Becoming Preceptor, Becoming Student: Private Practitioner-Medical Student Relationships in Medical Education

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Abstract

MEREDITH L. CLEMENTS: Becoming Preceptor, Becoming Student: Private Practitioner-Medical Student Relationships in Medical Education
(Under the direction of Steven K. May, Ph.D.)

Medical schools, like many institutions, are complex and evolving organizations. Over the late 20th and 21st centuries, we have seen deliberate changes in medical education, including efforts to introduce and enhance mentoring in the clinical setting. Founded 12 years ago, Florida State University College of Medicine (FSU COM) differs from traditional academic health centers, placing an emphasis on non-traditional methods of clinical instruction. By employing private practitioners to serve as preceptors, FSU COM de-centers the third-year clinical experience, arguing against the notion that training should occur in large teaching hospitals primarily under the instruction of residents and faculty. This study examines the mentor-mentee relationship from the perspective of those who experience it in order to broaden our understanding of teaching dynamics as well as the relational process as a whole.

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AHC	Academic Health Center(s)
FSU COM	Florida State University College of Medicine

Introduction

As the baby boomer generation ages and life expectancy continues to rise, the need for more primary care physicians continues to rise with it. In addition, health complications such as diabetes and heart-related illnesses span all age groups, forcing recurring hospital visits from chronically unhealthy patients. The baby boomer generation is synonymous with the state of Florida and thus, we see the need for quality patient care reflected in its population. Florida is geographically spread-out, heavily inhabited, and well known for its aging population, thus affirming the state's need to produce and retain quality primary care physicians.

If the American healthcare industry can shift its focus toward prevention with the commitment to restructure the process of reimbursements, reduce reoccurring patient visits, and (re)emphasize training of current and future providers, while maintaining a focus on wellness, we could see some productive change in healthcare. While this notion is not particularly new, public discourse addressing the possibilities of reform, I argue, has taken a backseat to what mainstream news media refers to as political rhetoric. The lack of public discussion concerning alternative perspectives on healthcare reform is unfortunate. We are in an era where healthcare is bankrupting America, and we, as a public, need to consider the less frequently discussed dimensions of health care, such as the training and education of our current and future physicians.

At a time when the political aisles are divided to a point where it seems reforms are either slow moving or reaching a stalemate, we must look to other sites of change

within the healthcare structure, sites such as medical schools that are responsible for producing the workforce that is, in turn, tasked with the responsibility of caring for patients. It is the medical student who has the potential to influence the future, but it is the medical school and its educational processes that must nurture and prepare the student. Therefore, it is important to examine how modern day medical students are trained, especially in the clinical setting where students interact with and often care for patients.

Medical schools, like many institutions, are complex and evolving organizations. Over the late 20th and 21st centuries, we have seen deliberate changes in medical education, including efforts to introduce and enhance mentoring in the clinical setting (Ferrara, 2012). Florida State University College of Medicine's (FSU COM) community-based educational model is an example of such change. Founded 12 years ago, FSU COM differs from traditional academic health centers (AHCs), placing an emphasis on non-traditional methods of instruction. By employing private practitioners to serve as preceptors, FSU COM de-centers the third and fourth year clinical experience, arguing against the notion that clinical training should occur in large teaching hospitals primarily under the instruction of residents and faculty. At Florida State, third-year students rarely interact with residents. Rather, the private practitioner and student engage in a one-on-one, dyadic relationship that is reminiscent of an apprenticeship. The third-year experience is composed entirely of the clinical rotation, placing the student-preceptor relationship in the center of the curriculum. The fourth-year experience, on the other hand, incorporates the clinical rotation as well as more specialized clinical training. In addition, fourth-year students spend a great deal of their last year applying and

traveling to different hospitals for additional clinical experience and potential residency interviews. After students earn their white coats and complete their residency, the vast majority enters the private sector, suggesting the one-on-one time in the field during the entire third-year and part of the fourth year might help students commit to a specialty in which they have already spent time. Students rotate through specialties (for example, family medicine, pediatrics, psychiatry, obstetrics and gynecology, and general surgery). The rotations promote exposure and experience in different areas, which is supposed to help students in their career decision-making and enhance their overall clinical skills. Since applications for residencies take place during the fourth year, most students choose or rule out certain specialties during the third year of study. Given the particular emphasis on the preceptor-student experience during the third year of study in FSU COM's education model, this paper focuses specifically on the third-year medical student's clinical experience as it is situated within the four years of medical school.

Private practice-based physicians enter into the preceptor-student relationship willingly, while the experience is required for third-year students. This dyad was established with the idea that private practitioners and students will benefit from such a relationship by engaging in instruction that more closely resembles mentoring and, as previously mentioned, apprentice-based skill acquisition. In addition to helping students commit to a specialty, participants benefit from "daily practice encounters" typical to everyday practice as opposed to the teaching hospital setting where patients "usually have exotic diseases" (FSU COM Web site, 2013). There is also a sense of continuity with the preceptor-student experience. As a student explains, "I felt like a very essential part of patient management all the way from when they [patients] first came into the clinic, to

assisting in their surgery, to seeing them post-op" (Third-Year Clinical, 2004, p. 2). Also, treating patients in smaller settings reinforces the value of keeping patients out of hospitals, which should be a primary goal of healthcare.

This study seeks to explore how private practitioners and third-year medical students come to understand and describe their preceptor-student relational dyads within the Florida State University College of Medicine educational model. In addition, I wish to know why private practitioners become preceptors and what they perceive as incentives for maintaining this role. To examine this relationship, I explore extant literature on medical education and engage in a case study method. I will explore the literature on mentoring in medical education, including more specific dimensions of mentoring such as motivation, rules and roles, and expectations as they are situated within Florida State University's non-traditional medical education model.

This study, I argue, is timely because FSU COM is a new medical school with a non-traditional clinical education model. As previously stated, a primary component of this model is the one-on-one preceptor-student relationship. This relationship is a particularly new, non-traditional component of medical education that is being considered as a skill strengthening, hands-on approach to clinical training. For example, some third-year students finishing their obstetrics gynecology rotation in 2012 shared their confidence in the hands-on model, saying they had the opportunity to deliver more babies than students in traditional teaching hospitals where they are more likely to be in the room but not in the center of procedure (personal interview, 2012). Before FSU COM was founded, there had not been a new medical school established in the nation for 20 years (Watson, 2012). The institution's newness offers a unique opportunity to study

an innovative model of education (Watson, 2012). Currently, there are less than 25 medical schools in the country that employ the same or a similar apprentice-like clinical experience and, as such, a study of the preceptor-student relationship may offer insight into how to strengthen these relationships and, in turn, medical education (Third-Year Clinical, 2004, p. 3).

My goal for this study is to better the educational experience for both private practitioners and medical students at Florida State University. As Dean J. Ocie Harris suggests, FSU COM's community-based model relies heavily on the participation and quality of the private practitioner. According to Harris, "without the dedication of these excellent physician role models, and their willingness to share their experience with our students, we certainly would not be enjoying such wonderful success" (Third-Year Clinical, 2004, p. 3). The idea that private practitioners are integral to the FSU COM educational model has already been established. What is needed now is an in-depth study of the motivations and expectations of the participating physicians so we can improve the preceptor-student experience. Furthermore, examining the clinical experience within a new model might increase both internal and external organizational dialogue so as to gain a better understanding of how private practitioners influence their students as well as how students encourage and/or discourage preceptors. Examining the mentor-mentee relationship from the perspective of those who experience it broadens our understanding of teaching dynamics as well as the relational process as a whole. Doing so allows us to account for what came before the specific relationship under examination and how the relationship may impact participants after it ends. Therefore, I ask, how do private practitioners and third-year medical students at Florida State University College of

Medicine understand and describe their preceptor-student relational dyads? Additionally, why do private practitioners become preceptors, what do they perceive as incentives, and what motivates them to maintain this role?

In the next section, I historically situate FSU COM within the larger field of healthcare and medical education. Then, I explore how current research in various areas of medical education conceptualizes mentoring in medicine. I wish not only to discuss the current state of the literature but also to interrogate the concepts medical education researchers use to describe mentoring. As I will explain, the relationship is often depicted as a linear progression in which the student and physician exit the relationship with more than they entered, especially if the mentor follows a form of best practices. While my aim is to problematize the dyad by taking an in-depth look into how students and physicians describe their motivations, rules, roles, and expectations, it is necessary to begin our discussion with a historical contextualization of FSU COM then proceed with a conceptual framework. Finally, I will propose a theoretical framework, discuss my research method, and conclude with preliminary interpretations of the data and remarks concerning future research.

"Rare but There:" A Historical Overview

I conceptualize the preceptor-student relationship as a process composed of participating actors, roles, rules, motives and expectations. I also approach the process as historically situated, meaning it is positioned in a particular place, space, and time. The preceptor-student relationship is influenced by previous systems such as institutions, informal and formal rules, and professional roles that are used to navigate interpersonal exchanges between students and instructors. An example of these influential institutions

is the healthcare system at large as well as teaching models employed by existing medical schools. Other factors in place are the political and financial forces that tend to influence organizational decision-making, especially in the case of a publically funded institution such as Florida State University College of Medicine. Thus, in an attempt to better familiarize the reader with the specifics of the preceptor-student relationship, I provide a brief historical overview of FSU COM and its community-based teaching model.

Founded in 2000, Florida State University College of Medicine (FSU COM) is the most recently established medical school in the nation (Watson, 2012). Since 2007, the student body has been at its full capacity of 120 and, as of 2012, 450 students have graduated from the college (Bradley et al., 2012; Fogarty et al., 2012). The College of Medicine was funded by the Florida legislature with the intent to produce and retain more primary care physicians, thus meeting the needs of a state with a large elderly population, underserved communities, and rural sub-populations (Fogarty et al., 2012). As I mentioned earlier, this model aligns itself with the notion that well-trained primary care physicians will result in quality patient care, which is (or should be) a goal for medical education.

FSU COM's education model is described in its mission in a rare, non-traditional manner, which they refer to as a community-based model (Bradley et al., 2012). There is a slight irony to the newness and rarity of an apprentice-based instructional experience considering the origin of the concept. Apprentices worked under experts who, for centuries, trained their students in a particular trade. Academic health centers, however, have been training students in a model unlike an apprenticeship, meaning students do not learn in a one-on-one exchange. Keeping these differences in mind, FSU can be

considered a non-traditional model even though part of the model is a slight reproduction of an age-old learning process. Unlike a traditional apprenticeship, however, FSU COM preceptors do not decide when students may break from their guidance and enter the field. Instead, students spend a specific amount of time under a preceptor's instruction ranging from a month to eight weeks depending on the specialty.

Students' clinical rotations vary from rural to town or city-based practices extended over 90 medical facilities throughout the state (FSU COM Web site). As some of the administrators explain, medical schools' emphasis on teaching is occasionally ignored or forgotten over time. By contrast, FSU COM's mission of teaching, they claim, remains a focal point of their decision-making processes (personal interview, 2012). This, as they explain, is different than traditional teaching hospitals with faculty who are under immense pressure to produce funding that, in turn, places teaching in a less prominent position. For this reason, having private practitioners serve as preceptors exemplifies the administration's commitment to the mission statement's emphasis on teaching (personal interview, 2012).

The school consists of a main campus, located in Tallahassee, Florida, where the administration is housed and first and second year students attend classes. In addition to the main campus, FSU COM has six regional campuses throughout the state. After the first and second year, students enter their clerkship rotations, which occur in the communities where the regional campuses are located. During each rotation, the student is assigned to one preceptor, who is a private practitioner in the community. As stated, this hands-on experience reduces interactions with residents, unlike AHCs where residents assign most of the students' tasks. Community-based learning is infrequent

during traditional clerkships. At AHCs, patients come to one site, yet FSU COM medical students are assigned to smaller, more rural areas where, in essence, students are coming to the patients. A teaching hospital such as University of North Carolina at Chapel Hill is an excellent example of a major AHC; it is famous, takes up most of the campus' land, generates the most money, and views research as the dominant component of its academic mission (Watson, 2012, p. 1). Interestingly, one of FSU COM's biggest critics was Dr. Watson (2012) who, at the time, was a professor at University of Florida, another major academic health center. Dr. Watson spoke against the necessity of another medical school in the state of Florida. According to Watson, "as [FSU COM] was being established…I was among its most vocal doubters and critics" (Watson, 2012, p. 2). Over time, Watson reversed his stance and became one of the most vocal advocates for one-on-one, apprentice-based learning. During this time, he was hired as a professor of neurology and executive associate dean for administrative affairs. As he explains, "…actually working at this new medical school convinced me that a different kind of medical school can be highly effective in the formation of future physicians" (Watson, 2012, p. 2).

Similar to Florida State's regional campus design, Michigan State University (MSU) has a clerkship program spread over six cities dispersed throughout the state. In an investigation of MSU's education model, Dodson (1998) examines the motives and attitudes of obstetricians and gynecologists in private practice who willingly serve as instructors. Dodson refers to private practitioners affiliated with the department as volunteers. Practitioners affiliated with Florida State, on the other hand, are referred to as preceptors. Similar to literature on FSU COM (Bradley et al., 2012; Watson, 2012),

Dodson views the practitioner as filling a key role in MSU's educational model. Therefore, I find the volunteer reference problematic because it distances the practitioner from the institution, taking agency away from her/his role as an instructor.

While the term "volunteer" may be used because private practitioners who work for Michigan State are not paid for their time, any private practitioner who educates students, regardless of receiving payment or not, is losing funds. In interacting with students, private practitioners decrease their volume of patients. Since each patient visit is timed, and the time and health issue are coded as a monetary charge to the patient's insurance, teaching a student is likely to cause physicians to generate less revenue.

FSU COM preceptors receive limited compensation from the university. The compensation is intended to serve as a gesture --or incentive-- and is not nearly equivalent to what physicians can earn seeing patients without a student (personal interview, 2012). For this reason, I find Dodson's labeling slightly misleading, possibly undermining the role of the practitioner as an instructor. Nevertheless, it is important to acknowledge existing terminology used to discuss similar relational dyads positioned in a similar historical context as this study.

As it stands, literature on FSU COM does not conceptually separate learning spaces, such as operating rooms or exam rooms. Some research (Hampton et al., 2009) claims it is important for medical education models to differentiate among places and spaces of student learning so students, instructors, and administration can gauge if and how exposure to certain spaces, such as the operating room, influences career choice. For instance, Bradley et al. (2012) explain the FSU surgical clerkship curriculum in detail, but do not consider the operating room as a separate learning space that requires

explicit teaching objectives. Perhaps FSU COM might place more emphasis on learning spaces within the private practices but, for now, the school focuses on spatial differences related to geographic location, population density, and patient access to primary care.

While the preceptor-student model appreciates the differences in clinical settings, FSU COM digitally monitors students' experiences across campuses through an electronic patient encounter log so the university can account for consistencies or inconsistencies of the clinical experience in rural or city-based practices at the individual level and across the state (preliminary interview, 2012). In other words, the school wishes to maintain the integrity of their different learning spaces so students have more practical experiences, yet they maintain the opportunity to monitor and report the differences. Private practitioners involved with FSU COM do not instruct students under a rigid curriculum, but they all use the same evaluation system at the end of each rotation to assess their students. Hence, the preceptor-student relationship is somewhat fluid and determined by the interactants but, ultimately, is dependent on FSU COM's guidelines and rules of assessment.

Conceptual Framework: Mentoring in Medicine

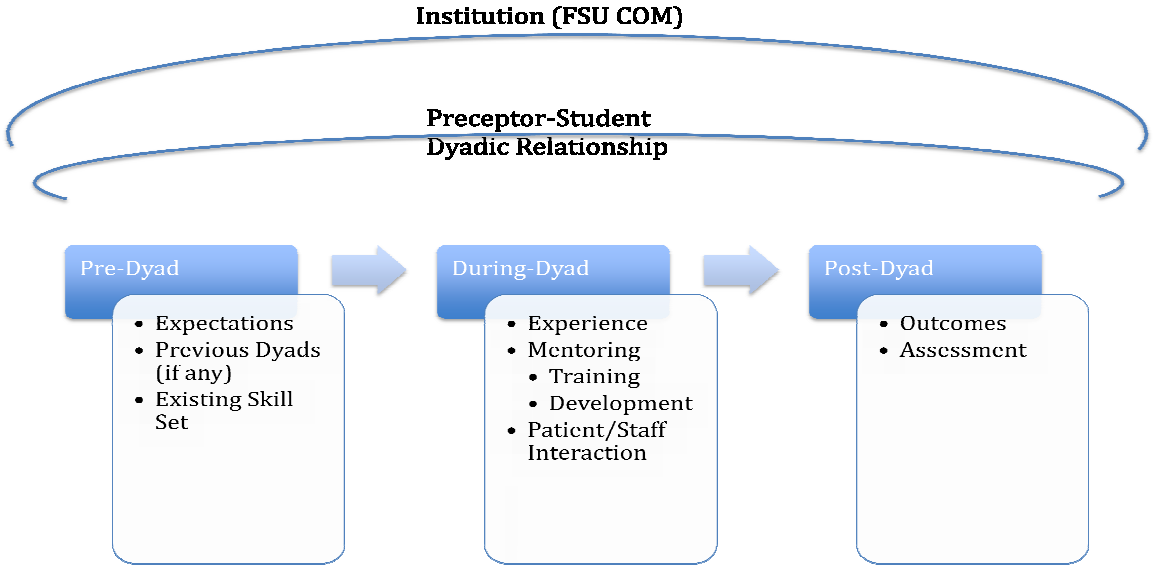
In this section, I discuss conceptions of mentoring in the field of medicine from the perspective of medical education researchers. The existing literature from the field informs my research design and helps assess and develop goals that are not only relevant to my research questions, but moves the issue of preceptor-student relationships forward. There is a vast amount of literature on mentoring and instructional role models in the field of medical education. Consequently, I have chosen to focus on research that addresses mentor-mentee relationships in the academic and private practice settings. The

following section frames the mentor-mentee relationship using the conceptions of the medical education field. Following this discussion, I look to complicate the relationship by using Giddens' structuration theory (1984) to consider the problem from a communicative and sociological perspective.

The images below represent how I visualize the mentoring process and the preceptor-student relationship as it is explained in the existing literature in the field of medical education.

Figure 3.1: Mentoring and Contributing Factors

Figure 3.2: Structure of Preceptor-Student Relationship as Liner Progression



As shown in Figure 3.1, the primary contributing factors in the mentoring process are assessment (Ansbacher, 2008), motivation (Ansbacher, 2008; Dodson, 1998; Ferrara, 2012), expectation (Ansbacher, 2008; Ferrara, 2012), type (Ferrara, 2012; Kalen et al., 2010), and participating actors (Quaas et al. 2009; Tracy et al., 2004). Ansbacher (2008) provides the reader with a sophisticated, quantifiable set of tables to allow administrators and preceptors to assess their abilities to mentor. A similar guiding assessment can be found on FSU COM's Web site, under the "faculty development" section, but it is not as detailed as Ansbacher's piece. Examples of advice for assessing a mentor-mentee relationship are asking students "why," and preparing mentors for moments where a student might give a challenging response (Ansbacher, 2008).

The assessment factor of the mentoring process is portrayed as an almost panacea, where an interested participant can review a codification of advice and become effective. For instance, Ansbacher suggests a mentor should suspend judgment so the mentor can consciously displace a position of bias. This is a difficult challenge, especially when coupling it with the encouragement to constantly "ask a student why" and receive her/his response in a nonjudgmental manner. The way in which assessment of self-as-mentor is portrayed in the literature may lead valuable preceptors to view themselves as "bad mentors," which, in my opinion, was not the intent of the article. Even so, pairing the goal of objectivity with the notion of a step-like guide to mentoring may lead to unnatural assessments of self-as-mentor, as if an effective, interpersonally conscious discussion of biases automatically classifies the mentor as "bad" or "ineffective." This interferes with Ferrara's (2012) call for informal dialogue between preceptor and preceptee.

Motivation is frequently discussed in the medical education literature on mentoring. Most pair the idea of motivation with the beginning phase of accepting the position as well as the phase where the relationship is still in progress, which is also conceived as recruiting and retaining physicians through incentivizing (Dodson, 1998). Ansbacher (2008) argues physicians are motivated by the idea of helping an individual solve academic, personal, and social problems. Motive, he goes on to say, forms the basis whereby the mentee can eventually become the mentor for others (Ansbacher, 2008). Similarly, Conley (2001) pairs the issue of motivation with filling a role, also suggesting physicians are motivated by the chance to help; he assumes they want to serve as a helper, guide, coach, and teacher.

The number of people taking part in the relationship categorizes the type of mentoring taking place, which can be between two or among a small group of people. Type of mentoring is connected with participants, tightly linking the two contributing factors. In this case, participants are members of the administration, healthcare providers, students, and potentially patients and staff. Quaas et al. (2009) describe mentoring as a process that can occur in a small group or a matched pair, but suggest that, ideally, mentoring should be between two individuals. As long as eye contact can be established and maintained among practitioners and students, Lang et al. (1998) typify the relationship as having the potential to influence students. Ferrara (2012) and Tracy et al. (2004) conceptualize it as a dyad made up of dialogue and support.

Lastly, expectations concerning the mentor-mentee relationship are conceptualized as a series of prospects, suggesting expectations occur before the relationship begins and are suspended and replaced by the challenge to adjust accordingly

as the relationship continues (Ferrara, 2012; Lang et al., 1998). Based on institutional framing, mentors and mentees should expect to gain more than they lose. FSU COM frames community-based clinical rotations as an opportunity for students to gain exposure to daily private practice activity and increase their clinical skills through hands-on experience. Thus, students enter the relationship with the expectation that they will and should get the chance to perform exams independently from their preceptor. Since the rotations span approximately more than a month, the students may be disappointed or surprised if they are not granted immediate contact with patients. The notion of an apprenticeship is categorized taking time, yet the preceptor-student relationship begins and ends in a matter of weeks and may or may not depend on the preceptor's confidence in the student's abilities (Ansbacher, 2008). We see the issue of time continuing to be connected to expectations in mentoring. For example, Ferrara (2012) views time as the most precious commodity in healthcare. Thus, there is an overarching expectancy that the preceptor will not have the "time required to make a partnership meaningful and the learning experience worthwhile" (Ferrara, 2012, p. 49). This is an issue participants have come to expect, and it is one that students must prepare. Thus, she poses managing this negative expectation by relying on pre-existing abilities, drawing on motivation from internal drives and critical thinking skills.

While the literature considers the contributing factors discussed above as central to the mentoring process, they are not recognized as mutually exclusive. Therefore, I accept that these factors provide insight into medical education, as a whole, and will investigate the perceived importance of each and their impacts on the mentoring process. With this in mind, none of the literature claims to encompass all aspects of mentoring in a

healthcare setting, which is exemplified by the lack of an initial definition of mentoring. Indeed, some authors choose not to acknowledge previous definitions because "no common operational definition [exists]" (Conley, 2001, p. ii). That being said, there are a few definitions in the literature that, I argue, are applicable to studying the preceptor-student relationship. For example, Tracy et al. (2004) define a mentor as, "an active partner in an ongoing relationship who helps the mentee maximize potential and reach personal and professional goals" (p. 1848). Though Conley (2001) does not attempt to describe mentoring in a single definition, she lists the ability to listen as one of the most important attributes of a mentor. This trait ties to Anschbacher's (2008) conception of the mentor as an individual who frequently "asks why" and listens without judgment. Again, this call to suspend judgment, when contextualized in the healthcare setting, seems unreasonable considering the student is in the position of learner and may benefit from the preceptor's judgment. Therefore, I argue, Ansbacher's argument would benefit from Kalen et al.'s (2010) conceptualization of the relationship as a developmental process facilitating the student's socialization into a health-related profession.

The theme of linearity underpins the literature, yet some interpret mentoring as an active and ongoing relationship, which suggests the potential for malleability within the linearity (Conley, 2001; Ferrara, 2012). This sense of linearity is also codified into an experience that can be influenced by a set of best practices (Ansbacher, 2006). That said, the majority of the literature is located in-between the extremes of conceptualizing the relationship as systematized or malleable (Kalen et al., 2010; Nivet, 2008; Quaas et al., 2009). As represented in the figure 3.2, the linear, stage-like progression suggests a sense of stagnation that can be seen even in the research that recognizes the participants' ability

to inform the process. Interestingly, there is a strong consensus in the role of a mentor and how she/he should function in the relationship. As Nivet (2008) argues, a mentor should maintain a focus on passing knowledge and skills to future practitioners. Similarly, Ferrara (2012) suggests preceptors "should view their role as an opportunity to demonstrate, share, and teach" (Ferrara, p. 52). Administrators also view this relationship as a teaching opportunity for physicians, which may or may not apply to the physicians participating in the FSU clinical dyad (Watson, 2012).

Despite the analyses of the mentor-mentee as a unit, and the proposed traits of a mentor (Ansbacher, 2006), there is little discussion concerning the mentee's agency (or lack thereof) and how it might (d)evolve during the relationship. Considering the FSU medical student-preceptor dynamic, where the student fills a role similar to an apprentice, it could be assumed the student, or mentee, would have little agency. Whether or not students and/or preceptors perceive such agency to exist within the exchange needs to be studied not only because it may be a contributing factor in the relationship, but also because it may impact specific relational communication in the field.

Ferrara (2012) calls attention to the student's agency, suggesting students have pre-existing abilities that make a partnership and the learning experience worthwhile. Also, according to Conley (2001), medical students bring declarative knowledge to the relationship, suggesting it is the mentor's role as expert to blend declarative knowledge with procedural and tacit knowledge, making connections between the new and the known. Even so, Ferrara (2012) and Conley (2001) are some of the few scholars who address the idea of students entering the dyad with pre-existing experiential and/or formal knowledge. This is surprising, given that the students are adult learners with two years of

medical education. The lack of attention paid to this issue may be because mentees do, in fact, have little agency. For example, Quaas et al. (2009) uses Greek mythology to historically situate and describe mentoring in medicine. As they explain, "Mentor is the person to whom Odysseus entrusted his son Telemachus when he had to go to war in Troy. By his return many years later, his son had grown on a personal and professional level under the influence of Mentor" (p. 132). Here, we see the notion of mentoring as more than a process of guidance. It is a relationship of dependence, where the mentor serves as *the* model of behavior, possessing most (if not all) of the agency. Failing to address the students' agency (or lack thereof) hinders the assessment of the learning experience. Therefore, we need a stronger, more in-depth focus on both mentor *and* mentee agency before and during the mentor-mentee experience.

Developmental training is often conceptualized as having clear beginning and endpoints, and mentoring in medicine is no different (Beinhocker, 2007). Clinical rotations rest on the idea that students go through a developmental process that will improve the students' interpersonal and technical skills (Lang et al., 1998). While the relationship is treated as both an instance and a process (Quaas et al. 2009), the literature depicts the clinical learning process as linear, which may lead current and future participants, as well as outsiders, to view the clinical rotation experience in an overly hopeful, almost romantic manner (see Figure 3.2 and Hampton et al., 2011; Tracy et al., 2004). This, I argue, may hinder, rather than facilitate clinical learning.

The literature's conception of this relationship can be interpreted not only as overly hopeful but also cautious to the point of idealization. Too often, practitioners are portrayed as possessing the necessary skills to navigate a mentor-mentee relationship, as

if expert physicians who participate are inherently "good" mentors (Tracy et al., 2004). On the other hand, Tracy et al. (2004) position mentees as entering and exiting the teaching relationship smoothly, as if they do not bring issues and skills into the exchange. Indeed, physicians' willingness to participate does not automatically equate to excellence in mentoring, which is why it is important to investigate what motivates practitioners to participate in the FSU COM model (Dodson, 1998). As Ferrara (2012) explains, "good" mentoring can evolve through dialogue between the mentor and mentee. Discussing expectations and goals can lead to "good" mentoring, but it is not a skill that many naturally possess (Ansbacher, 2008). If such idealized depictions inform participants' expectations, it could lead to disappointment and confusion, possibly diminishing the value of the experience.

Theoretical Framework

Economist Werner Hildenbrand compares the general equilibrium model to a gothic cathedral, dividing participants into architects and master builders, representing the process of (co)construction (Beinhocker, 2007). As I see it, we can draw on this comparison as a starting point from which to interrogate the possibility of a healthy balanced preceptor-student relationship (it may be noted, however, that Hildenbrand would be more fitting had he made reference to partial equilibrium since our problem considers a single relational occurrence). Nevertheless, using the analogy helps differentiate between assumed roles in the relationship. FSU COM administration can be seen as the architect, leaving practitioners and students to be the master builders. The preceptors are participatory actors, which differs from institutional actors who administer the professional expectations and assessment tools for the preceptors who are actively

building the relationship on a daily basis. According to Hildenbrand, the metaphorical cathedral rests on shaky ground. The preceptor-student relationship reflects this suggestion because it relies on the participants and, as interpersonal communication tells us, beings are ever changing.

Having reviewed the medical education literature on mentoring, and keeping Hildenbrand's architect-master builder analogy in mind, I turn to Anthony Giddens' (1984) conception of structuration, specifically rules, roles, and agency to help explain the communicative and social aspects of the FSU COM preceptor-student relationship. Ongoing, face-to-face interactions in a professional organization lend themselves to an application of structuration theory which, I argue, is a rich approach to examine such a relationship. The preceptor-student dyad is particularly interesting because FSU COM's institutional presence remains (in)visible throughout the relationship, yet interaction between the student and preceptor occurs within a different organizational setting--the private practice. This (in)visible structural presence suggests a tension among the dyad as it (re)occurs within private medical practices, the dyad as it is established by Florida State University College of Medicine, and the dyad itself.

As previously discussed, the dyadic relationship is conceptualized in the field of medicine and medical education as an imbalanced, linear development. While useful, this notion fails to acknowledge the interdependence between the larger, institutional structure of the private practice as well as the university and the small-scale instance of a particular preceptor-student dyad. Thus, I turn to Giddens' (1984) work to help navigate the underbelly of everyday negotiations taking place between preceptor and student. Giddens' theoretical perspective challenges the rigidity between paradigmatic boundaries

posed by theorists such as Mead (1967) and fellow symbolic interactionist and structuralist thinkers such as Parsons (2001) by conceptualizing structural problems as active (re)formations dependent on actors and social systems. His argument embraces subjective constructivism, claiming actions and participants are bound by institutional structure yet simultaneously maintaining and recreating it. Therefore, everyday negotiations between preceptor and student are guided by (re)created rules and roles within and around the dyadic exchange. This circularity simultaneously contributes to the structuring and restructuring of the particular preceptor-student relationship as well as the organizational institution in which it occurs.

I use Giddens' (1984) argument to explore how participants interpret their rules and roles as well as further complicate the relationship by looking for instances of agency (or lack thereof) to see who and what impacted it. To better analyze agency, we need to refer to instances of meaning making as they are related to power dynamics that contribute to a participant's ability to act in a way that impacts her/his position in the relationship. Actors such as the preceptor and medical student have the ability to self-reflect and potentially monitor current and future action, yet the outcomes of this reflectivity are not awarded equal agency due to unequal (and potentially unacknowledged) positioning. The positioning of preceptor and/or student within the medical setting conditions the circumstances in which action can occur (Giddens, 1984). This is demonstrated in the existing medical education literature's (Anschbacher, 2008; Quaas et al., 2009) conception of preceptors and students, where the preceptors are portrayed as enforcers of the conditions of student activity (for example, a student's amount of patient exposure is determined by the preceptor).

The preceptor-student relationship is treated as both an instance and a process (Quaas et al. 2009), transcending the dichotomy between powerful structures and passive subjects. Unlike Marxist scholarship, my study does not necessarily call for emancipation from existing structures in the medical education system. Instead, I employ structuration to suggest the idea that agency emerges in and through both participants and structures. Nevertheless, the agency of preceptors and students is not equitable. The literature suggests the preceptor has more influence over the structuring of the relationship (Anschbacher, 2008, Tracy et al., 2004), which supports Giddens' (1984) notion of the conditions of action and agency. The preceptor-student relationship takes place within two malleable yet bounded structures, or social systems, that serve as a guide for rule-based interaction--FSU COM and the specific private medical practice in which s/he works. In order to better understand the relationship and instances of agency (or lack thereof), we must examine how the participants are producing, conforming, and reforming the social system in which they interact.

While I do not aim to devote this section of the paper to an in-depth differentiation of Giddens from other theorists of the post-linguistic turn, it is important to highlight Giddens' conceptualization of organizational and behavioral sense-making as a conscious, organizational process that adds and retracts from the structure and those who compose it. As Poole and McPhee (2005) suggest, other forms of research strive to construct and maintain a balance in communication processes. Structuration theory, on the other hand, does not attempt to reach such a balance. Instead, more attention is paid to the structural components that constitute the imbalance we find between preceptor and student. As discussed earlier, the medical education literature refers to an imbalance in

the preceptor-student relationship, placing most of the attention on the mentor and less on the mentee (Anschbacher, 2008). This study does not have the goal of equalizing the roles of preceptor and student. Nevertheless, we must recognize that the preceptor-student relationship is more than a one-way transaction of knowledge from expert to novice. While the relationship exists for the purpose of teaching medical students, structuration helps us understand the interconnectedness of the actors with one another, their structural environment, and others who inform the relationship (for example, patients and staff). Therefore, I argue, the lens of structuration helps us look past surface level issues, such as the assumed linear transfer of information and, instead, confront the issues underneath the imbalance, such as the professional roles the student and preceptor employ and the power dynamic between the two.

In fitting with structuration theory, my analysis of the preceptor-student relationship places little emphasis on determinism and more emphasis on active constructionism. Giddens' notion of circular duality suggests there is a slight, and sometimes strong, deterministic structural hold on preceptors and students. Yet student and preceptors, as agents, are actively constructing the structure that is holding and, at times, determining their positions. This deterministic hold, however, is not totalizing; hence, the circular nature-- or recurrence--of structuration in a setting such as healthcare, where the conditions governing the continuity of the private practice are reproduced by the actors and their relational interactions (Cohen, 1989, Giddens, 1985, Spiegel, 2005). The different yet intertwined nature of agents and structures suggests a duality that is in tension with one another. For instance, as preceptors and students internalize structure through social practices, they are both enabled and constrained by healthcare

organizations and the rules and roles that constitute the practice of medicine (Giddens, 1984).

This way of thinking diverges from other popular theorists such as Bourdieu who accentuates the role of the unconscious in social behavior, which he refers to as habitus (Spiegel, 2005). While Giddens addresses the unconscious as one of three levels of awareness, he connects it to reflexivity, suggesting we often reflexively monitor behavior. Thus, while meaning making and awareness might be complex or emerge from unknown places, students and preceptors discursively (re)construct rules and roles for themselves and others, such as fellow classmates (Poole and McPhee, 2005). In addition, much of Bourdieu's work on forms of social capital suggests we are partially determined by linguistic and cultural barriers. These barriers are set in place by those in power, often deeming us socially (un)valuable (Yosso, 2005). I argue both Bourdieu and Giddens acknowledge human behavior as existing on a sliding scale of power, yet Giddens' structuration theory tends to empower the system *and* the individual more evenly than Bourdieu, bringing the active agent to the forefront of analysis. For example, some FSU COM students compare experiences during their clinical rotation through storytelling, which they shared with me (personal interview, 2012). The students shared positive comments about the FSU COM experience, yet also described stories about other students who experienced instances of discomfort. This type of framing (re)constructs the notion that students with rich preceptor experiences (the one telling the story and the ones confirming it around her/him) are the norm and cannot relate to their colleague's "abnormal" experience (personal interview, 2012). Thus, the students who had negative interactions with preceptors are characterized as outliers, maintaining the notion that the

experience should be positive at all times. With this in mind, we can see how some students are actively contributing to the empowerment and/or disempowerment not only of their own experiential voice, but the structuring of their student-preceptor relationship and how it is perceived by others.

As previously discussed, a primary feature of structuration theory is the duality of structure, where the properties composing an organizational relationship are both the vehicle and the outcome of the rules participants recursively apply to organizing (Giddens, 1985). Watson (2012) suggests preceptors are incentivized to teach by "paying it forward." If this view is consistent with participants' perceptions, we can see how "paying it forward," or giving back to the medical community through teaching, partially informs the process and the outcome of the preceptor-student relationship. Organizational relationships such as the one between preceptor and student are comprised of systems, practices, and structures (Poole and McPhee, 2005). FSU COM and private medical practices are both systems. While FSU COM establishes the relationship, the dyad interacts in private practices throughout the state. Following the establishment and initiation of the relationship, we can classify FSU COM's relational guidelines as loosely structured.

Poole and McPhee's (2005) analogy of a university library exemplifies how I conceptually separate the two systems. The library, while part of the university system, is its own organization with specific employees and procedures. Similarly, I view the private practice as connected to FSU's larger learning system. Since each practice has its own system with roles, rules, and actors, it is important to acknowledge the differences in the systems and their perceived influence on behavioral practice patterns. For example, a

small medical practice located in a rural community most likely has a different organizational environment than a large-scale practice in a city such as Orlando, Florida. Proponents of structuration view differences in location and size as having great impact over human behavior than action (Spiegel, 2005). While acknowledging structural differences, structuration theory addresses the agency of the preceptors and students, suggesting actors have more influence over structure than scholars may imply. This is an important notion to consider when conceptualizing the specifics of this case study. The system in question, a large private practice in Florida, actively limits the conditions of possibility. It provides preceptors, students, and myself as researcher, with boundaries, suggesting the relational experience is both specific to the system in question as well as fitting into the larger FSU COM educational system. Preceptor and students engage in professional and social activity, creating and recreating rules, roles, and expectations of the relationship on a daily basis, yet the essence of the relationship is unknown because it relies on a rotation of actors in different spaces at different times.

Human practices, or meaningful patterns of activity, rely on context and help organize preceptor-student interactions (Pool and McPhee, 2005). The contextual components of everyday interactions between preceptor and student alter the relationship, leaving room for practices to (d)evolve. For instance, significant participation in patient diagnoses or treatment plans do not occur in the everyday life of a medical student, yet the unpredictability of daily, routinized interactions in private practices among doctor-patient-student communication contribute to the (d)evolution of contextual practices. Such practices allow the student to participate in decision-making, which is an opportunity to demonstrate one's skills. This demonstration will enhance, harm, or

maintain the preceptor's perception of the student. In turn, the student's role as decision maker will (d)evolve, which exemplifies the restructuring of roles within the preceptor-student relationship as they occur on a daily basis.

As stated earlier, the institution (FSU COM) initiates the preceptor-student relationship, but it is the preceptor and student who navigate how the relationship is maintained at large, as well as on a daily basis. Outside of attendance and timeliness, there are few standardized rules spanning all FSU COM preceptor-student relationships, yet all preceptors assess their students at the end of every rotation using the same assessment tool. Structuration, I argue, suggests students and preceptors do not necessarily benefit from an increased amount of standardized rules because preceptors and students will consciously and unconsciously interpret and actively respond to rules and roles within their specific organizational relationship. By conceptualizing the relationship in this manner, it is necessary to investigate the relationship as an ongoing, encased instance that is partially structured by varying healthcare organizations connected to one another through FSU COM. Giddens' structuration theory is a progressive approach to the problem of non-traditional education models such as FSU COM's. From this theoretical perspective, we glean a sense of interconnectedness between not only student, preceptor, and structure, but among all students and preceptors throughout the state of Florida who participate in the structuring and restructuring of the clinical rotation the relational experiences that make up the clinical rotation. This interconnectedness is prone to change and is context dependent, which is why we must engage the specific rules and roles (re)established by actors in specific preceptor-student relationships (Spiegel, 2005).

Methodology

In order to explore the experiences of third-year medical students and participating preceptors, I employ a case study methodology. This type of approach fits well with an analysis of individual and dyadic experiences (Le Dorze et al., 2009). Data were collected from both preceptors and students on a daily basis using electronic journals over the course of six-weeks. The aim of the electronic journal was to provide a private yet accessible space for participants to share their thoughts and experiences in their own words. Private, virtual space, I argue, is a promising way gather data from participants whom the researcher is unable to engage in a face-to-face exchange. The case study approach, according to Yin (2003), is useful when examining an environment where the boundaries between the particular problem of interest and context are blurred. The preceptor-student relationship should not be directly separated from everyday context or the conditions of possibility set in place by FSU COM. Therefore, the use of case study as a method, or tool of investigation, as well as methodology, or way of approaching a phenomenon of interest, reinforces the need for breadth and depth when investigating interpersonal and organizational relationships in the healthcare setting. Furthermore, the aim of this methodological approach was to examine two specific preceptor-student relationships as bounded relational dyads occurring in the same time, space, and specialty to gain insight into how participants come to understand and describe their relationship and accompanying experiences.

Participants included two third-year medical student attending Florida State University and two male private practitioners specializing in obstetrics and gynecology (Ob/Gyn). As stated earlier, this is a one-on-one relationship, so each physician was

paired with one student. The relationship spans six weeks, with the preceptor and student interacting every day including some periods of on-call interaction (after office hours occurring in the private hospital). Each of the participating physicians has more than five years of experience serving as a preceptor for FSU COM and they are partners in the same large medical practice located in Florida. The students (one female and one male) began this specific rotation after experiencing other rotations, meaning they were both exposed to previous preceptors and other specialties.

After forming a potential timeframe for the study with my adviser, I contacted the school's administration to propose the case study. I conducted preliminary interviews with members of the administration in 2012, so they were familiar with the project's aim. Upon gaining permission, I was informed that two students were starting their rotation in the same private medical practice with experienced preceptors, so I contacted them and their assigned preceptors separately via e-mail with a recruitment request. The institutional review board approved the recruitment request, along with the study at large. After each potential participant agreed to participate in the study by electronically journaling about their experience, I began working on prompts to serve as possible guides for the journaling process. The decision to provide prompts as a guide or journaling came from previous experience working with physicians. Doctors and medical students are members of the "hard science" community, so qualitative research efforts are often outside the norm. In addition, I took time into consideration. As Quaas et al. (2009) propose, a lack of time is one of the most significant influences on the mentor-mentee relationship. Similarly, Ferrara (2012) argues, "time is the most precious commodity for healthcare providers" (p. 49). Thus, in an effort to respect the lack of time in the

healthcare field, I argue possible prompts might have allowed participants the time to journal instead of devoting the majority of their participation time contemplating appropriate subjects of which to journal. In addition, I intentionally used prompts to guide participants' entries in hopes to gain an understanding of how the literature pertained to this specific case. As it turned out, only one of the four participants felt comfortable enough to journal without prompts, while the others waited or requested prompts. For this reason, I continued to electronically post prompts to each participant's journal every few days over a six-week period. The journals were password protected and accessible only to myself and the specific student or preceptor. I provide some examples of the prompts below:

-Prior to meeting your student or preceptor, please journal about your expectations.

-What do you hope to get out of this experience? Why? How might your previous preceptor-students experiences impact this upcoming rotation?

-Please journal any general or specific moments or interactions you perceive as critical incidents. What was it about these critical incidents that made them stand out to you?

-Please describe this specific preceptor-student relationship. How does your preceptor/student fit with your expectations? What surprised you?

-In your opinion, what motivates private practitioners to participate in the FSU COM preceptor-student relationship?

-How do you describe yourself as a participant in this specific FSU COM preceptor-student rotation? If you are a physician, do you see yourself as a mentor? If you are a medical student, do you see yourself as a mentee or protégé? Why or Why Not?

-How are the rules of your preceptor-student relationship negotiated? Are you guided by formal or informal rules set by Florida State College of Medicine or do you set some type of rules and expectations? Are you influenced by FSU, the private practice you work within, or previous experiences with other preceptors or students?

-Please journal your final impressions about this preceptor-student relationship: Are you pleased or displeased (or both) about the experience? Why? What specific instances can you recall that impact your opinion? What surprised you? Why? If you could, what would

you have changed?

This method was not employed to predict but instead to produce knowledge about the experiences encased within this specific relationship. According to Denzin and Lincoln (2011), case study method moves the learning process past the limitations of analytic rationality. Context-independent knowledge may provide the reader with breadth, but its lack of depth limits our awareness of an experience (Denzin and Lincoln, 2011). In contrast, I look to context-specific knowledge, such as in the case of the FSU COM student-preceptor relationship to potentially, to actively gain insight as it is (re)created by organizational participants. Giddens' call to examine rules and roles fits well with Denzin and Lincoln's (2001) call to utilize health-related cases as bounded instances that influence our notion of mentors and mentees and the clinical experience. My intent is not to help, but to inform. Helping, I argue, implies some sort of obligation or essentialized need to inspect a community of learners. Dissimilarly, a case study informed by the actors themselves, medical education literature, and structuration theory allows me to deepen the understanding of the student-preceptor relationship as it is actively produced and redefined through questioning rule-based interaction. The case study method is a step we can take to inform and, in turn, work together to better understand a key component in the FSU COM non-traditional education model.

In the following section, I discuss preliminary interpretations in this ongoing analysis. As data collection is coming to an end, and interpretation is in its early stages, we can look to the findings thus far to explore emerging issues and introduce the in-depth interpretation of the student-preceptor relationship that is to come in the future.

Preliminary Interpretations

Data from the electronic journals are not intended to provide a singular, generalizable conclusion about the FSU COM preceptor-student relational experience. Rather, I seek to interpret how the participants describe their experience and discuss how their descriptions compare to the principles of structuration theory and concepts deemed important in the literature. The study's findings complement the theory of structuration, suggesting participants complicate their roles within the relational dyad as well as the applicability of the notion of mentoring, which suggests an intriguing problematic and further situates the relationship as specific to the FSU COM educational model.

I am still struggling to make sense of how the electronic journal as a medium influenced data collection. While my aim was to have participants journal their opinions and experiences, I wonder how and to what degree the findings would differ if I had mailed them traditional, hardcopy journals. If I had the aim to employ an ethnographic approach to the problem of how actors describe and experience their relationship, impromptu and moving dialogue would have been part of the methodological goal, but this was not the case (or at least how I viewed the case at the time of the data collection). Instead, I approached the case study and journaling method with a desire to gain a better understanding of the relationship through the written words of those who experience it.

Since my problem of interest involved researching the relationship over a six-week rotation period, I acknowledge that the study was affected yet not hindered by the asynchronicity of the medium. As a consequence, I expected and encouraged loosely constructed journal entries but came to realize participants wanted prompts. After reviewing a few of the entries, it became clear that the participants were conscious of

their grammar prior to saving their entries. Thus, I am attracted to the notion of asynchronicity in this case study and the idea that participants had the chance to edit their entries. Is this type of virtual writing behavior usual for participants such as these who are highly educated and frequently use computers, or were they more conscious of the response format because they knew I would review it and possibly quote their writing? According to participants, the lack of time is a driving factor in their relationship. Therefore, it is surprising participants would take the time to potentially check and correct the grammar of their entries. While the aim of this paper is not to deconstruct participants' syntax or virtual communication habits, it is important to keep such issues in mind when discussing processes of interpretation because smaller issues such as this may add insight into future research.

Interpretations of the data were less emergent as they were a reflection of what I interpret from the participants' responses to my prompts. As I found, the journaling-with-prompts method of data collection was not a direct series of questions and answers. Instead, participants, for the most part, relied on the prompts to guide the topic or theme of their entry, but they clearly chose how to respond or if to even respond, if at all. In the remainder of this section, I present the key interpretations from the journal data and discuss how they support and/or contradict existing research. As these findings complicate the concept of the clinical relationship as a linear progression, I argue there is a need to continue researching student and practitioner perceptions and descriptions of the preceptor-student relationship. It is important to critically examine this relationship as it progresses. In doing so, I can address the problematic of nontraditional teaching

methods in the healthcare system and their impact on current and future physicians, especially those entering specialties within primary care.

There exists an evolving logic to the preceptor-student relationship that applies across various sorts of instances: to doctor-patient interaction, reading assignments and outside research, and one-on-one discussions of treatment plans. There are few formal rules or expectations, so participants rely on self and one another to formulate a logical structure, or set of rules and roles, that drive the relationship. This system of interaction structures day-to-day interaction, but is established primarily in the first-impression stage, which occurs during week one of the rotation. For example, on the fourth day of the relationship, one of the preceptors explains:

> *[The student] has impressed me thus far. She seems to be very humble and really gets along with the office and hospital staff. This is sometimes my first impression about how a student is going to do on the rotation.*

It is during this first week that, according to the participant, a preceptor forms a relational dynamic. As he explains, the dynamic evolves over time.

> *[The student] spent the first week 'shadowing' with little responsibility other than being on time and listening to my interactions and counseling with patients. Last week, she began seeing patients on her own, including pre-rounding in the hospital. This week, I will expect her to be more autonomous, to start making the most of her time alone with patients to start forming differential diagnoses…[as] the dynamic changes, she hopefully will progress from an observer trying to soak things in to an active participant with patient care.*

This relationship is not about the promises and threats of "getting it right." It is important for students to articulate formulated answers to the preceptor's questions, but the actual answer is not a driving force behind the experience. Indeed, participating preceptors shared that they expect students to enter the relationship with little specialty-specific preparation. According to a participating preceptor,

> *My expectations are the same each time I get a new student…I do not base their grade or evaluation on how well prepared they are for our rotation.*

In a sense, the relationship begins before the preceptor and student meet, yet this particular preceptor does not view it that way. He suggests each student begins the rotation with a clean slate, free from judgment, just as Anschbacher (2008) suggests. Even so, both participants are part of the FSU COM clinical rotation, and both have experienced previous dyads. Yet, as we see in the above description, the first impression sets a tone of approval/disproval, and the remainder of the first half of the experience is detailed through a plan of (inter)action. The expectation of autonomy, however, indicates the relational dynamic may be complicated.

As structuration theory suggests, relationships have the potential to increase in complication as the actors within the relationship form and reform one another's roles within the social exchange. As demonstrated in the previous block quote, the preceptor has a clear set of expectations regarding the student's amount of patient engagement. Forming treatment plans and differential diagnoses are specific tasks both actors perceive in a certain manner. As these activities are enacted and perceptions of appropriateness converge (or diverge), recursivity occurs, which leads preceptor and student to actively address and (re)create the conditions of the relationship (Spiegel, 2005). The conditions

of the relationship impact the continuity of social and organizational practices. In turn, these social practices, or flows of action (Giddens, 1984), enable and constrain future activity, grounding the relationship in a circular duality that (re)shapes itself over time.

In the first two weeks, a student journaled about her role in the rotation. She shared her surprise, saying,

> *I'm used to being a little more autonomous than I was this week-he wanted me to shadow for the whole fist week, which I think is good and bad. I'm looking forward to being able to perform some more exams on my own.*

Here, we see disconnect between the preceptor's teaching plan and the student's expectations and desires. As discussed earlier, the preceptor is not ready to encourage independence until the third week of the relationship, yet the student is eager to begin exams on her own. This, to me, is a potential foreshadowing of a problem but is not drastic enough to verge outside of the day-to-day negotiations between student and teacher that I have discussed as contributing to the complexity of interaction. For the most part, students attracted to this model of education may actively seek more autonomy than a private practitioner is willing to grant in the beginning. As the relationship progresses, we see how this initial disconnect of expectations may have contributed to an instance of remediation.

The preceptor continued to share his positive opinion of the student, referring to her as "punctual," "responsive and encouraging," and "empathetic," yet I interpreted an interesting "relational speed bump," if you will, halfway through the rotation. I interpret this as having a profound impact on the dynamic between preceptor and student, and I detail the preceptor's perception below:

> *I am trying to encourage [the student] to be more aggressive with gathering patient information and developing treatment plans, yet she continues to be more comfortable "shadowing" and listening to my counseling of patients. I am concerned about her being able to apply the things she hears and sees to actual patient care. I plan openly discussing this issue at week's end if she has not improved.*

When reading this in comparison with the student's eagerness to break away from shadowing, it becomes clear there is some type of confusion between student and preceptor. The student states that a lack of time has deterred their communication. She explains, "he is quite busy [so] there's somewhat of a time constraint in how much he can talk with me." This fits with Ferrara's (2012) framing of time-as-commodity interfering with the mentor-mentee relationship. The journal entry that followed the previous entry further details the preceptor's experience:

> *…Third week of rotation is nearing end. [The student] has done well, definitely showing progress in her knowledge of skills. However, she did not make much progress with clinical problem solving…this has been a difficult rotation for me thus far. I just don't feel like we are making the progress I was hoping. I feel I am not doing a good job of helping her progress from the role of observer to the role of clinician. I have to admit, I found this month more stressful. Maybe this is my fault somehow, and I am hoping to instill confidence in her the next couple of weeks. I think I realized how busy day-to-day schedule detracts from teaching more in the rotation past.*

As we see in the preceptor's description, time does indeed interfere with their relationship, but his entry suggests the problem is more complex than a lack of time. Around the same time of his entry, the student voiced her frustration with the lack of formality.

> *With this rotation, there seems to be fewer clear cut guidelines for what is expected of me, so I'm mostly going off of previous experiences and my on internal set of rules/expectations development from them.*

The student does not tell the reader if s/he desires more formalized rules, yet it is clear that the lack of such formality increases behavioral uncertainty. Formulated rules, such as arriving on time, are generalizable in that they are not specifically formulated to fit or meet a need within this specific preceptor-student relationship. Instead, the rule of timeliness is a rule of medical social life, where exams, meetings, and surgeries are scheduled to occur at certain times, and, physicians, like other hierarchical professions, expect subordinates (in this case, the medical student) to be present when expected. According to Giddens (1984), these types of rules are both preliminary as well as significant because they lock actors into the reproduction of an institutionalized practice. As demonstrated in the student's journal entry above, previous clinical rotations had more formalized rules, thus reducing the uncertainty of the day-to-day, negotiated routine. This specific dyad operates with more informal rules, which, in the case of this student, deviated from expectations, which could potentially disturb the student's sense of security or signal an opportunity for agency (Cohen, 1989; Giddens, 1984).

By the conclusion of the six weeks, however, all participants ended their journals with extremely positive impressions about one another and the clinical experience. One

of the preceptors explained the experience as a joy and a chance to show another how to function as a doctor. He also noted he realized "his way was surely not always the right way." The instance of remediation may have improved the preceptor-student relationship, and, in turn, the final perception of the experience, which was quite positive. One of the preceptors noted that the student did not wish to choose obstetrics and gynecology as her specialty, yet he enjoyed seeing the student's excitement of learning the rewards of childbirth. Likewise, the student interested in surgery did not wish to choose Ob/Gyn as a career. This surprised the preceptor because, as he explains, obstetrics and gynecology involves a great deal of surgery.

> *[The student's] field of interest overlaps and encompasses somewhat of what I do. I would have thought [the student] would have recognized this and shown more enthusiasm.*

The expectation of enthusiasm and willingness was common in all four participants' journals. Each wanted to demonstrate to the other her/his sense of willingness to teach or learn and treat the patient with the best plan.

Both preceptors emphasized patient involvement as playing a role in the teaching process. One preceptor represented the patient as having agency in the process, suggesting she has a positive influence in the preceptor-student relationship. He explains:

> *Sometimes I will even have the patient describe directly to the student the nature of her problems or relate some helpful bit of her past history to him/her…Patients really get into the educational role when they know the student is there to practice and learn and not be a casual observer. It's the one-on-one interaction between*

the doctor-student-patients that I feel really makes a difference and helps solidify the art of being a doctor.

While this may be accurate, the discomfort patients may or may not experience is not recognized to the degree it deserves. Perhaps the preceptor actively chooses patients who are more open to the idea of a student in the exam room, thus leading to a greater chance of a comfortable patient, but I find it interesting that the preceptor assumes the patient will be eager to contribute to the educational process. In contrast, the other preceptor acknowledges the potential uncertainty and discomfort of the interaction, saying,

There is a stress of wanting to get your student adequate experience with gynecological exams, but understanding that these exams are very difficult for some patients. They have enough anxiety just watching me walk through the door, not to mention a third-year medical student.

Here, the preceptor addresses the stress and anxiety of health problems. Patients want to be treated and physicians want to treat; yet the presence of a medical student alters the communicative structure. This is evidence against the assumed linearity of the relationship suggested in the literature, as if a student can enter and exit a relational dynamic without altering what came before, during, and after her/his presence. Indeed, s/he plays an active role in not only the preceptor-student dyad but also other relationships such as the one between practitioner and patient, especially if the patient is having health complications.

One of the students wrote against the recurring theme of romanticism promoted in the framing of doctor-patient interaction by presenting the more natural side of the interaction. S/he discussed the challenge of seeing and treating emotional people who, at

times, utilize their agency as patients to object to the physician's treatment options. The student describes a specific instance:

> *There was one moment during a patient encounter that I thought could have been handled differently. The couple had recently lost their pregnancy. The woman was understandably upset and short with us. The visit ended abruptly with us leaving. Frankly, I was shocked because I just saw a few moments earlier, and after, where this exact same scenario was handled differently. I speculate that the physician was offended by some of the patient's comments and decided to end the encounter quickly.*

Given the constraints of her/his role, the student chose to remain silent, filling the role of observer during the doctor-patient encounter. Yet, since the student chose to include the moment in the journal, it clearly resonated as significant. As structuration theory suggests, the medical student reflexively monitored her/his current and future actions during the doctor-patient-student interaction. This monitoring, coupled with the (self)-imposed constraints of her/his role as mentee or learner, actively constructs current and future conditions for action (Giddens, 1984).

As the patient is an integral part of the relational experience, the patient as well as the student's agency (or lack thereof) needs to be discussed more openly in the literature. After all, the potential discomfort of a patient contributes to how student and preceptor (re)structure their behavior. This suggests, first and foremost, that discomfort is a part of providing healthcare and should be addressed as a component of practice. In doing so, we reject the romantic notion of doctor-student-patient interaction as an ever-joyous experience for all participants. Actively discussing the enjoyment *and* discomfort that is

(re)produced, maintained, or relieved by doctor, student, and patient on a daily basis will enrich how we conceptualize healthcare and the preceptor-student relationship.

This case study demonstrated the duality of structure between and among preceptor and student and the private practice system. Therefore, I argue, preceptor, student, and patient behavior influence the relational process as well as the experiential outcome. The preceptor-student relationship is not a linear progression, but an ongoing progression and digression of experience that is (re)negotiated by those involved in the system. I interpret the various representations of roles and expectations as, at times, overly romanticized. This may be a reflection of the institutional framing of what the relationship is supposed to look like instead of the messiness that is the six-week clinical rotation. Yet, as demonstrated by some of the participants, actors within the system are openly discussing the inaccurate nature of such framing. Furthermore, this messiness is exemplified in the ongoing confusion of expectations within one of the preceptor-student dyads. Nevertheless, all of the four participants were pleased with their experience. Fitting with previous research (Watson, 2012), both preceptors felt they were fulfilling a duty to give back to the medical field. Previous interviews with FSU COM administrators suggested the participating physicians want the opportunity to "pay it forward" and, in this case, that inclination was reinforced. Likewise, students felt a similar sense of duty, voicing the pressure to perform for the patient and a sense of "owing hard work " to the preceptor because of her/his position in the community.

Concluding Remarks

In state or federally funded organizations, we have seen how structural programs can lead to a reduction in the delivery of health services. Large-scale endeavors such as

vaccination efforts by the International Monetary Fund (IMF) (Rogers, 2003) or impersonal clinical training programs in some traditional academic health centers (Scheibel, 1996) can fail to acknowledge active contributors in healthcare structures, such as members of a community who wish to participate in health-related efforts. FSU COM's educational model, on the other hand, is structured to enhance the quality of the delivery of health services. With an emphasis on primary care, FSU COM's preceptor-student relationship is established with the intent to produce well-rounded physicians, which they claim can be better achieved through one-on-one training in private practices located outside traditional teaching hospitals.

Upon conducting this case study, I argue the student-preceptor relationship is, and will continue to be, a key issue in the field of medical education. As the literature and data suggest, the clinical experience is a crucial component of the process of becoming a doctor. Fitting with the Geertz's notion that scholarly interpretation is intrinsically incomplete, I aim to continue investigating the student-preceptor relationship. Mentoring is an imperfect concept and warrants further study. As the literature suggests (Anschbacher, 2008; Quaas et al. 2009; Tracy et al., 2004), the role of a mentor is a meaningful position, yet the notion of a mentor may not accurately fit the teaching task at hand which, in this case, is to expose and train primary care physicians. Nevertheless, we should continue to examine the concept of mentoring as it applies to specific relationships, especially since there are conflicting perceptions concerning what it means to mentor in medicine. This, I argue, will give us greater insight into a "non-definable" phenomenon (Conley, 2001), which we can incorporate into future research concerning the FSU COM preceptor-student relationship.

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