Lessons Learned in Bioterrorism Can BeApplied to Medical Practice

To the Editor:

Osteopathic medical schools—individually and as a coalition within the American Association of Colleges of Osteopathic Medicine—are in an ideal position to rapidly adapt to and implement strategies in response to societal changes because of the mobility derived from being a small, highly dedicated cadre of professionals. Our schools reflect their communities and, therefore, can respond effectively to regional needs. Faculties of osteopathic medical schools may distinguish themselves by creating centers that focus on crucial issues, such as research, public health policy, and bioterrorism. Such niche opportunities demonstrate the skills and talents of faculties and the vital role our profession can play in health care. Emerging issues that may present such opportunities include adolescent and school health and geriatrics.

In addition to educational and financial benefits, special centers provide opportunities to collaborate across disciplines and agencies with whom our schools may not usually interact. Through our Center for Bioterrorism and Weapons of Mass Destruction Preparedness (CB-PREP), Nova Southeastern University College of Osteopathic Medicine has forged important collaborations as part of the Florida University Alliance for Weapons of Mass Destruction.

This Florida consortium may be unique among states for arranging that all state medical schools, as well as private and state universities, share resources, best practices, and selected grants for a common mission: preparing and protecting Florida. For example, the University of Miami, Florida, is the principal investigator on a behavioral health initiative with CB-PREP as a sub-principal investigator, while CB-PREP is principal investigator on a risk communications program and the University of Miami is a sub-principal investigator.

This summer, our center, under the leadership of Vincent T. Covello, PhD, and in collaboration with the Center for Risk Communication in New York City, was asked to deliver 14 risk communications training programs throughout Florida.

Risk communication has evolved as a specialty within the field of communication. It is a science-based approach to conveying information during highly stressful, emotionally charged, or controversial situations. Studies reveal that individuals process information differently when they are under high stress, feel at-risk, or are involved in emotional or controversial events. A complex message that might be easily understood in a low-stress situation can become unintelligible during moments of high concern.

One of the lessons learned in the aftermath of the attack on the World Trade Center in New York City, September 11, 2001, and the anthrax outbreak is that public trust, empowerment, and preparedness are enhanced by effective, frequent, and honest communications. Public response to such events—whether appropriate or inappropriate—is directly related to how timely and effective communications have been. The impact such events have on behavioral health, health care, and resource utilization by the public is self-evident.

During delivery of the risk communications training programs, we were immediately struck by similarities in the physician-patient encounters that occurred across high-stress events, such as the outbreaks of West Nile virus and severe acute respiratory syndrome. Yet, how often do we consider the physician-patient encounter as a potentially high-stress situation? For physicians, that interaction is a normative part of the job, yet to someone in pain or fearing a poor prognosis, the encounter is a high-risk event. Should we, therefore, convey information to our patients as if this were a risk communication situation, with the goal of enhancing outcome, promoting healing, and providing calm?

Studies reveal that medical schools do not currently offer specific training in risk communications, despite the fact that in 2001, Assistant Surgeon General, Edward Baker, MD, MPH, suggested that communications may become a central science in public health practice.

Osteopathic medicine enjoys a heritage of innovation and providing patient-centered care. With concerns over medical malpractice, quality of care, and patient satisfaction, a re-rededication to effective communication...
is both a worthy endeavor and an opportunity for the osteopathic medical profession to take the lead on an important issue.

Empowering our students—our future physicians—with skills that increase their ability to protect patients, as well as enable them to affect health policy and exert social leadership, is critical to the success of our profession. Further research, curriculum development, and implementation of enhanced communication skills will require effort, time, collaboration, and expertise, resources with which our proud profession is amply blessed.

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Support Needed for Clinical Faculty in Osteopathic Emergency Medicine Residencies

To the Editor:

From the perspective of many residents in osteopathic graduate medical education programs, problems in patient care result from insufficient time for interaction between clinical faculty and residents in the emergency department. Residents must be continually mindful of the need to appear competent in front of patients, though they fear making clinical errors. At the same time, residents realize that attending physicians have enormous responsibilities, and they are reluctant to make demands on attending physicians’ time.

From the perspective of faculty, residents are often difficult to supervise in a clinical setting. It is impossible to know a resident’s level of expertise and residents sometimes may not appear to be open to teaching or critique.

A literature review using PubMed revealed that mentoring of residents by clinical teaching faculty varies considerably in residency programs. Burdick and Schoppstall found that 20% of residents claim they have never been observed taking a patient history, doing a physical examination, or performing procedures during their emergency medicine residencies. Attending physicians are often not allowed adequate time to both work efficiently in patient care and supervise residents. There are also deficiencies in funding, protected time for teaching, faculty development, and other resources to support teaching physicians.

Other reasons for variations in training include increased stress on attending physicians, emphasis on the managed care issue of cost consciousness and increased productivity, and the fact that “teaching does not bring in grant money or generate patient fees.” An additional factor may be the shift in the demographics of attending physicians.

The trend in medical education includes a shift toward heavy reliance on community and volunteer clinical physicians to educate residents. This shift also involves using clinicians at nonacademic training sites.

Currently, 20% of all emergency medicine residency training programs nationwide are osteopathic. We sought to identify the characteristics of clinical faculty and factors that motivate or hinder emergency medicine physicians’ participation in osteopathic resident education.

A 22-item survey was sent to the directors of all 30 osteopathic emergency medicine residency programs. Questions targeted financial compensation, volume of emergency department patients, experience as a resident, desire to teach, potential for academic advancement, and teacher training. Completed questionnaires were received from 66 of 156 surveyed physicians: 50 were osteopathic physicians and 16 were allopathic physicians. Sixty of these were trained in residencies. Most (70%) of the respondents were in practice fewer than 10 years, and most (76%) were involved in resident education fewer than 10 years. Only 27 of the physicians reported their practice location as academic.

Respondents agreed that they were involved in resident education because they expressed a desire to teach and indicated that the residents they worked with were well-trained. Many believed that relying on community physicians rather than paid academic faculty adversely affected the quality of osteopathic residency education.

Several studies have highlighted the factors that motivate or hinder clinical teachers, including bonus and incentive programs, tenure or academic advancement, personal fulfillment, time constraints, and career goals. Respondents identified the most highly motivating factors as personal desire to support and guide residents, protected time for teaching, and personal experience as a resident. Respondents identified the greatest hindrances as time and large volume of patients.

The surveys compared the responses of (1) osteopathic physicians to allopathic physicians, (2) physicians who practice in academic settings to those in nonacademic settings, and (3) physicians in practice fewer than 10 years to those in practice more than 10 years.

Allopathic physicians disagreed (mean, 3.44) that teaching residents limits their ability to work efficiently in the emergency department, while osteopathic physicians agreed (2.76). Physicians in academic settings agreed (2.59) teaching residents limits their ability to work efficiently in the emergency department, while physicians in nonacademic settings disagreed (3.15). Finally, although not reaching statistical significance (P = .12), physicians in practice fewer than 10 years agreed (2.50) that teaching residents limits their ability to work efficiently in the emergency department, while the physicians in practice more than 10 years disagreed (3.25).

The biggest differences of opinion were apparent when comparing the attitudes of physicians based on the number of years in practice. Physicians in practice fewer than 10 years were significantly more in agreement with the following items: (1) “My personal experience as a resident most highly motivates me to teach” (2.11 vs 2.75); (2) “The large volume of patients is the greatest hindrance to my academic teaching” (2.78 vs 3.25); and (3) “Residents were rotating where I work prior to the time of my employment” (2.04 vs 3.40). Physicians in practice fewer than 10 years most strongly disagreed with the statement, “I am specifically financially compensated for my teaching role” (4.26 vs 3.15).

Responses were examined to determine the strength of factors that motivate emergency physicians to teach residents. Faculty in practice fewer than 10 years specifically cited that their motivation to teach was based on their own experiences in residency. Most physicians believed they were less efficient in the emergency department when working with residents, yet expressed a strong desire to teach, regardless of degree, practice environment, or years in practice.

The desire to teach does not appear to be optimally supported. Physicians in practice fewer than 10 years (most of the respondents) indicated that they received little

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financial compensation for teaching. The large volume of patients was also a significant hindrance to teaching.

It appears that physicians with less experience are providing most of the teaching and receiving less of the financial compensation and support for their teaching. Clinical faculty view much of osteopathic emergency medicine residency training comparably, though significant differences were evident in comparing physicians in practice fewer than 10 years and those in practice more than 10 years. Most notably, physicians in practice fewer than 10 years who work in low-volume, nonacademic environments are the most motivated and efficient clinical faculty.

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References


