents staff patients on an "as needed" basis. The Clinic Director's survey suggests that only 64% of PG1 patients, 44% of PG2 patients, and 34% of PG3 patients are seen by a faculty supervisor. In approximately 20% of programs, all patients are staffed in some fashion. The "as needed" approach allows graduated autonomy and is consistent with the principle of adult learning in which students are most receptive to relevant information that they perceive as immediately valuable. However, the "as needed" approach limits the teacher's ability to monitor and assess an individual's learning needs and can raise quality of care issues. A more appropriate approach is to staff every patient using a variety of methods tailored to the individual resident and patient. Techniques such as case presentation, demonstration of skills, passive observation, quizzing, mod-

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Focus

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I am amused at their initial efforts to deny their limitations and remain triple threats. I don't think this situation is unique among generalist researchers, but it is particularly prevalent and acute among them. But I keep my mouth shut (most of the time) and commiserate silently with them as the joy and pride of their successes in research are accompanied by the strain of their three roles and their unavoidable need to focus: focus on a particular research theme and/or methodology, and focus on a research career to the detriment of their clinical and teaching roles. I can only assuage their anguish by telling them that I see all academic generalists having one common goal: to care for their patients by providing the very best health care possible. The clinician does this one patient at a time. The educator does it one provider at a time. And the researcher does it by fixing one problem at a time, raising the "floor" of minimally acceptable care. We each contribute the skills we possess and must sustain ourselves on the fruit that our efforts bear. These fruits must be found in many small victories (solving problems), occasional intermediate achievements beginning a study (seeing a mentored colleague receive an award), and rare larger successes (getting a grant funded, receiving an award myself). For teaching, research, and clinical care, the everyday processes and struggles have to be rewarding in themselves. Focus allows the academician to accept the small gains as small steps towards a specific goal. We all share in the toil and rewards of providing care with our unique skills. All of them are necessary, but none of them is sufficient to provide the high quality care our patients deserve. ■

References:

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2. Tierney WM, McDonald CJ, McCabe GP. Serum potassium testing in diuretic-treated outpatients: a multivariate approach. Med Decis Making. 1985;5:89–104.

Sleep Apnea: Is Your Patient at Risk? is a 10-page booklet designed as a quick reference for physicians and other health professionals. It helps physicians recognize which patients may have sleep apnea by highlighting signs and symptoms that raise the index of suspicion and that can be assessed in a patient. This booklet also summarizes different types of sleep apnea, comorbid conditions, diagnostic and treatment options, and information sources. It is a useful tool for the office or clinic, medical students, residency programs, and in-service continuing education. This booklet is a product of the National Center on Sleep Disorders Research (NC SDR) which is administered by the National Heart, Lung, and Blood Institute (NHLBI).

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Precepting in the Ambulatory Care Clinic

(continued from page 9)

eling, etc., can be used as needed to further the educational and patient care objectives. Graduated autonomy is quite feasible in such a system as long as the nature of the supervisor's interactions with the student evolves with the increasing skill of the learner.

In general, teaching in the ambulatory clinic is an important but challenging enterprise; the pressures of time, the inability to prepare or predict the nature of the next case, and the lack of complete information can make it difficult. Because of this, it is crucial that there is a curriculum with clearly defined goals that is understood by the faculty and residents alike. This agenda is best carried out by a combination of didactic and informal one-to-one teaching. Above all it is essential that the agenda supports, and is supported by, a structure that facilitates teaching while providing quality care. ■

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1. Irby D. Teaching and learning in ambulatory care settings: a thematic review of the literature. Acad Med. 1995; 70:898–931.
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4. Malone ML, Steele DJ, Jackson TC. What do senior internal medicine residents do in their continuity clinics? J Gen Intern Med. 1993;8:185–8.

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The editorial staff of the *SGIM Forum* invites your input regarding the coverage provided by the newsletter. Please complete the following questionnaire and mail or fax it to the following address:

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		More	About the Same	Less
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G.	Teaching/Clinical Issues in Women's Health	____	____	____
H.	Women in Academia	____	____	____
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		Yes	No	No Opinion
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