

Lost Mail

Due to a mailing glitch, many preceptors did not receive the Fall 2003 issue of *The Front Line*. Although some of the information in that issue is no longer timely, several articles are still relevant. We are therefore reprinting the "challenging case" from that issue (see pages 4-5) as well as Dr. Peter Curtis's article on mentoring (beginning on page 3).

Conferences and Continuing Education

NOVEMBER 11

11th Annual George T. Wolff, MD, Primary Care Symposium. Moses Cone Hospital, Greensboro. Contact Pam Reavis, 336-832-8214.

17
Multidisciplinary Treatment of Eating Disorders. The Friday Center, Chapel Hill. Contact Gail Wilkins, 919-962-2118.

18-19
North Carolina Infectious Disease Society Annual Conference: Hot Topics for 2005. Moses Cone Hospital, Greensboro. Contact Jane Radford, 336-832-8214.

19
Obesity: A National Epidemic. Holiday Inn I-95, Fayetteville. Speaker: Dr. David Satcher, 16th Surgeon General of the United States. Contact Southern Regional AHEC, 910-678-7226.

(continued on page 2)

Coming Soon: Preceptor.org

Currently there is no single web site through which all of the North Carolina AHECs and health professions schools using community-based preceptors can communicate with preceptors. To fill that void, the Office of Educational Development (OED) at the UNC School of Medicine is developing Preceptor.org as an easy-to-use

communications tool. Designed to be a comprehensive web site for community preceptors, Preceptor.org will serve as a central resource for educational materials transfer. North Carolina AHEC is providing start-up funds for the project.

Although the site is being developed specifically with North Carolina preceptors in mind, much of the content will be general enough to be relevant to all preceptors. In its initial stages, Preceptor.org will be a repository of many already existing online resources, in addition to some information features specifically developed for the site. The collection of various resources under the Preceptor.org web site will allow for "one-stop shopping" access to information for busy community practitioners.

OED webmaster Dale Krams is working with a graphic designer and an applications developer to build a high-quality, easily accessible site. Navigation will be intuitive; information will be easy to find and read. There will be functionality so that preceptors can request resources or register for activities. As the site develops, so will the information archives, as well as, where possible, the features of functionality of the site, including the option of adding searchable archives and additional interactive tools.

(continued on page 3)

PRECEPTOR.ORG
...to teach them the art.

MORE INFO
Culturally Appropriate Care
The demographic picture of the United States is changing dramatically. According to the 2000 census, approximately 30% of the U.S. population consists of members of ethnic or cultural "minority" groups, and it is estimated that these groups will make up almost 50% of the population by 2050. A population shift is also occurring in North Carolina, particularly evident in the rapidly growing number of Latino residents. At the same time, the composition of the health care workforce, particularly physicians, does not reflect that of the patient population. [READ MORE](#)

TAKE THE TEST
Check Your Cultural Sensitivity
When I am providing health care services to persons from a background different from my own, I am able to recognize when:

1. Their idea about their illness is different from my diagnosis.
 Always Sometimes Never Depends on situation
2. Their idea about the way the body works is different from mine.
 Always Sometimes Never Depends on situation
3. They don't believe the treatment I would use would be effective.
 Always Sometimes Never Depends on situation
4. A misunderstanding occurs as a result of miscommunication between us.
 Always Sometimes Never Depends on situation

SIGN ME UP
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THE FRONT LINE

Profile of the Class of 2009



New students and parents gathered for Family Day in September.

Statistics for the class that entered medical school in August show a continuation of recent trends among entering students. Eighty-two women and seventy-eight men comprise the class, with an average age of 24.9 years. They bring impressive academic credentials: an average MCAT score of 31.74; average undergraduate GPA in biology, chemistry, and mathematics courses of 3.59, and an overall GPA of 3.65.

The most popular undergraduate major was biology, chosen by 60 students. The next most frequent majors were chemistry (16), biochemistry (12), and psychology (8). Other majors pursued by two or more class members were English, health education, biomedical engineering, mathematics, business, chemical engineering, economics, neurosciences, philosophy, physics, and Spanish.

Sixteen members of the Class of 2009 have master's degrees, and one has a Ph.D.

Although only 22 class members are residents of other states, 39 different states were listed as birthplaces. New students come from 58 different undergraduate schools, including 11 of North Carolina's public universities and five private North Carolina colleges (Davidson, Duke, Guilford, Wake Forest, and Warren Wilson). UNC-Chapel Hill continued to provide the largest number of graduates for the entering medical school class.

Continuing its commitment to recruiting outstanding students from under-represented minority groups, the School of Medicine enrolled 20 African American, six Native American, and two Vietnamese students in the new class.



OFFICE OF EDUCATIONAL DEVELOPMENT

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Conferences and Continuing Education

NOVEMBER

19

EHR Roadshow for Practicing Physicians: Discover and Explore Electronic Health Records. Coastline Convention Center, Wilmington. Contact Christy Ayscue, cayscue@ncafp.com.

19-20

Psychiatry Across the Ages: 10th Annual Update in Psychiatry and the 22nd Annual George C. Ham Symposium. The Friday Center, Chapel Hill. Contact Gail Wilkins, 919-962-2118.

DECEMBER

1-4

Winter Family Physicians Weekend. Grove Park Inn, Asheville. Contact Christy Ayscue, cayscue@ncafp.com.

JANUARY

25

Cultural Perspectives on Parenting. Wake County Commons Building, Raleigh. Contact Elizabeth Moore at Prevent Child Abuse North Carolina, 1-800-CHILDREN.

26

Falls in Older Adults: Evaluation and Management in Primary Practice. The Andrews Conference Center, WakeMed, Raleigh. Contact Wake AHEC, 919-350-8547. **(Note: This same course will be repeated on February 9.)**

28

Update in Orthopaedics. Cape Fear Community College North Campus, Wilmington. Contact Paula Studebaker, 910-343-0161, ext. 325.

FEBRUARY

11

17th Annual New Hanover Health Network Trauma Symposium. Hilton Wilmington Riverside, Wilmington. Contact Paula Studebaker, 910-343-0161, ext. 325.

17-18

Challenges in Geriatric Practice: 17th Annual Conference. The Friday Center, Chapel Hill. Contact Deirdre Boyer, 919-962-2118.

17-18

North Carolina Chapter/American College of Physicians 2006 Annual Meeting. Millennium Hotel, Durham. Contact Roni Baker, 800-722-1350, ext. 108.

18

Community Service Day. Medical Biomolecular Research Building, Chapel Hill. Contact Suzanne Marchionini, 919-966-6405.

To Be a Mentor

by Peter Curtis, M.D.

Department of Family Medicine

At some time in our lives, most of us have had at least one mentor—someone who somehow made an important and vivid impression on us and in some way changed how we behaved or perceived our lives. That mentoring could have occurred in any place at any time, and didn't even need to take much time.

In my own case, at the age of 16, I received one of my most intense mentoring experiences from a 65-year-old retired English teacher sitting opposite me in the same train compartment on a 12-hour ride to Belgrade, Yugoslavia. It was the first time anyone had openly questioned and discussed my personal opinions with me—and had made me think about who I really was and what I wanted to do with my life. I never saw him again after that train ride, although I did send him a postcard from time to time. The fact that this memory is so vivid is surely proof of the great impression and influence this meeting had on me.

This incident suggests that, for those of us involved in medical education, even for those community preceptors teaching students for periods of just a few weeks, there exists the opportunity to become or act as a mentor rather than simply to be a teacher or medical advisor.

Becoming someone's mentor sounds a little challenging, and one might feel unskilled in taking on such a task. Actually, mentoring often "happens" without much self awareness, depending on circumstances and people. However, for people working in formal academic settings, mentoring is perceived to be an important and often organized part of the university environment, and there is a fair amount of literature that examines this vital process (Dazol, 1999).

I will start this brief discussion of mentoring with some definitions and explanations to clarify the mentor role. First, some history. In *The Odyssey*, Homer tells us that when Ulysses was preparing to leave the island of Ithaca to join the Greek campaign against Troy, he had a feeling that he would be away for a long, long time. In addition to his island kingdom, he was leaving behind his wife, Penelope, and his young son Telemachus. To cover his parental role while he was absent, he chose one of his closest associates, Mentor, to take the responsibility for Telemachus' mental and physical education and to act as his guide as he grew into manhood.

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Preceptor.org (continued from page 1)

Links to articles on preceptor/faculty development drawing on a variety of sources will be updated frequently. The site will, on a regular basis, identify articles and other sources of information on other preceptor, community health, clinical teaching, and similar web sites. This information will be presented as links on Preceptor.org, with perhaps one particularly relevant or interesting article featured. An archives section of the web site will retain links to prior articles and information.

On a quarterly basis, North Carolina AHEC will provide a column or other AHEC-related information specifically relevant to preceptors for inclusion on Preceptor.org. Previous columns and information will be retained in the archives.

The Front Line section will not only link to the latest issue of *The Front Line*, but will also include archives of back issues. An online form will permit preceptors to sign up with an e-mail address to receive information whenever a new issue of *The Front Line* is available. Preceptor.org developers hope, as future funding permits, to make the archives of *The Front Line* searchable for specific content. This would involve installation of a search engine capability.

The home page of Preceptor.org will also include a link directly to EPIC (Expert Preceptor Interactive Curriculum). Information of upcoming conferences of possible interest to preceptors (as in *The Front Line*) will be included in a reserved space on the site. On a monthly basis, the list will be reviewed to ensure that it is kept up-to-date. Finally, links to the websites of key partners will be maintained on the site: AHEC, AHEC Digital Library, UNC School of Medicine, OED, and the Health Sciences Library.

The site will be maintained by the OED webmaster. Links from Preceptor.org to outside web sites will be checked monthly to ensure viability of those links. As new information is added, outdated materials will be removed. As appropriate, they will be moved and retained in the archives so that once materials are removed from prominent display on the site, they will still be available to users. If Preceptor.org eventually has search engine capability, that would allow the archives to be searched for specific content.

Katherine Savage, faculty development coordinator in the Office of Educational Development, is seeking input from preceptors on the kind of site content they would find helpful. Please e-mail your suggestions to kdsav@med.unc.edu.

Challenging Cases

Challenging Cases is a regular feature in *The Front Line* intended to assist you in your role as a preceptor. It needs preceptor input in two areas. First, the editor is seeking suggestions for cases to be considered in future issues. If you have encountered a “challenging” situation with a student (or course director or university administrator) during your precepting, please consider sharing it through this feature as a teaching/learning tool. Fictional scenarios—cases that one might encounter—are also acceptable. Second, volunteers are also sought who are willing to serve as commentators on the general precepting issues the cases present.

If you will help in either of these ways, please contact Katherine Savage, newsletter editor, at UNC-Chapel Hill, Campus Box 7530, Chapel Hill, NC 27599-7530.

Case

“The student you have been precepting for the past several weeks tells you that he was interested in your specialty until seeing the demands it makes on you, professionally and personally. Now he is uncertain of his career goals. How do you advise him?”

David Wells, M.D., Hominy Valley Family Health Center, Candler:

First, I thank him for recognizing how hard I work and ask him to tell my patients who are tired of waiting for their appointments, tired of waiting more than 24 hours for their lab results, tired of being asked for prompt payment of their bill, tired of waiting on the automated phone system, and tired of doctors being in medicine just “for the money.”

My own practice does involve a full day of scheduled appointments, but it usually involves three to six more hours per day of a multitude of other tasks: paperwork; voluntary representation on hospital committees, or with the local chapter of the American Red Cross, or at the local free medical clinic; endless dictations; lab result interpretation and notification; development of follow-up plans or referral; “managing care” with the patients’ insurance companies who want me to explain in duplicate and greater detail why I want to order a certain test or use a particular medication (which

usually has to be justified every six months); dealing with patient complaints regarding perceptions of medical management issues based on their new knowledge from the multiple “ER” episodes or “Claritin” or “Viagra” TV commercials they watch, or bogus Internet sites some find; trying to learn how to use my new PDA (personal digital assistant, or “Palm”) and figuring out how fearful I am to press the reset button when it misbehaves; trying to help decide what kind of electronic medical record system to use in our office; dealing with office staff issues; and a few other things.

It is true that my life is as full of work as I could ever want it to be. But I also go to work each day looking forward to seeing (most of) my patients and trying to figure out the puzzles of their as-yet-undifferentiated illnesses or concerns, the kind of thing you dream about doing before you enter medical school. I like seeing that I have prevented someone’s colon polyp from becoming a cancer by taking the time to talk them into doing their screening endoscopy when they seem

hesitant to go looking for problems (“if it ain’t broke...”). I enjoy the feedback most of them give me regarding their appreciation of the time I spend listening to them and trying to understand how to help them. Or sometimes they appreciate my just admitting that I cannot understand what troubles them, but reminding them that I will be here for them nonetheless and will continue to work toward understanding their concerns and referring to others when necessary.

I look forward to a few home visits I do for the Hospice Home Care patients where I always see a sigh of relief from the family and patient when I tell them that I will help keep them at home as long as we can, without having to pay for the \$400 ambulance ride to come see me in the office, and working with their wish to stay out of a nursing home, and promising never to hospitalize them again if they choose not to go. I like being the one my friends and family go to for their own medical questions to get the perspective of someone they know they can trust. I like the look on the kids’ faces at the school my own children attend when I show them how to use a stethoscope, or show them an x-ray of a bone or chest.

I look forward to the next issue of *American Family Physician* or *Wilderness Medicine* that I read whenever I have the spare time from the mandatory work and fun family time I have. From a practical perspective as a physician, I know I make a decent living and will likely never have to worry about job security in any economy. I like having some input into making my own work schedule, as long as I meet some minimums my partners and I request of each other, and being able to have a

“I go to work each day looking forward to seeing my patients and trying to figure out the puzzles of their as-yet-undifferentiated illnesses or concerns, the kind of thing you dream about doing before you enter medical school.”

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decent work environment and relatively comfortable (albeit certainly not extravagant) quality of life, and the ability to be able to choose where I want to live and practice as a Family Practice physician, unlike many specialists. I like the potential for someday being able to work as a medical volunteer in another part of the world. After seeing a few nursing home 90-year-olds just before coming home from work, I like being able to see my neighbor's one-year-old child who has had fever and irritability for three days and then helping the parents decide if they need to take him to the ER now or wait to see the child's own doctor in the morning.

Every single day is different. I never need a cup of coffee to keep me awake like I have in other jobs in which the drudgery of sameness was a tremendous burden and big yawn. Yes, the workload is great, but I would not want to do anything else, AND my workload is my choice in the big picture. I could choose a different place to live, a different group of partners, possibly a decrease in work hours and pay (maybe even better pay if I looked hard enough), a new school system for my children, and so forth. I could change relatively quickly to a job with more defined (shorter) hours. If I worked in an Urgent Care even as a Family Physician, or in a number of other specialties, I might gain more free time, but could lose the continuity of care that I and my patients enjoy so much. As a Primary Care Physician, I can usually deal effectively with the broad spectrum of pediatric and adult problems, and if I can't, I just pick up the phone and refer for consultation.

Sure, there are drawbacks to every field of medicine and every career option, and there are certainly other ways to make money, but I have found the right career for me even with all the perceived headaches. I think the grass is already pretty green over here, even if not the perfect work and family life that I might have envisioned when making my decision to go to medical school.

Karen Bash, M.D., Clinical Associate Professor of Obstetrics and Gynecology, UNC-CH, and Director of Medical Student Education, Department of Obstetrics and Gynecology, Wake AHEC, Wake Medical Center: This is not an uncommon scenario. Many students are attracted to the blend of medicine and surgery unique to obstetrics and gynecology. When counseling students about such an important decision, I feel it is essential to present a comprehensive picture.

“We have great flexibility, and few within our field would ever say they have a boring career.”

The physical and emotional demands of our field are difficult. Most obstetricians continue to work 24- to 36-hour shifts. Few of our patients would be willing to accept their spouse's or parent's being away from home night after night, weekends, and holidays, but many are quite distressed when their choice of an obstetrician is not available and they may not have the person they trusted for nine months of care there to participate in the final hours of their birth experience. To the obstetrician, call nights and weekends can be long and lonely without family and friends.

Practicing obstetricians are burdened with decreasing reimbursements along with increasing malpractice insurance premiums and the rising costs of maintaining an office. Physicians in general are held to a higher standard of job performance than most of the rest of society, and few couples accept less than a perfect baby without looking for someone to blame and expecting monetary compensation. The thought that we might jeopardize our own family's financial security for the well-being of others can be overwhelming.

With all this said, why would anyone ever consider a career in Ob/Gyn? Maybe because it is without a doubt one of the most rewarding lifestyles anyone could ever consider. As obstetricians, we are present at the most intimate family event: the birth of a

child. We share in the laughter and tears of a long-anticipated birth, and few women ever forget the details of their birth experience. Being reminded by a patient that we were present for the most rewarding experience of her life can certainly reenergize us and erase the fatigue of a long call night. It is truly a privilege to be such an integral part of so many lives.

On an intellectual basis also, few careers are more rewarding. There are so many options open to us within the field of Ob/Gyn. Generalists participate in all aspects of women's health, providing primary care to women from teenagers to the elderly. A generalist may care for a patient by providing birth control, follow her through her childbearing years, and participate in her peri- and postmenopausal care while providing family planning and obstetric services to her children that he or she delivered years earlier. Generalists can choose to provide Ob care, perform surgical procedures, and practice office-based medicine. There's the flexibility of practicing alone or as part of a larger group. There are private practices, hospital-based practices, and university-based practices, all with their own unique challenges and rewards.

The specialties within the field are also growing. There is fellowship training in gynecologic oncology, reproductive endocrinology, pelvic reconstruction and urogynecology, maternal-fetal medicine, and advanced laparoscopy and pelvic pain syndromes. These specialties also allow physicians flexibility to practice within the field of Ob/Gyn and Women's Health while maintaining a lifestyle more suitable to their personal needs.

Although there are many challenges facing obstetricians and gynecologists today, our career choice remains one of the most rewarding in medicine. We have great flexibility, and few within our field would ever say they have a boring career. Our days are fast-paced and exciting, and I would encourage our medical students to learn as much as they can about the field and consider a career in Ob/Gyn.

To Be a Mentor (continued from page 3)

To this day, Webster’s Unabridged Dictionary defines a mentor as a wise and trusted counselor or teacher, or an influential senior sponsor or supporter. This is something more than an educational adviser, who is “a teacher responsible for advising students on academic matters,” or a preceptor, who is “a teacher, instructor or tutor.” Thus mentoring is more than the bread and butter of instruction in medical education—teaching or transmitting knowledge, skills and attitudes.

Mentoring implies the building of a closer mutual relationship with the learner than just an instructor-student interaction. Usually there is an initial **attraction** that draws the two together. From the perspective of the learner, he or she may perceive the teacher as someone s/he would like to imitate or whose accomplishments s/he admires and aspires to. This role model therefore inspires and energizes the learner. From the teacher’s perspective, the learner offers a willingness and openness to learn, often provides resources in the form of assistance in the teacher’s tasks, and shows a capacity for personal growth. There are usually one or more other personal, cultural, or social factors that can also draw the two together in a common interest; for example, a common heritage, religious affiliation, interest in music, or a particular aspect of medicine. Therefore, mentoring cannot be considered a one-sided affair and is not something to be programmed or required for every teacher and student.

In the nascent mentoring process, although the attraction is there, **action** is needed to begin the mentoring relationship. This may involve a request from the learner—“I wonder if you have time to review this write-up I’ve done for my elective? I would really respect your opinion”—or an invitation/intervention by the teacher—“I have got to fill out a disability form for this patient. Would you like to help me do it?”

What follows then is the process of **cultivation** of the mentoring relationship—a little like tending a garden! This is where the relationship goes beyond the teacher-learner dyad, for it involves the sharing of personal issues and often shared work, usually guided by the mentor. Cultivation also means implicit (“let’s have lunch sometime and talk about it”) or explicit (“why don’t we meet for an hour every week”) development of a structure to the relationship. Cultivation is enhanced by the strong evidence of positive affect from the mentor: support, encouragement, and affirmation by the teacher, and need, gratitude, admiration, and responsiveness by the learner.

The Mentor’s Role

In general, the mentoring role involves two key strategies in guiding the learner: providing support and posing challenges. These are summarized in the table below.

Mentoring Strategies	
■ Support	■ Challenge
Listen	Set standards
Give feedback	Set positive expectations
Be a reflective mirror	Introduce to a different world
Offer a safe place	Permit learner to speak in own voice
Acknowledge legitimacy	Have learner challenge himself
Socialize into professional life	Set tasks
Promote/Advocate for learner	Help learner reflect on actions
Build relationship	Peel away boundaries

Returning to the definition of the mentor in Webster’s Dictionary, it can be seen that many of the strategies in mentoring are concerned with guiding the expectations and goals of the learner, helping broaden horizons and peel away the boundaries of his/her own experience and beliefs. Furthermore, the mentor helps the learner feel safe to express his/her opinions, take some risks and explore new ways of doing things with legitimacy, while adhering to professional standards and ethics. Finally, the mentor may actively promote or advocate for the learner in the form of recommendations or specific professional assignments.

An effective mentor in medical education usually exhibits a range of attributes, professional and personal, that contribute to success. Personal attributes include honesty; a sense of justice; role modeling of personal, family, and community life; the ability to give direction; enjoyment in guiding or teaching learners, and an innate interest in the learner’s life. The learner may even become a long-term protégé. Good mentors frequently have a strong memory of positive mentoring in their own lives.

Professional attributes of the mentor include good clinical skills, an understanding of the principles and needs of medical education, an understanding of the health care system, and the ability to model self-reflection about clinical practice and guide the learner in the “medical life.” Mentoring about the medical life is extremely important, because professional habits form early in a physician’s career, when many functions and thought processes become streamlined and “automated.” Ideally, the young physician should be helped to acquire good habits and achieve a harmonious and balanced life without becoming trapped in unrealistic expectations and behavior patterns.

An Example of Mentoring

At the office, the preceptor, accompanied by a third-year female medical student, has just seen a 15-year-old girl who is pregnant. They discuss management of her prenatal care and some of the dangers of premature labor. The preceptor questions the student about the tasks the physician must perform at different stages of the nine-month pregnancy. They then move on to see other patients. At lunchtime, the preceptor brings up the subject of the pregnant young girl.

“What’s your personal thinking about teenage pregnancies?” he asks. “Do you think that this is just an inevitable part of our contemporary society, or should the medical profession try to change social behavior to prevent this kind of thing happening?”

The student hems and haws and seems reluctant to discuss the issue. The preceptor says, “Don’t be afraid to speak your mind to me. This is a very controversial issue, and there are many opinions out there. I’m not trying to trap you into saying something you will regret. Some day you will have to decide about such issues for yourself, because you will make decisions based on your thinking.”

The student seems relieved and admits that she is a Catholic and is much troubled by the prospect of advising women about contraception in her role as a physician.

“The mentoring role involves two key strategies in guiding the learner: providing support and posing challenges.”

The preceptor says to her, “I can see you have a conflict here. But you will gradually come to some balance in your mind about this through experience. For my part, many years ago, I missed diagnosing pregnancy in an unmarried teen whose mother brought her in complaining of weight gain. The girl totally denied the possibility that she could be pregnant, and I believed her—didn’t bother to check her because I was in a hurry to get home. Later, she was admitted in labor at 32 weeks, with no prenatal care, and had a fine baby.

“Afterwards, I lectured her and her parents about the importance of prenatal care and contraception in the future—and darned if she didn’t do the same thing a year later! I was pretty ashamed of myself about this case. Since then I have decided not to lecture to youngsters and just help them sort out their problems.”

In the example above, the preceptor did more than teach about the management of prenatal care. He probed and challenged the student to reflect on the problem, he made it clear that she could be safe in voicing her opinion, and he frankly revealed his clinical error, his attitude towards counseling teens, and his somewhat conflicted views.

From this the student gained some useful insights into other aspects of the life of a medical professional beyond clinical management. One could say, therefore, that this incident had the makings of a mentoring relationship.

The mentor can rely on a few valuable homilies to help the learner:

- “Perfect is the enemy of good.” One of the dangerous balancing acts in medical education is the quest for excellence, the inflated importance of “knowing

everything” and the internal stress produced by expecting to achieve these goals. Doing something well or competently is okay; it doesn’t have to be perfect!

- It is also okay to be uncertain about one’s work, diagnoses, and management, particularly in primary care, in which so often symptoms are not related to pathology.
- As we all have clinical role models in our lives, try to pick ones that have small- to medium-sized shoes. This will make the goal of becoming like the role model achievable and more satisfying.
- Make sure to enjoy life, family, and outside interests; try to make time to play.

The effectiveness of mentoring has been quite well studied in the realms of higher education and the corporate world. And there is good evidence from academic medicine that it increases research productivity and career trajectories, although little data exist on its value to those whose major commitment is the practice of clinical medicine. In an interesting 1998 report on the educational needs of its physician staff at the Carolinas Medical Center in Charlotte, the junior staff placed mentoring as the number one priority, while senior members placed it around 10th in order of importance.

Rewards of mentoring

Intuitively, mentoring would seem to be “a good thing,” even though it means a greater investment of effort and time, than straightforward teaching. Although there may be the simple rewards of having an “apprentice” perform specified tasks and save you some work, the key issue from my personal experience is the realization that one is leaving, in someone else’s clinical style and career, a legacy of ways of knowing, clinical skills, and lessons learned. This can be as satisfying as caring for patients.

Dazol LA. Mentor: Guiding the Journey of Adult Learners. Jossey-Bass, 1999.



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Information Please

In this issue, we would like to highlight several clinical electronic resources available to UNC-Chapel Hill preceptors via the AHEC Digital Library (ADL).



New *InfoRetriever/InfoPOEMS* is a database and alerting system of filtered, synopsized, evidence-based information drawn from journal articles and other sources. It includes decision support tools, diagnostic calculators and tests, and practice guidelines.

ACP PIER *PIER* is evidence-based clinical guidance presented electronically in a unique layered and telegraphic format. It is designed for rapid access to clinical information at the point of care. *PIER* includes recommendations based on all levels of medical evidence including RCTs, cohort and observational studies, case reports, and expert opinion.

FDC publications The *NDA Pipeline*, *Pink Sheet*, *Tan Sheet*, and *Pharmaceutical Approvals Monthly* are now available in electronic format.

eMedicine This peer-reviewed resource provides a database of information in a variety of areas, such as selecting a resource center or searching for a topic. You can examine images, search for CME, develop a differential diagnosis, or view entire site by your specialty.

UpToDate Your ADL login and password provides you with access to this very popular resource.

Changes Currently the Cochrane EBM resources and ACP Journal Club are available collectively as *Ovid EBM Reviews*. Beginning December 2005, look for these resources separately as *Cochrane Library* and *ACP Journal Club*.

Looking for Scientific American Medicine (SAM)? The American College of Physicians began publishing this e-textbook in 2004 with the new name *ACP Medicine*.

Access: Go to the Health Sciences Library *Clinical Reference* page <<http://www.hsl.unc.edu/Collections/clinicalref.cfm>>. If accessing from off campus, you may use your ADL login and password when prompted.

Log into the AHEC Digital Library. Use the search feature to locate each of the resources listed above. Unsure of how to log into the ADL? Please contact your local AHEC Librarian for questions regarding your ADL Preceptor Membership, or send an email to adl-questions@listserv.unc.edu for technical assistance.