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The Uncertainty in Family Medicine Training

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The 'uncertainty' nature of family medicine health care services

Ever since we heard about family medicine training, there have been lots of differences within the context of primary care compared to the specialization in the hospital's settings. One of them is the 'uncertainty.' The uncertainty of health care started from the process of development of diagnosis because of the first contact nature of patients in primary care settings with possible signs and symptoms can lead to number of diseases[1]. A cough symptom can be uncomplicated influenza, a very sign of the start of an epidemic, or signs of a more contagious severe illness like Tuberculosis, or a non-infectious problem but can be life-threatening for the patient. We also still need to consider the 'illnesses' so that the patients can have their perceptions regarding the health problems and the treatment they should receive. At this point, two-way dialogue to overcome the uncertainty in handling health problems is the key to understanding patients' perspectives. Only by understanding patients' perspectives can family doctors work together with the patient to approach a more suitable treatment and health care planning.

The ultimate goal of primary health care is to achieve better and increased healthcare outcomes. A complex health problem with an optimum family support system can be handled more subtly by health professionals, including the family doctor. However, a simple health problem with a lack of a family support system may lead to a more complex situation requiring family doctors to think through and work with inter and multidiscipline stakeholders. So, in the family medicine scope of health care, we have already learned about uncertainty in establishing the correct diagnosis and providing comprehensive treatment to patients and their families. The uncertainty of health care delivery in family medicine happens in daily practice situations; compared to a more certain name of a disease and the medication in the referral hospital settings.

The 'uncertainty' nature of family medicine training

Training in family medicine also requires doctors who are clinical preceptors or clinical teachers to face 'uncertainty.' Even more, in a situation where family medicine residential training is starting, the older doctors are family medicine by a cross-program, not formal training; the situation in which Indonesia is facing up to one or two more decades later. So, what do we do to provide the best facilitation in learning for the new residents while maintaining our dignity? When the older doctors do not possess any of the knowledge the new doctors will have, neither in family medicine approaches nor clinical matters.

Similar to the 'uncertain' nature of family medicine health care, as illustrated in the first paragraph above, the key is to have a two-way dialogue. A mutual dialogue can begin when the two parties respect each other, understand the strengths and weaknesses within individuals, and therefore initiate participation for others to be involved or oneself to be involved in others' activities. The fundamental is to ask questions. Asking questions is a powerful strategy in medical education to stimulate reflection, further learning, and motivate others. The boxes below describe an example of an uncertainty in clinical family medicine training:

BOX 1. The uncertainty in clinical reasoning/ evidence example

An FM resident: Doctor, I would like to consult a patient with you, he is having T2DM, but he denies that he should take medication for longer period. He insisted that he can be cured in a couple of months.

A clinical preceptor: This clinical preceptor is with the unsaid words: Well, I am doubtful of what to and how to provide feedback since I am not that familiar with the clinical guide of T2Dm at present, what should I say...)

TIPS: Remember, the OMP (One Minute Preceptorship) approach is a powerful tool. It will guide you through the process and ensure you are well-prepared to handle this case[2].

- Engage the learners by asking question: "what do you think is going on with this patient?"
- Probe for supporting evidence-evaluate the learner's knowledge or reasoning, by asking question: "why do you think it is T2DM? what supports the diagnosis? What is the DDs? What can be excluded and how?"
- Teach general rules-teach the learner common "take-home points" that can be used in future cases, aimed preferably at an area of weakness for the learner by asking question: "So what if the patient has no clue of T2DM? What tools would you do? Do you know how to collect patients' perception of illnesses? Do you know the Arthur Kleinman 8 questions? Do you know Anamnesis Illness? Do you know ask-tell-ask model?"
- Reinforce what was done well-provide positive feedback by asking question: "which part do you proud of yourself when taking care of this patient? What do you learn best by taking care of this patient that you could re do in the near future?"
- Correct errors-provide constructive feedback with recommendations for improvement by asking questions:" How do you improve for next time what you see the same patient, or different patient? What and where would you learn? Books? Journal? Asking teachers/friends?"

Your role as a clinical preceptor is vital in this consultation. Your insights and guidance will be instrumental in helping the FM resident navigate this challenging case[3]. However, there will be an event when a clinical preceptor does not know the answer. Therefore, they can also just be honest that they do not know the latest clinical guides and ask the residents to search for the newest one so we can learn together about the current EBM treatment of T2DM. The preceptor can also say they do not know the latest guidelines, and we will ask our colleague in the hospital or the District Health Care Office about this matter. When students understand that the teacher also keeps learning together with them, they are more likely to not necessarily feel embarrassed when they learn from the patients during informed and shared decision-making. Participation of others can be central to better health outcomes. Remember that when a patient comes to a doctor asking for something, a doctor cannot know everything. So, a similar learning approach can be helpful for both sides, rather than being dishonest and giving incorrect information that could threaten patient safety.

BOX 2. Understanding self-limitation and asking for help

An FM resident: Doctor, I would like to consult you about a technical matter when I use the ultrasonography device.

A clinical preceptor (the unsaid words): Wow, I did not know how to use it since it just got here one year ago. Also, with the government's recommendation and instruction to do this, what should I say to the student to save my dignity?

TIPS:

Again, this is not something embarrassing. As clinical preceptors, we can still learn with the students, especially on the knowledge part of the device, the aim of using the tool, what to expect, and what signs we should be aware of. We can also be honest about what was unsaid above. Not all family doctors should be skillful in using any device; what is more important is to understand our limits and to know whom to ask for help so that we can maintain the latest EBM for the sake of patient safety. Remember that medical knowledge, tools, and skills continuously develop. To continue learning for a lifetime or lifelong learning is the aim of medical education and health care.

In Bahasa Indonesian, we say, "Malu bertanya sesat di jalan" (Whoever feels ashamed of asking a question will be misled).

The power of "I don't know."

In medical education, we know about 'constructivism' theory when knowledge is not simply gained or absorbed or replicated but constructed by oneself after a learning experience and a reflection (which fostered up with constructive feedback)[4,5]. Therefore, a better learning design program always has adequate time to reflect on experiences and construct meaning from what they just read, discussed, heard, or tried. Furthermore, the more time of shared experiences with peers and supervisors, the more meaningful learning. People (including students and patients) should also learn to construct knowledge. This process will be helpful when the teachers and doctors stimulate them to think by asking questions or by saying, 'I don't know…. let's figure it out together' or 'I don't know….what do you think, you search and tell me.' One example of a response from a good teacher when a student asked if he did not know the answer was replying: "I also struggle to find out about this in the same way as you." Therefore, by learning to understand our limitations, we can invite others to learn together, whether doctor-patient or teacher-student.

'Learning together as doctor-patient or teacher-student will result in better outcomes, whether health or learning outcomes.'

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