

## References

1. Anastasio GD, Harston PR. Fetal tachycardia associated with maternal use of pseudoephedrine, an over-the-counter oral decongestant. *J Am Board Fam Pract* 1992; 5:527-8.
2. Briggs GG, Freeman RK, Yaffe SJ. *Drugs in pregnancy and lactation*. 3rd ed. Baltimore: Williams & Wilkins, 1990.
3. Pritchard JA, MacDonald PC, Gant NF. *Williams obstetrics*. 17th ed. Norwalk: Appleton-Century-Crofts, 1985.

The above letter was referred to the authors of the article in question, who offer the following reply:

*To the Editor:* We thank Dr. Filardo for bringing to our attention a new and well-referenced text entitled *Drugs in Pregnancy and Lactation*<sup>1</sup> by Briggs and colleagues. This reference was published in 1990 and therefore not available in 1989, when the case we reported occurred.

The Food and Drug Administration (FDA) pregnancy categories were established in 1979 and rank a drug on its ability to cause risk to the fetus. Pseudoephedrine was approved for use prior to 1979 and therefore does not have an FDA pregnancy category rating. Briggs, Freeman, and Yaffe<sup>1</sup> have assigned pseudoephedrine to category C. The most recent edition of *Williams Obstetrics*<sup>2</sup> gives this description of category C drugs:

Drugs for which there are no adequate studies, either animal or human, or drugs in which there are adverse fetal effects in animals studies but no available human data. Many drugs or medications commonly taken during pregnancy are in this category; therefore, it presents the most difficulty for the physician both with respect to clinical use and from a medicolegal standpoint.

Neither reference cited by Dr. Filardo states a concern for using pseudoephedrine in the third trimester. Briggs, et al.<sup>1</sup> state that an association in the first trimester was found between the sympathomimetic class of drugs as a whole and minor malformations. *Williams Obstetrics* states, "Most antihistamines and decongestants are classified as categories B or C, and while they are apparently harmless, they should be avoided, at least in early pregnancy." Historically, data on the risk of drugs in pregnancy focused on the teratogenic effects that occur during the first trimester. More data need to be obtained concerning the pharmacologic and physiologic effects of maternal use of drugs on the developed fetus.

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## References

1. Briggs GG, Freeman RK, Yaffe SJ. *Drugs in pregnancy and lactation*. 3rd ed. Baltimore: Williams & Wilkins, 1990.

2. Cunningham FG, MacDonald PC, Grant NF. *Williams obstetrics*. 18th ed. Norwalk, CT: Appleton & Lange, 1989.

## Microskills Model of Clinical Teaching

*To the Editor:* Neher, Gordon, Meyer, and Stevens reported in the July-August issue of *JABFP* their experience with a microskills model of clinical teaching in presentations to faculty in family practice and other specialties at several national and regional meetings and to fellows in family medicine.<sup>1</sup> We would like to report our experience in instructing medical student preceptors and 3rd-year residents in family medicine in the use of these microskills in clinical teaching.

In the last 2 years we have presented a workshop entitled Teaching Skills for the Physician: The One-Minute Preceptor at three continuing medical education courses for family physicians, three annual meetings of state academies of family practice in the Northwest region, and on two occasions to 6 graduating family practice residents. At each of the state and continuing education meetings, 20 to 30 family physicians, the majority of whom have been engaged in teaching medical students or residents, attended the presentations. The session usually occurred in a 1½-hour to 2-hour format and included an overview of the microskills, a more in-depth description of the microskills, an opportunity to practice each microskill individually in a demonstration, and, finally, small-group role playing simulating the clinical teaching environment. We utilized materials prepared by Katherine Gordon. In all cases the content of the workshop was rated at least a four on a five-point scale. Seasoned clinical teachers of medical students and residents often commented that the presentation finally made sense of what they were attempting to do in clinical teaching and that they wished they had learned the microskills earlier. Graduating 3rd-year residents have said that the model would have made teaching younger residents a less frustrating experience and would have given them an increased sense of confidence in their teaching skills. Interestingly, they believed that learning the microskills even during their 1st year would have facilitated their learning during residency by helping them to know what to expect from the clinical teaching environment.

We have found that preceptors do not believe that students formulate an opinion very early when seeing a patient. It is often enlightening to these preceptors to learn that research in medical education has shown that even the beginning student or the novice forms at least a rudimentary differential diagnosis within minutes of meeting a patient.

We often begin our presentations with a discussion of how to balance the dual roles of teacher and physician. The metaphor of two hats, in which one hat is the teacher's hat and the other is the physician's hat, has been useful. We encourage our preceptors not to try to wear both hats at one time because of the potential conflicts in agendas involved. Rather, the pre-

ceptor needs to delineate when the job as a teacher ends and when the role as a physician begins. As a teacher, having the student provide endless amounts of information without ever making a commitment to a diagnosis leads to lack of learning. Once we have performed our jobs successfully as teachers, we can then put on the physician hat and walk into the room to gather more information directly from the patient, to perform any necessary physical examination, and to provide the patient with our diagnosis and treatment plan.

In teaching the concept of "probing for supporting evidence," we have found another metaphor, the mind map, useful to our preceptors. We describe that the expert's mind map includes clear differential diagnoses for presenting problems and connections of each diagnosis to appropriate evaluation and treatment. The expert's mind map can include looser associations of clinical information with basic science information. In contrast, the student's mind map often includes extensive information about the basic sciences but sparse lists of differential diagnoses, treatments, or evaluation strategies and loose links between these elements. The job of the teacher in "getting a commitment" is to find out where the student is on his or her mind map, and the job during "probing for supporting evidence" is to explore the student's thinking and knowledge around this point on his or her mind map. In using "probing for supporting evidence" in our own teaching with students and residents, we have found that we often do not recognize that a student has not really made a commitment until we begin to probe for supporting evidence. Regarding "teaching general rules," we find that it is important to teach both to what the student or resident is thinking and to what is actually most important in taking care of the patients. For example, in evaluating a patient for sleeplessness, the resident could focus on the choice of an appropriate sleeping medication but ignore the possibility that the sleeplessness is a symptom of depression. In this case it would be helpful to teach the resident additional information about the choice of sleeping medications, as well as teaching him or her to include the diagnosis of depression in the differential diagnosis for sleeplessness.

We appreciate the fact that Drs. Neher, Meyer, and Stevens and Ms. Gordon have described these microskills in the literature. Our experiences in teaching this model and in using the model in our own interactions with students and residents also have been very positive.

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#### References

1. Neher JO, Gordon KC, Meyer B, Stevens N. A five-step "microskills" model of clinical teaching. *J Am Board Fam Pract* 1992; 5:419-24.

#### Obstetrics in Rural Family Practice

To the Editor: Greer, et al.<sup>1</sup> and Nesbitt, et al.<sup>2</sup> address important issues in the specialty of family practice about the delivery of health care in rural areas of the United States. In his editorial, Dr. Wall<sup>3</sup> correctly suggests that the multitude of stressors on our health care system in general is magnified in rural obstetrics. I identify with these issues, having practiced in rural Colorado for 17 years. My practice included obstetrics both in group practice and then in solo practice. It was not easy. I quit obstetrics when my insurance premium was to take a 1-year jump of about \$10,000 per year. Although this differential for family practice with obstetrics persists to this day, Dr. Wall is correct that liability cost is not the only obstacle here.

The following could be valid reasons why physicians who had promised to take up obstetrics again do not do so:

1. There is significant change in skill and a loss of comfort with that skill when one stops practicing it.
2. If one quits obstetrics, it would be logical to stop reading the literature in that field (there are so many other topics in medicine with rapid technical advances). It would be likely also that one's choice of continuing medical education courses would not be in obstetrics.
3. The anxiety associated with the liability and risks of doing obstetric procedures often outweighs the fees earned. Once the physician becomes free of such feelings, he or she might wonder, "How did I ever do (tolerate) it? Was it worth the money?"
4. Dropping the cost of coverage does not reduce this associated anxiety. Nor does it make us trust the medical legal system more.

The validity of listing liability and liability costs of doing obstetrics as important reasons to stop doing obstetrics is not negated by physicians not returning to obstetric practice if malpractice premiums drop again. Liability and liability costs are important, but there are many other considerations that come to mind after the liability issue is resolved. Dr. Wall discusses some of these; they are real and not easily addressed. We physicians need to be more kind to ourselves and our colleagues. Are we now feeling less good about ourselves, just as society seems to rank us lower? Is this not inappropriate?

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#### References

1. Greer T, Baldwin L, Wu R, Hart G, Rosenblatt R. Can physicians be induced to resume obstetric practice? *J Am Board Fam Pract* 1992; 5:407-12.
2. Nesbitt TS, Arevalo JA, Tanji JL, Morgan WA, Aved B. Will family physicians really return to obstetrics if malpractice insurance premiums decline? *J Am Board Fam Pract* 1992; 5:413-8.