Hands-on Teaching in a Touch-Free World

Jill T. Schenk, MD, FAAFP, CPE

(Fam Med. 2021;53(5):383-4.)
doi: 10.22454/FamMed.2021.997332

February 10, 2020

In the midst of a busy rural practice, I prepared to teach medical student and budding primary care physician, Casey, who rotated with me once every three months. I adjusted the March schedule so she could see her continuity patient, Geraldine, a lively octogenarian with a penchant for hugs and a stated aversion to technology.

March 10, 2020

COVID-19 arrived full force in the United States. The way physicians practiced medicine, taught learners, and interacted with patients—all of it changed. Our focus shifted to PPE, public health data, and COVID testing. Virtual visits replaced hands-on care. We had to practice a new kind of medicine—medicine that relied on 20 questions asked over the phone, rather than a quick otoscopic exam. How could we prevent disease and diagnose conditions without touching the patient?

When we finally settled into a tenuous new normal, I had time to consider other things besides Zoom meetings and virtual disease management. Something was missing.

What about teaching?

Regional classes were cancelled, including Casey's rural rotation. I thought back to my own medical education. The experience wouldn't have been as formative if I hadn't been able to sit down with patients, talk with them, and examine them. How could I connect Casey with real-time cases when we were asking patients to stay home?

I cobbled together topics regarding rural medicine and COVID. We had email discussions about hospital preparations and practicing medicine during a public health crisis. Slowly, an idea grew.

I asked Casey if she would become the primary point of contact for Geraldine. We discussed medical risks related to elder patients and how social isolation impacted health. We strategized ways to address these concerns. We reviewed Geraldine's specific health issues: recent chemotherapy, a heart condition, and diabetes. What data *could* Casey collect virtually? When would risks outweigh the benefits, and Geraldine would require an in-person visit?

Casey dove into the assignment, calling Geraldine every month and addressing her health conditions. Each call included wellness and safety topics that Casey and I discussed beforehand. After these visits, Casey wrote up the telephone encounter as a SOAP note. I reviewed the note and provided feedback, then incorporated the document into Geraldine's medical record. During one call, Casey identified a new finding of ankle swelling that prompted us to monitor for worsening chronic heart failure and review the pathophysiology of chronic heart failure.

The next question was how to get Casey back into the exam room when in-person rotations were still restricted. The answer: do it virtually. Our clinic had reached a point where we could safely bring in select patients who required labs and hands-on exams.

I decided to see Geraldine in the office but have Casey remotely conduct the entire history and physical. I acted as the eyes, ears, and hands for Casey. She directed me to complete the exam elements, and I described my findings—all in real time via video. She reviewed lab work prior to the visit and recommended medication adjustments and follow up.

I didn't know how Geraldine would find this experience; she hadn't been able to do virtual visits before because she didn't have a video-capable device. This in-person visit was lengthy and cumbersome. Not the smooth, efficient care she was used to receiving.

She didn't like it.

She *loved* it! Her eyes lit up as she held the tablet and chatted with Casey, a medical professional whom Geraldine clearly trusted. Geraldine told me how she felt like a "pioneer" with the fancy electronic device. She enjoyed the regular phone visits and had come to value her connection with Casey. Geraldine told me how

From Essentia Health, Ashland, WI.

proud she was to teach "her" medical student! For Casey's part, she had learned more about Geraldine, her family, and her entire life in those months of phone visits than I had in the past five years caring for this wonderful lady.

Casey and I wrapped up the visit and set Geraldine up for a recheck in three months' time. Hopefully by then, Casey would be able to see Geraldine in person.

How did the teaching piece work? Casey said that she felt like "part of the team" these past months. She wasn't wrong. She had navigated the complexities of care for an elderly patient in a pandemic. Although we agreed that the experience could not replace seeing multiple patients during a typical rotation, the longitudinal nature of this interaction brought unexpected depth to the student-patient relationship. Casey's knowledge of chronic heart failure and diabetes increased. Geraldine's understanding of her own health and her confidence in technology also grew.

Did it take extra time for me? Of course. But the depth of medical education delivered made the activity worthwhile. I couldn't do this teaching method daily; office productivity and patient access would suffer. But one patient, one student, every three months? It worked well. Casey's demonstrated knowledge made it clear that the value of the process offset the additional effort required.

Going forward, I plan to incorporate more care delivered outside of the office. Medical education can also mirror this new paradigm. I have made changes in my practice, not only to teach the mechanics of care delivery via video and telephone visits, but to recognize advantages and limitations of these formats (technology, comprehension styles), while creating solutions to barriers (brief and more frequent visits, written communication). The future of medicine involves innovation, and the training of physicians should be part of that innovation. Students like Casey can be part of the health care team and provide meaningful insight into patient care while still striving to meet the goals of rural rotations. This training does not replace in-office, bedside learning, but rather provides a new layer to the education experience.

The COVID pandemic has changed not only the fabric of our work as physicians but that of medical education itself. It is up to us to adapt, for the betterment of our patients' health care and the education of our next generation of physicians.

CORRESPONDENCE: Address correspondence to Dr Jill T. Schenk, Essentia Health, 1615 Maple Lane, Suite 1, Ashland, WI 54806. 715-685-7500. Fax: 715-685-7099. Jill.Schenk@EssentiaHealth.org.