2026, Volume 0, Issue 0, 1-2, e-ISSN 1938-3800

Family Medicine

LETTER TO THE EDITOR

Precepting Dissonance: Reconciling Expectations in Graduate Medical Education

Maria Montanez Villacampa, MD; Stacy Ogbeide, PsyD, ABPP; Yajaira Johnson-Esparza, PhD

AUTHOR AFFILIATION:

Department of Family & Community Medicine, UT Health San Antonio, The University of Texas at San Antonio

CORRESPONDING AUTHOR:

Maria Montanez Villacampa, Department of Family & Community Medicine, UT Health San Antonio, The University of Texas at San Antonio, montanezvill@uthscsa.edu

HOW TO CITE: Villacampa MM, Ogbeide S, Johnson-Esparza Y. Precepting Dissonance: Reconciling Expectations in Graduate Medical Education. *Fam Med.* 2026;0(0):1-2. doi: 10.22454/FamMed.2026.589020

FIRST PUBLISHED: February 19, 2026

TO THE EDITOR:

We are writing in response to the article by Shaughnessy et al on behaviorally based precepting practices desired by family medicine residents.[1] We applaud the authors' efforts and would like to offer additional perspectives considering generational changes documented in academic medicine.[2,3] There is a generational shift in graduate medical education, and this highlights the importance of evolving precepting practices to best support resident physicians' needs in the clinical setting. Specifically, we want to highlight[1] the importance of being grounded in the purpose and function of training, and[2] the tension between resident autonomy and the preceptor's ethical role of protecting the public.

Though there are different methodologies to achieve precepting goals in the clinical setting, the goal remains the same throughout: to provide the best possible care to our patients and communities while developing resident physicians' professional identity.

Nonviolent communication, a safe environment that upholds psychological safety, and a learning environment that promotes resident professional development should be a cornerstone of every training program. Generational shifts with different expectations, values, and communication styles among trainees impact faculty development and precepting practices; therefore, it is necessary to reexamine our approach.

Professional identity is an evolving process that develops through curriculum, experiential learning, mentorship, critical incidents, feedback, and self-reflection. The development of professional identity is gradual, often nonlinear, and requires trainees to navigate unavoidable tensions between their professional ideals and the reality of medical practice and their own professional development stage. The Accreditation Council for Graduate Medical Education competencies highlight graduated responsibilities during residency training and offer a framework for evaluating an individual's capacity for decision-making suitable for independent practice. The relationship between faculty member and resident physician is dynamic, with inherent differences in knowledge, experience, level of autonomy, and ethical and legal responsibility to protect the public. These nuances necessarily influence how we precept.

An undeniable tension in the precepting dynamic is the trainee's desire for autonomy and self-direction and the faculty member's legal, ethical, and professional responsibility for safe and adequate patient care under their credentials. Autonomy is earned by consistently demonstrating decision-making elements that prove a solid understanding of patient care and practice. Due diligence requires the preceptor to patiently assess a resident's clinical decision-making, especially when the resident is unsure, to guide them toward the acceptable next step rather than providing an answer when pressured for time. Younger generations of physicians may value efficiency for a better work-life balance. This also highlights the importance of real-time feedback and teaching to optimize experiential learning during the clinical encounter.[4] Though we often strive to minimize disruptions and facilitate a resident's workflow, independent practice requires the ability to balance competing responsibilities involving patient care and managing tasks related to the clinical encounter with other team members. Ultimately, we hope residency training prepares residents for the reality of independent practice upon graduation.

Reframing supervision and autonomy as a gradual process that requires mutual understanding and renegotiation through trust building can positively influence and support the precepting relationship between the faculty member and resident physician.

REFERENCES

1. Shaughnessy AF, Wahid O, Fleishman J, Sokol R. What do residents want from clinical supervision in primary care practice? Identifying desired behaviors for outpatient precepting. *Fam Med*. 2025;57(9):622–626. doi:10.22454/FamMed.2025.122314
2. Pascarella L, Marulanda K, Duchesneau ED, Sanchez-Casalongue M, Kapadia M, Farrell TM. Preferred feedback styles among different groups in an academic medical center. *J Surg Res*. 2023;288:215–224. doi:10.1016/j.jss.2023.02.044
3. Morreale M. Generational differences in medical education: can we all just get along? *Acad Psychiatry*. 2018;42(3):394–395. doi:10.1007/s40596-018-0915-5
4. Eckleberry-Hunt J, Lick D, Hunt R. Is medical education ready for generation Z? *J Grad Med Educ*. 2018;10(4):378–381. doi:10.4300/JGME-D-18-00466.1