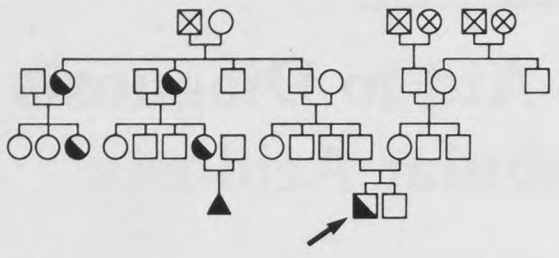

Figure 1. The patient's genogram

potassium 3.1 mEq/L, chloride 113 mEq/L, and bicarbonate 12 mEq/L. These data are consistent with the diagnosis of renal tubular acidosis. The child was begun on modified Shohl's solution. Since institution of the appropriate therapy, the child has made dramatic growth improvement and presently is above the 10th percentile for his age. On 12.5 mL of Shohl's solution four times daily his serum bicarbonate is normal.

Comment

This case illustrates the usefulness of obtaining a genogram as a routine part of the patient's history. In this particular patient a diagnosis had been delayed because it was not known that the child had distant relatives with renal tubular acidosis, and the diagnosis was not suspected. In this and in a number of other cases seen in which a diagnosis either was not suspected or was suspected, but difficult to confirm, the genogram has been invaluable. Consequently, it is advocated that a genogram be obtained for every patient, especially for those patients who pose difficult diagnostic problems.

References

1. Guerin PJ: Family Therapy, Theory and Practice. New York, Gardner Press, 1976
2. Gordon H: The family history and the pedigree chart. Postgrad 48:123, 1972
3. Jolly W, Froom J, Rosen MG: The genogram. J Fam Pract 10:251, 1980
4. Sebastian A, Morris RC Jr: Renal tubular acidosis. Methodology 7(5):216, 1977
5. Wyngaarden JB, Smith LH (eds): Cecil's Textbook of Medicine. Philadelphia, WB Saunders, 1982, pp 574-575

Teaching Family Practice Residents to Identify and Treat Battered Women

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In recent years the medical and psychological problems of battered women have come to the attention of the medical community. Current research places the degree of the abuse as occurring in one out of six couples.[1] The startling numbers of physically abusive relationships have triggered a response in the medical community. Protocols for emergency room treatment of abuse have been developed at hospitals and medical schools, often with the cooperation of community agencies who help battered women.[2-5] However, the recognition of abuse in a non-emergency-room setting and the implementation of appropriate response in the family practice setting have not been addressed.

Continued on page 712

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Continued from page 708

The following clinical teaching program was designed to provide family practice residents with the skills to diagnose an abusive relationship, to develop a treatment plan, and to test resident effectiveness by using simulated patients.

Methods

Two seminars on domestic violence were presented, using the learned helplessness model developed by Seligman,[6] described in greater detail by Symonds,[7] as a theoretical model. The first seminar, given by staff from a battered women's counseling center, reviewed the scope of the problem, treatment interventions, and available data on how patients may present to physicians. Effective interviewing techniques were presented. Two former battered women described their experiences and answered questions. Clinically relevant interventions were summarized in a physician behavior checklist* developed by the faculty and residents. The checklist goals included inquiry about abuse and its history, education and support of the patient, and assistance in formulating a plan for the physical safety of the patient and her children.

At the second seminar held four months later, the checklist was reviewed with the residents, and an assessment plan was developed using simulated patients. The residents suggested that the simulated patients should be scheduled as new clinic patients, unknown to them, to provide the most accurate assessment of their ability to recognize and treat abuse.

A group of simulated patients were trained using actual histories of battered women. The simulators presented with vague somatic complaints and were unwilling to reveal that they were abused unless questioned directly.** An additional four months elapsed before simulated patients were scheduled for clinic visits. Nursing staff were aware of the simulations and cooperated

Continued on page 715

*Available from authors upon request.

**Samples of the simulated patient scripts are available from the authors on request.

Continued from page 712

by not divulging to the residents the nature of the patient visit. Residents performed their interview and examination, ordered tests and prescriptions, and left the examining room. At this point the simulated patient filled out the assessment checklist. The resident and faculty member then held a 20-minute debriefing session with the simulator, who provided immediate feedback about the patient visit. Prior to being contacted by the faculty member, none of the residents had been aware that they had just interviewed a simulated patient.

Results

Included in the study were 16 residents, 8 first-year and 8 second-year. The 8 third-year residents, although they attended the seminars, were excluded from the simulations because they were not receiving any new patients in their practices. Of those who discovered that the simulated patient was in an abusive situation, 70 percent had attended the seminars; and of those who did not make the diagnosis, 67 percent had attended the seminars. Thus, seminar attendance was not a factor in discovering abuse. Self-selection may have been a factor as those who chose not to attend either seminar (5 out of 16 residents) may have been well-informed about battered women.

Although the actual discovery of abuse did not differentiate the two groups of residents, follow-through on the treatment plan was quite different. Residents who had attended seminars showed a more complete and specific plan for the abused woman than those who did not attend. Several specific differences deserve mention.

Of the 10 residents who diagnosed abuse, 4 gave no medications, 2 gave appropriate medication for migraine-like symptoms described by one patient-simulator, and 4 gave prescriptions (Valium, Dalmane, Fiorinal, and Darvocet). Thus, 40 percent of the women who had abuse diagnosed were given unnecessary prescriptions. Of the six women whose abuse was not diagnosed, five (83 percent) were given a prescription. Medications prescribed included Soma, Norgesic Forte, Fiorinal, and Elavil. Although the numbers in the study are too small to merit statistical tests of significance, there is a clear indication that physicians who did not correctly uncover an abusive situation frequently provided inappropriate medications that may cause additional problems for the patient.

The treatment protocol specifically required residents to ask about alcohol use both by the spouse or partner and by the woman herself, as alcohol is often a concomitant of physical violence.[8,9] Seventy-three percent of those who had attended the seminars asked about alcohol use in their interviews, whereas only 40 percent of those who had not attended seminars asked about alcohol use.

Additional data were sought about the abuse of children. Forty-five percent of those who attended the seminars asked about the presence of children in the family and their safety. Only 20 percent who had not attended seminars had inquired about this problem.

Finally, when abuse was not diagnosed, the psychosocial history was lacking or incomplete. Specific checklist questions covered current living situation, marital functioning, employment, financial stresses, and recent illnesses or stresses among family members. The seminars affected the specificity and thoroughness of both the interview and the treatment plan.

Comment

Simulated patients offered face-to-face evaluation of the resident's specific skills in the interview and physical examination. For the time and money expended, a cost-effective way of providing high-quality clinical teaching was demonstrated. Several important areas of management were identified, including the appropriate use of medications, alcoholism history, possible risk of child abuse, and inclusion of a thorough psychosocial history.

The time sequences involved in the teaching program provided an additional means of strengthening learning by keeping the residents alert to possible abusive relationships while anticipating the simulated patients and again during the period following the simulations and feedback. This time frame enhanced their efforts to practice new skills.

The checklist and simulations proved effective teaching tools, providing a specific protocol to residents for clinical intervention about a specific patient problem. This approach is applicable to a

wide variety of problems in clinical medicine requiring assessment of resident learning.

References

1. Strauss MA, Hotaling GT (eds): The Social Causes of Husband-Wife Violence. Minneapolis, University of Minnesota Press, 1980
2. Cooper B: Wife Beating: Counselor Training Manual No. 2. Ann Arbor, Mich, NOW Domestic Violence and Spouse Assault Fund, Inc, 1976
3. Resnick M: Wife Beating: Counselor Training Manual No. 1. Ann Arbor, Mich, NOW Domestic Violence and Spouse Assault Fund, Inc, 1976
4. Rounsaville B, Weissman MM: Battered women: A medical problem requiring detection. Int J Psychiatry Med 8:191, 1977
5. Mandel JB: The role of the medical community in treating family violence. In Domestic Violence, The All American Crime. Milwaukee, Wisc, Milwaukee Task Force on Battered Women, 1982
6. Seligman MEP: Helplessness: On Depression Development and Death. San Francisco, WH Freeman, 1975
7. Symonds A: Violence against women: The myth of masochism. Am J Psychother 33:161, 1979
8. Hanks SE, Rosenbaum CP: Battered women: A study of women who live with violent alcohol-abusing men. Am J Orthopsychiatry 47(2):291, 1977
9. Appleton W: The battered-woman syndrome. Ann Emerg Med 9(2):84, 1980

The Rural Preceptorship as a Factor in the Residency Selection: The Nebraska Experience

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The medical student preceptorship is an integral part of undergraduate training in family medicine at many US medical schools. Patterned after the apprenticeship training programs used for many years in England and Scotland, preceptorships in this country have been variously in and out of favor as a teaching method.[1] Since the 1950s there has been renewed interest in the preceptorship concept as a teaching method in undergraduate family medicine training. The preceptorship concept is valued because of the role model provided for the student both by the supervising physician and by the practice itself. At no other point in training does a medical student have an opportunity to work and learn in a setting more closely resembling the actual practice of family medicine than in the preceptorship rotation.

The question of the value of a preceptorship program in influencing students to undertake residency training in family practice is one that has not been answered completely. Presented here are the results of a three-year survey of first-year house officers who had completed a rural preceptorship through the University of Nebraska Family Practice Department.

Background

A preceptorship program has been in place at the University of Nebraska Medical Center (UNMC) since 1949. The original program used 30 practicing physicians outside the metropolitan areas of Omaha and Lincoln. The supervisory physician was responsible for the education and room and board for the student during the preceptorship rotation. Since 1971 there has been a mandatory eight-week rural preceptorship at UNMC to be completed in either the junior or the senior year. The eight weeks can be extended electively to a 12-week rotation. The preceptorship program is administered through the UNMC Family Practice Undergraduate Program. All students are placed with practicing family physicians in Ne-

Continued on page 719

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