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Preceptorship mirror in Family and Community Medicine: the resident–medical intern relationship and its effects on preceptor development

Espelho de preceptoria em Medicina de Família e Comunidade: a relação residente–interno e seus reflexos na formação do preceptor

Espejo de preceptoría en Medicina Familiar y Comunitaria: la relación residente–interno y sus reflejos en la formación del preceptor

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Abstract: Preceptorship is a central element of medical education, especially in Family and Community Medicine (FCM), where teaching takes place through practical and longitudinal activities. This study aims to critically reflect on the experience of an FCM resident acting as a preceptor for medical interns and on its effects on pedagogical and professional development. This is a qualitative experience report conducted in a Primary Health Care setting. The experience showed progress in the development of communication skills, the adaptation of teaching strategies, and the provision of feedback, while also revealing gaps in formal pedagogical training. The experience functioned as a ‘mirror’ of the traditional preceptor–resident relationship, enabling a deeper understanding of the teaching-learning process. It is concluded that the structured inclusion of preceptorship training during residency can improve teaching and strengthen the development of future preceptors.

Keywords: Preceptorship; Medical Education; Family and Community Medicine; Medical Internship; Medical Residency.

Resumo: A preceptoria constitui elemento central na formação médica, especialmente na Medicina de Família e Comunidade (MFC), na qual o ensino ocorre de forma prática e longitudinal. Este estudo tem como objetivo refletir criticamente sobre a experiência de um residente de MFC no papel de preceptor de internos de medicina e seus impactos na formação pedagógica e profissional. Trata-se de um relato de experiência, de abordagem qualitativa, realizado em cenário de Atenção Primária à Saúde. A experiência evidenciou avanços no desenvolvimento de habilidades de comunicação, adaptação de estratégias de ensino e construção de feedbacks, ao mesmo tempo em que revelou lacunas na formação pedagógica formal. A vivência funcionou como um “espelho” da relação tradicional preceptor–residente, permitindo maior compreensão do processo ensino-aprendizagem. Conclui-se que a inserção estruturada de formação em preceptoria durante a residência pode qualificar o ensino e fortalecer a formação de futuros preceptores.

Palavras-chave: Preceptoria; Educação Médica; Medicina de Família e Comunidade; Internato; Residência Médica.

Resumen: La preceptoría es un elemento central en la formación médica, especialmente en Medicina Familiar y Comunitaria (MFC), en la que la enseñanza se da de forma práctica y longitudinal. Este estudio tiene como objetivo reflexionar críticamente sobre la experiencia de un residente del MFC en el rol de preceptor de internos de medicina y sus impactos en la formación pedagógica y profesional. Se trata de un relato de experiencia, con enfoque cualitativo, realizado en un escenario de Atención Primaria de Salud. La experiencia destacó avances en el desarrollo de habilidades comunicativas, adaptación de estrategias de enseñanza y construcción de retroalimentación, al mismo tiempo que reveló vacíos en la formación pedagógica formal. La experiencia funcionó como un “espejo” de la tradicional relación preceptor-residente, permitiendo una mayor comprensión del proceso de enseñanza-aprendizaje. Se concluye que la inserción estructurada de la formación preceptora durante la residencia puede calificar la docencia y fortalecer la formación de futuros preceptores.

Palabras clave: Preceptoría; Educación Médica; Medicina Familiar y Comunitaria; Internado; Residencia Médica.

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1. Introduction

Contemporary medical training has advanced towards integrating theoretical knowledge, practical skills and professional attitudes, with an emphasis on the development of skills necessary for comprehensive, ethical care centered on the needs of people and communities. In this context, learning is no longer restricted to traditionally academic environments and begins to occur in an increasingly significant way in real practice scenarios, in which students and doctors in training are exposed to concrete clinical situations and need to articulate knowledge, communication skills, clinical reasoning, decision making and teamwork. In Family and Community Medicine (FCM), this perspective assumes particular relevance, since Primary Health Care (PHC) constitutes a privileged space for the longitudinal monitoring of individuals, families and communities, favoring the integration between care and professional training. Clinical teaching carried out in these scenarios depends, therefore, not only on the availability of cases and learning situations, but also on the presence of professionals capable of monitoring, supervising and guiding apprentices in the daily services (Botti; Rego, 2008; Ramani; Leinster, 2008).

Within this training process, different subjects occupy different positions and responsibilities, although they are inserted in the same teaching-learning dynamic. Among them, the medical internship student, the resident doctor and the preceptor stand out. Understanding the particularities of each of these roles is important to analyze the pedagogical relationships established in the practice scenario and, especially, to understand situations in which a resident doctor assumes, even partially, functions related to the preceptorship of undergraduate students.

The medical internship corresponds to a specific stage of undergraduate medical training, characterized by greater insertion of the student in practice scenarios and a progressive approach to the responsibilities inherent to professional practice. The National Curricular Guidelines for the Undergraduate Medicine Course establish the importance of competency-based training and the insertion of students in different health care scenarios, including Primary Health Care. Law No. 12,871/2013, which established the More Doctors Program, also established that part of the internship workload should be developed in Primary Care and in urgent and emergency services of the Unified Health System (SUS), reinforcing the importance of real care scenarios in medical training (Brazil, 2013; Brazil, 2014). Thus, the intern finds himself in a transition phase between predominantly academic learning and professional practice, mobilizing previously acquired knowledge and progressively developing clinical, communicational and professional skills.

Although the intern already has theoretical knowledge and skills developed during graduation, his work in the service takes place under supervision and within limits compatible with his training stage. Student autonomy, therefore, is progressive and must be related to their level of competence and the complexity of the activities carried out. In this sense, supervision

not only represents a form of control over the activities carried out, but also constitutes an important pedagogical resource, allowing the student to assume gradually greater responsibilities as they demonstrate the ability to do so. The clinical setting thus becomes a space in which autonomy and supervision need to be continually negotiated, considering both learning needs and the safety and quality of care offered to patients.

At a later stage of medical training is medical residency. According to Law No. 6,932/1981, Medical Residency is a type of postgraduate education aimed at doctors, characterized by in-service training and developed under the guidance of qualified medical professionals (Brasil, 1981). The resident doctor, therefore, presents a particular position in the training process: although he is already a graduated professional and legally qualified to practice medicine, he remains in the process of specialization and development of specific skills. Its training occurs through a combination of care practice, supervision, theoretical-practical activities and reflection on situations experienced in everyday services.

This intermediate position gives the resident unique characteristics in the teaching-learning process. While remaining an apprentice to their preceptors and other more experienced professionals, the resident can take on teaching duties alongside undergraduate students and other professionals in training. In this way, the resident does not exclusively occupy the place of the learner, but can also actively participate in the training of other subjects. This experience can be understood as a type of teaching between peers or teaching carried out by a professional in training, a situation that has the potential to produce benefits for both those who learn and those who teach (Ten Cate; Durning, 2007).

Preceptorship, in turn, constitutes an important component of medical training in practice settings. Although the terms preceptor, supervisor, tutor and mentor are sometimes used interchangeably, they have different meanings and functions in the field of health education. Botti and Rego (2008) highlight that the preceptor is the professional who works in the work and training environment, particularly in the context of clinical practice, bringing theoretical knowledge closer to the reality of care. Their role may involve clinical teaching, supervision, assessment, guidance, monitoring the development of skills and using real care situations as learning opportunities. Furthermore, the preceptor can influence the ethical and professional training of apprentices, functioning as a model of professional performance.

Teaching in the clinical environment, however, has its own characteristics and demands from the professional who teaches skills that go beyond the technical and scientific domain. The professor or clinical preceptor can assume different roles throughout the same activity, acting as a source of information, learning facilitator, evaluator, advisor and professional model (Ramani; Leinster, 2008). Therefore, knowing how to practice medicine does not necessarily mean knowing how to teach medicine. Clinical competence and pedagogical competence constitute related but not equivalent dimensions, and care experience alone does not guarantee that the professional is prepared to organize educational objectives,

adapt teaching strategies, evaluate the learner's performance or offer feedback appropriately.

In this sense, feedback plays an important role in medical education. In the clinical context, it allows the learner to understand aspects of their performance that need to be maintained, modified or improved, contributing to the progressive development of skills. To be effective, feedback must be related to observable behaviors and offer information that can guide future performance, differentiating itself from a merely classificatory assessment (Ende, 1983). The ability to offer adequate feedback, therefore, constitutes one of the pedagogical skills that can be developed during the preceptorship experience and that are not always formally taught during medical training.

Another relevant aspect for understanding the relationships between intern, resident and preceptor concerns adult learning. The majority of subjects involved in medical training are in the adult education process, which makes it pertinent to consider the assumptions of andragogy. The concept, associated especially with the work of Malcolm Knowles, is based on the understanding that adults have previous experiences, needs, motivations and forms of participation in the learning process that must be considered in the organization of educational strategies. In the education of health professionals, adult learning theories value aspects such as the learner's previous experience, active participation, the practical relevance of the content, problem solving and the integration between what is learned and concrete everyday professional situations (Mukhalalati; Taylor, 2019).

In the FCM and PHC scenario, these principles find particularly fertile ground. Contact with real patients, families, multidisciplinary teams and complex clinical situations allows learning to be directly related to concrete and contextualized problems. Knowledge is not only mobilized as theoretical content, but as a tool to understand and resolve situations that emerge from practice. The apprentice can participate in the consultation, carry out anamnesis and physical examination, formulate diagnostic hypotheses, discuss conduct, monitor users longitudinally and reflect on the decisions made. In this context, the role of the preceptor or any professional who assumes an educational role is to encourage the active participation of the learner without losing sight of the limits necessary for patient safety and the level of competence of the person undergoing training.

The relationship between intern, resident and preceptor can, therefore, be understood from different levels of experience, responsibility and autonomy. The intern is in the process of developing the skills necessary for professional practice and requires supervision proportional to his or her level of training. The resident, in turn, has greater experience and clinical autonomy, but remains under supervision during his specialization process. The preceptor assumes greater responsibility for the supervision, guidance and evaluation of professionals in training. These levels should not be understood as static positions or as an exclusively vertical hierarchy, but as a dynamic organization, in which autonomy must be progressively expanded according to demonstrated competence and the complexity of the

clinical situation.

This dynamic becomes especially interesting when the resident starts to act as a preceptor or educator for interns. In this situation, a relationship is established that can be represented as a movement between different positions in the training process: the resident is an apprentice before his preceptor, but can assume the role of educator before the intern. There is, therefore, an overlap of roles and a possibility of circulation of knowledge and experiences between the different levels of training. The resident needs not only to master certain content, but also to select what is relevant to the intern's level of knowledge, adapt their language, stimulate clinical reasoning, monitor the degree of autonomy possible and recognize when it is necessary to intervene or request support from the responsible preceptor.

This experience can have a pedagogical effect on the resident himself. When teaching, he begins to observe the learning process from a different perspective than the one he had when he was exclusively an apprentice. Situations previously experienced with your own preceptors can be revisited and reinterpreted. Teaching strategies can be reproduced, modified or deliberately avoided. Certain attitudes that previously seemed natural can acquire new meaning when the resident needs to play the role of guiding another person. The act of teaching can, therefore, favor the explanation of knowledge that previously remained implicit, in addition to stimulating reflection on communication, supervision, autonomy, evaluation and feedback.

It is at this point that the metaphor of the “preceptorship mirror”, proposed in this report, is established. The resident, when temporarily occupying the position of teaching, can recognize in their own behavior elements of pedagogical practices previously experienced with their preceptors. The mirror, however, does not necessarily imply passive reproduction. By perceiving themselves in the position of educator, the resident can identify practices they wish to maintain, strategies they wish to adapt and experiences they prefer to transform. The relationship with the intern can, in this way, function as a device for reflection on the formative trajectory itself and on the preceptorship model that is being constructed.

This perspective also allows us to problematize the pedagogical preparation of resident doctors. Although medical residency's main purpose is specialized training and the development of skills for professional practice, the day-to-day services can place the resident in situations of teaching and supervising students. When this occurs without specific pedagogical training, the resident can predominantly rely on the experiences they had as a student and the strategies they observe in their own preceptors. Such a process can be productive, but it can also reproduce teaching models that are poorly reflected or inadequate to the needs of learners. The literature on clinical teaching rightly highlights that many professionals assume educational responsibilities without specific preparation for carrying out these functions (Ramani; Leinster, 2008).

Thus, the insertion of the resident in preceptorship activities can be understood not

only as a strategy to support undergraduate teaching, but also as an opportunity for the professional and pedagogical development of the resident himself. The experience can contribute to improving communication, leadership, knowledge organization, supervision, evaluation and feedback skills, in addition to favoring the construction of a professional identity that recognizes the educational dimension as part of medical work. On the other hand, the lack of formal preparation can generate insecurity and difficulties in defining the limits of autonomy, conducting teaching and evaluating the learner.

Given this scenario, it becomes relevant to reflect on what happens when an FCM resident doctor assumes the position of preceptor of interns and how this experience impacts her own training. More than describing activities carried out with students, it is important to understand how this experience changes the resident's perception of the teaching-learning process, his own professional performance and the role of preceptor that he may perform in the future. The experience of teaching can, in this sense, constitute an opportunity to look again at one's own training and understand how previously experienced preceptorship models influence current educational practice.

Therefore, this study aims to critically reflect on the experience of a Family and Community Medicine resident in preceptorship of medical interns, considering the relationship between the different levels of training, the processes of autonomy and supervision, the principles of adult learning and the impacts of this experience on the development of pedagogical and professional skills for the future exercise of preceptorship.

2. Objectives

2.1 General objectives

This work aims to report and critically reflect on the experience of a resident doctor in Family and Community Medicine, member of a Family Health team (eSF) linked to two Medical Residency programs in Family and Community Medicine, developed in Montes Claros, Minas Gerais, and in Brasília, Federal District, in the exercise of teaching and monitoring medical interns in the Primary Health Care scenario, considering the repercussions of this experience for the development of skills pedagogical, clinical and professional aspects related to the future exercise of preceptorship.

2.2 Specific objectives

Describe the context of the Primary Health Care scenarios in which the teaching experience took place;

Characterize the relationship established between the resident doctor, medical interns and preceptors involved in the teaching-learning process;

Describe the main teaching, supervision and monitoring activities developed with

medical interns;

Reflect on the different levels of autonomy attributed to residents and medical interns, considering their respective stages of training;

Identify the pedagogical strategies used during the experience, including case discussion, consultation follow-up and feedback;

Analyze the difficulties and limitations encountered by the resident in carrying out teaching activities;

Reflect on the influence of experiences previously experienced by the resident with their own preceptors on their educational practice;

Identify the pedagogical and professional skills developed from the preceptorship experience;

Analyze how the experience of teaching interns contributed to the redefinition of the resident's own training trajectory;

Reflect on the experience as a possibility of preparation for the future exercise of preceptorship in Family and Community Medicine.

3. Methodology

This is a descriptive study, with a qualitative approach, an experience report, based on the experience of a resident doctor in Family and Community Medicine (FCM) in developing teaching, monitoring and supervising medical interns in Primary Health Care (PHC) settings. The experience report constitutes a modality of academic production that enables systematization and critical reflection on a concrete experience, articulating practical experience with theoretical references and allowing the construction of knowledge based on the analysis of situations experienced in daily professional life (Daltro; Faria, 2019). The choice of this modality is justified by the nature of the object of this study, which seeks to describe and critically reflect on an experience during medical training, considering its meanings, potential, limitations and repercussions for the development of pedagogical and professional skills.

The experience was built longitudinally throughout the author's training in two Medical Residency programs in Family and Community Medicine, in different contexts of Primary Health Care. It began on March 1, 2024, in the Medical Residency Program at FCM in Montes Claros, Minas Gerais, where the author remained until May 31, 2025. Due to the transfer of residency program, the training continued in Brasília, Federal District, from June 1, 2025. In this second stage, the author remained active until September 3, 2025, when she began a period of maternity leave, lasting six months. The return to activities occurred in March 2026, with the author remaining in training until the period considered for this report.

The experience took place in PHC services linked to the respective residency programs, with the author's involvement in the daily life of Family Health teams (eSF).

Although both scenarios presented particularities related to the organization of services, team composition, care flows and institutional characteristics, both enabled integration between care, professional training and teaching activities. Passing through different contexts also allowed us to observe how the organization of the service, the performance of preceptors, the profile of students and the degree of autonomy of those involved influence the teaching-learning process.

The main people involved in the experience were the resident doctor, author of the report, the medical interns inserted in the practice scenarios and the preceptor doctors responsible for supervising the residency. The author occupied an intermediate position in the training structure: she remained a doctor in specialized training, under the supervision of preceptors, but, at the same time, undertook in certain situations monitoring, guidance and teaching activities for interns. This overlapping of roles constituted a central element of the experience, enabling the author to experience the teaching process from a perspective different from that previously occupied as a student and resident.

During periods of activity, the monitoring of medical interns was integrated into the daily care of PHC, especially in consultations, case discussions and other clinical situations that provided learning opportunities. Teaching activities included monitoring consultations, discussion of clinical cases, elaboration and discussion of diagnostic hypotheses, therapeutic planning, guidance on how to approach patients, discussion of aspects related to clinical communication and reflection on the organization of care in PHC. Guidance was also provided during consultations, discussions on conduct after consultations and moments of feedback on observed performance.

The pedagogical strategies were used in a contextualized manner, considering the level of training, prior knowledge and skills demonstrated by each intern, as well as the learning objectives identified in each situation. Among the strategies used, questions aimed at stimulating clinical reasoning, joint discussion of hypotheses and conduct, and feedback after carrying out the activities stood out. Teaching occurred predominantly based on concrete everyday situations in PHC, using consultations and clinical cases as learning opportunities.

The experience also involved situations related to defining the degree of autonomy of medical interns. Autonomy was understood as a progressive process, defined according to the student's level of training, the skills already demonstrated, the complexity of the clinical situation and the need to guarantee patient safety. Faced with more complex situations or doubts regarding conduct, the author resorted to the supervision of the responsible preceptors. This dynamic enabled reflections on the limits between autonomy, supervision and responsibility in the medical training process.

The construction of the report was carried out retrospectively, based on the author's memory and the recovery of personal records produced throughout the residence. During the training periods, notes were made in personal notebooks, cell phone notebooks and files stored

in personal digital storage space. These records were not originally produced for scientific purposes, but as a way of recording situations, perceptions, doubts, learning and events considered relevant during training. They were later recovered and organized according to their relationship with the object of this study.

Spontaneous and feedback statements made by residents during the experience were also considered, as complementary elements to the reflection, especially comments related to teaching activities, the conduct of consultations, the guidance received and the strategies used by the resident. These manifestations were used exclusively as contextualizing elements of the experience, and were not treated as research data, nor analyzed or presented individually.

After recovering the records and memories related to the experience, the material was organized thematically, considering the main aspects related to the teaching-learning process experienced by the author. Four axes were defined to organize the experience: (1) contextualization of practice scenarios and insertion of those involved; (2) relationship between resident, interns and preceptors; (3) situations related to autonomy, supervision, teaching strategies and feedback; and (4) perceptions, feelings, difficulties, potential and learning resulting from the experience.

The analysis was carried out in a reflective manner, seeking to go beyond the chronological description of events and understand their meanings for the author's professional and pedagogical training. The situations experienced were interpreted in light of references related to medical education, preceptorship, adult learning, clinical teaching, autonomy, supervision and feedback. Both the strengths and weaknesses identified during the experience were considered, including the development of communication skills, leadership, knowledge organization, supervision, clinical reasoning and feedback, as well as the difficulties related to the lack of formal pedagogical training, the definition of the limits of autonomy of medical interns, the reconciliation between care and teaching and the insecurity initially experienced in the role of educator.

The analysis also considered the influence of the author's previous trajectory as a student and resident on her way of teaching. Situations were observed in which practices previously experienced with their own preceptors were reproduced, adapted or questioned. The perception of this movement between reproducing, adapting and giving new meaning to teaching practices constituted a central element for the construction of the metaphor of the “preceptorship mirror”, used as the interpretative axis of the report.

3.1 Theoretical basis

To support reflection on the experience, a narrative review of the literature was carried out on preceptorship, medical education, clinical teaching, adult learning and andragogy, autonomy and supervision in medical training, peer teaching and formative feedback. The narrative review allows a broad and interpretative approach to the available literature, being suitable for the theoretical contextualization and discussion of experiences and phenomena related to professional practice (Rother, 2007).

The review aimed to provide theoretical support for the interpretation of the situations experienced, relating the author's individual experience to concepts and discussions present in the literature on medical training. It was not intended to carry out a systematic review of the literature or produce a quantitative synthesis of the studies found. Scientific articles, normative documents and references considered pertinent to medical training and Family and Community Medicine were used, especially those related to the concepts of preceptorship, adult learning, teaching in the clinical environment, feedback and progressive development of autonomy.

3.2 Ethical aspects

When preparing the report, the principles of confidentiality, anonymity and protection of the privacy of patients, interns, preceptors and other professionals involved in the experience were observed. No names, initials, medical record numbers, contact information or other data that would allow individual identification of those involved were used.

The selected clinical situations were described in a way that preserved the identity of the patients and other people involved, prioritizing the pedagogical and reflective aspects relevant to the objective of the study. The personal records used in the construction of the report came from files for the author's private use. The spontaneous manifestations of the medical interns were used only in a contextual way and were not presented individually or associated with characteristics that could allow their identification.

Considering the nature of the work as an experience report and the characteristics of the records used, the ethical and institutional guidelines applicable to the execution and presentation of this type of academic production were observed.

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4. Experience Report/Results

The experience of monitoring interns began during training in Family and Community Medicine in Montes Claros, Minas Gerais, in a Primary Health Care unit in which three resident doctors and medical interns worked. Initially, the medical interns rotated daily among the residents. Although this organization allowed students to learn about different ways of conducting care, in practice some difficulties were identified. Each resident had their own schedule, specific times and different ways of organizing and discussing cases, while interns sometimes arrived at different times than previously agreed and had difficulty following the routine and finding their way to appointments.

In addition to issues related to schedules and organization of the service, it was noticed that the daily rotation made it difficult to continue the teaching process. Each resident had their own way of conducting consultations, organizing clinical reasoning and discussing conduct, and the intern's stay for just one day did not allow him to sufficiently understand the work dynamics of each professional.

Faced with these difficulties, the residents discussed the situation with the preceptor and proposed a reorganization of the internship, so that the interns remained linked to the same resident for longer periods, initially established at approximately six to eight weeks. Subsequently, this organization allowed each medical intern to remain with a resident for approximately three to four months, before changing rotations.

The change provided greater continuity in the relationship between resident and medical intern. With the prolonged stay, the student became better acquainted with the resident's routine, her way of conducting consultations, organizing clinical reasoning and discussing cases. In the same way, the resident became better acquainted with the intern's level of knowledge, difficulties and degree of autonomy, allowing her to progressively adapt her supervision and teaching strategies.

During the first week of follow-up, the resident remained primarily responsible for the care, while the intern observed the consultations. After each appointment, the case was discussed, including the main findings of the anamnesis and physical examination, the diagnostic hypotheses, the conduct adopted and any doubts the student had. This first moment also allowed the intern to understand the organization of the consultation and the routine functioning of the unit.

After this initial phase of observation, the medical interns progressively began to take on less complex care. In cases where they were more confident, they carried out the consultation more autonomously, while in situations considered more complex they requested the presence of the resident. At the end of the anamnesis and physical examination, the intern presented the case to the resident, who reviewed the information obtained, discussed the clinical reasoning and jointly evaluated the proposed course of action. In this way, autonomy was progressively expanded, maintaining the supervision necessary for patient safety.

The stay of the medical intern with the same resident also favored the development of a trusting relationship. As the period of coexistence increased, it became easier to identify which situations the student could manage alone and which required greater supervision. For the resident, this experience also made it possible to realize that clinical teaching was not limited to the transmission of knowledge, but involved monitoring the student's development, recognizing their limits and adapting supervision to their needs.

In this process, the resident also began to reflect on her own way of providing care and teaching. The fact of needing to explain the reasons for certain behaviors and respond to interns' questions required greater organization of clinical reasoning and knowledge used during the consultation. The experience thus allowed care and teaching to become interconnected processes, in which patient care constituted simultaneously a care activity and a learning opportunity.

Therefore, initially insecurity was observed in the conduct of teaching activities, especially in the balance between assistance and supervision. The responsibility for guiding interns brought about the need to organize clinical reasoning in a more didactic and structured way. Over time, interaction with interns enabled the development of teaching strategies more adapted to individual needs, recognizing different learning styles. Situations such as discussion of clinical cases, shared care and review of conduct became bidirectional learning opportunities.

Building feedback was one of the biggest challenges. Initially punctual and unstructured, it evolved into a more conscious practice, focusing on specific aspects and constructive guidelines. At the same time, the experience led to reflection on their own experience as a resident, allowing them to identify similarities and differences in relation to their preceptors. This process reinforced the perception of preceptorship as a complex practice, which requires not only technical mastery, but also pedagogical skills.

5. Discussion

The reported experience shows that the insertion of the resident doctor in the teaching of interns produced repercussions that went beyond the transmission of clinical knowledge. By assuming, even partially, an educational role, the resident began to deal simultaneously with care demands, learning needs, supervision, evaluation and patient safety. This intermediate position — apprentice in front of their preceptors and educator in front of interns — constitutes a central aspect of the experience and allows us to understand preceptorship as a practice that also participates in the training of the resident himself.

The literature recognizes that residents play an important role in the education of medical students and other professionals in training, although they often assume these responsibilities without formal pedagogical preparation. Teaching skills development programs for residents have demonstrated favorable results in confidence to teach, knowledge

about educational principles and teaching behavior (Bensinger; Meah; Smith, 2005; Hill et al., 2009). More recently, a review of resident-as-teacher programs reinforced that teaching by residents is often informally incorporated into training, while residents themselves identify the need for explicit educational objectives and structured training to fulfill this role (Residents as teachers…, 2026).

In this sense, the experience described in this report can be understood as a form of teaching learning located in the work environment itself. The resident did not begin her work with a previously structured set of pedagogical skills, but developed strategies based on the concrete needs of the medical interns and the situations encountered in practice. This process is particularly relevant in FCM, in which teaching occurs in an integrated manner with care and in which consultation, case discussion, longitudinal monitoring and organization of care constitute continuous learning opportunities.

One of the most significant aspects of the experience was the reorganization of the interns' internship, moving from a model of daily rotation between residents to a longer stay with the same professional. The change, initially motivated by organizational difficulties, had important pedagogical repercussions. The continuity of the relationship allowed the resident to progressively learn about the level of knowledge, skills, difficulties and limits of autonomy of each intern. At the same time, the student began to better understand the work dynamics, the organization of the consultation and the form of clinical reasoning used by the resident.

This experience is close to the principles of longitudinal clinical learning, in which the continuity of relationships favors not only the monitoring of patients, but also the progressive knowledge of the learner by the educator. In the model initially adopted, characterized by specific meetings, each resident needed to quickly adapt to a student they knew little about, while the intern needed to understand different forms of clinical management in very short periods. The prolonged stay reduced this fragmentation and made it possible to build a more consistent pedagogical relationship.

The relationship established between resident and medical intern can also be understood in the light of peer teaching or near-peer teaching. Although the resident was at a different level of training than the intern, there was proximity in relation to the educational experience and the language used, in addition to less hierarchical distance compared to the traditional relationship between student and specialist teacher. Literature reviews indicate that peer teaching strategies can present similar results to conventional methods in different educational outcomes and can be particularly useful for developing practical skills (Brierley; Ellis; Reid, 2022; Harris et al., 2022).

In the present report, this proximity seems to have favored a relationship of trust, in which the intern could present doubts, recognize limitations and request help in the face of more complex clinical situations. For the resident, getting to know the apprentice over time made it possible to replace little differentiated supervision with supervision that was more

adjusted to the demonstrated skills. Thus, continuity not only represented more time together, but enabled more individualized and progressive supervision.

The autonomy of the medical interns constituted another important axis of the experience. Initially predominantly observational, student participation was expanded to less complex services and, later, to situations in which they demonstrated greater security. The resident needed to decide, in each situation, how much she could delegate and under what circumstances she should intervene. This process highlights that autonomy in clinical teaching should not be understood as an absence of supervision, but as a progressive construction, dependent on the competence demonstrated by the learner, the complexity of the situation and patient safety.

The need to make these choices also had a formative effect on the resident herself. When supervising an intern, it became necessary to clarify criteria that, previously, could remain implicit in clinical practice itself. Questions such as “why this conduct?”, “what do you consider most important in this case?” or “what would you do next?” they began to constitute instruments to make clinical reasoning more explicit. Teaching, in this sense, worked as a stimulus to professional metacognition, as it forced the resident to reflect on knowledge and decisions that were previously mobilized in a more automatic way.

This phenomenon can be related to the principle that teaching also constitutes a learning opportunity for those who teach. In the near-peer teaching experience, the educator in training needs to reorganize their own knowledge, select relevant information and adapt the complexity of the explanation to the learner's level. The literature on peer teaching describes precisely this potential benefit for the different subjects involved in the educational process (Ten Cate; Durning, 2007; Brierley; Ellis; Reid, 2022).

Another relevant aspect was the development of communication. At the beginning of the experience, the resident reported insecurity regarding the need to explain in a didactic way clinical decisions that, in some situations, were made intuitively during the consultation. The need to teach required greater organization of thought and greater clarity in communication. This process can be understood as a consequence of the transition between “knowing how to do” and “knowing how to explain how and why to do it”, an important distinction for the development of pedagogical competence.

The initial difficulty in constructing feedback is another relevant finding. In the beginning, returns were punctual and unstructured; progressively, they began to incorporate more specific aspects of the observed performance and guidance on possibilities for improvement. This transformation is consistent with the literature that considers feedback to be an essential tool in clinical education, but also a complex skill that does not necessarily develop through the care experience alone (Ende, 1983; Bing-You et al., 2017).

Effective feedback must provide the learner with specific information about their performance in relation to a certain standard or objective, enabling the identification of aspects

that should be maintained or modified (Ende, 1983). More recent studies reinforce that interventions involving feedback can produce positive effects on the knowledge, attitudes and skills of medical students, although the literature still presents important heterogeneity regarding the strategies used (Castro et al., 2021).

In the reported experience, the resident's evolution in the construction of feedback seems to have occurred precisely due to the need to transform general impressions into more concrete guidelines. This change represents one of the clearest examples of pedagogical development throughout the experience. The resident progressively stopped occupying the role of someone who identifies mistakes or successes and began to understand feedback as part of the learning process, oriented towards future performance.

The so-called “preceptorship mirror” constitutes, in this context, the main interpretative contribution of this report. By occupying the position of someone who teaches, the resident began to recognize pedagogical practices that she had previously experienced as a student and as a resident. Some were reproduced because they were perceived as positive; others were modified when they proved to be inadequate for the situation; and some began to be questioned based on their own experience as an educator.

This movement is relevant because doctors' pedagogical training does not occur exclusively through disciplines or formal courses. A significant part of learning about how to teach happens through observation of teachers and preceptors, through participation in real situations and through the reproduction, consciously or not, of previously experienced pedagogical models. In this way, when the resident starts teaching, it becomes possible to make teaching models explicit that previously remained implicit. The “mirror” therefore represents not only the reproduction of behaviors, but the possibility of recognizing, evaluating and transforming these models.

The metaphor also allows us to understand preceptorship as a component of professional identity. The doctor not only acts as a caregiver, but often participates in the training of students, residents and other professionals. At FCM, this educational dimension assumes particular importance, since PHC constitutes a space for clinical training, teamwork, longitudinal care and integration between different levels of training. The reported experience showed that the identity of an educator can begin to be constructed during residency, even before the formal exercise of the role of preceptor.

However, the report also highlights an important tension between educational responsibility and assistance activities. The resident needed to balance caring for her own patients with monitoring interns, respond to clinical demands and, simultaneously, create learning opportunities. This overlapping of roles can produce insecurity and overload when there is no clear definition of responsibilities, protected time or institutional pedagogical support.

This question is particularly relevant because the literature on training residents as

teachers points out that the existence of teaching opportunities, in itself, does not guarantee that these experiences are pedagogically qualified. Structured training programs can address teaching planning, communication, supervision, evaluation and feedback, promoting greater safety and effectiveness in teaching (Hill et al., 2009; Ostapchuk et al., 2010). In Family Medicine, specifically, resident training programs for teaching have included clinical teaching skills, leadership, feedback and evaluation, with positive results in teaching behaviors (Albanese et al., 2009).

The absence of formal pedagogical training, therefore, did not prevent the development of skills during the experience, but made this process predominantly intuitive and based on trial, observation and reflection on practice. This finding should not be interpreted as a devaluation of informal learning, which proved to be important in experience, but as an opportunity to discuss how institutional training could enhance this process.

In this sense, experience suggests that the inclusion of preceptorship activities in the residency must be accompanied by structured spaces for reflection. Simply assigning students to residents can produce learning opportunities, but the inclusion of pedagogical objectives, supervision of residents, discussion of teaching cases, and feedback tool training could transform a spontaneous activity into an intentional formative experience. Evidence on resident as teacher programs indicates that structured interventions can improve teaching skills and that longitudinal strategies tend to favor greater consolidation of skills than isolated interventions (Hill et al., 2009; Residents as teachers…, 2026).

Another important element is that the experience should not be interpreted as demonstrating the effectiveness of a particular teaching method. As this is an experience report based on the author's own perspective, objective instruments were not used to measure the evolution of the interns' or resident's skills, nor was there a comparison with a group of students subjected to another pedagogical strategy. In this way, the findings represent perceptions and learning constructed from a particular experience and do not allow causal generalizations.

This limitation, however, does not reduce the relevance of the report. The objective of a production of this nature is not to establish cause and effect relationships, but to systematize a concrete experience and produce reflection on its meanings and possibilities. In this sense, the experience made it possible to identify aspects that may be relevant for other residency programs, especially the importance of continuing the pedagogical relationship, progressive supervision, feedback and preparing the resident to assume educational responsibilities.

Finally, experience allows us to understand that preceptorship should not be seen as a role that begins only after completing the residency. The resident already participates in the training process of other professionals during their career and, in doing so, develops skills that may later be fundamental to their role as a preceptor. The residency can, therefore, constitute a privileged space to intentionally begin the pedagogical training of the future family and

community doctor.

6. Final considerations

The experience of a resident doctor in Family and Community Medicine in monitoring and teaching medical interns showed that the exercise of the educational function can constitute an important component of professional training itself. When moving between the positions of apprentice in front of preceptors and educator in front of interns, the resident experienced a change in perspective that made it possible to understand in a more concrete way the complexity of the teaching-learning process in the clinical environment.

Experience has shown that the continuity of the relationship between resident and medical intern was a central element for the qualification of the educational process. Prolonged stay with the same apprentice allowed progressive recognition of their prior knowledge, difficulties and skills, favoring the adaptation of supervision and the gradual expansion of autonomy. In this context, teaching was no longer understood as a mere transmission of information and began to be experienced as monitoring the learner's development, articulating assistance, supervision, clinical reasoning and reflection.

For the resident, the experience also produced significant learning. The need to explain clinical decisions, formulate questions, discuss cases, evaluate interns' performance and offer feedback required greater organization of their own knowledge and greater awareness of their professional practice. The development of pedagogical communication skills, the construction of more structured feedback, the definition of autonomy limits and the adaptation of teaching strategies constituted skills that went beyond the exclusively clinical domain.

The metaphor of the “preceptorship mirror” allowed us to understand another dimension of this experience: when teaching, the resident began to observe her own training from a new perspective. Previously experienced preceptorship models could be recognized, reproduced, adapted or questioned. The process therefore favored not only the development of teaching skills, but also the construction of a professional identity more aware of the educational dimension of medical work.

At the same time, experience showed that the acquisition of these skills occurred predominantly informally, through daily practice, observation of preceptors and reflection on situations experienced. The initial insecurity and difficulties related to creating feedback and reconciling assistance and teaching demonstrate that practical experience, although powerful, does not replace the need for structured pedagogical training.

Therefore, it is considered pertinent that Residency programs in Family and Community Medicine also recognize the resident as a subject capable of participating in the training of students and future professionals, offering conditions for this responsibility to be exercised in a safe and pedagogically qualified manner. The inclusion of medical education content and strategies, such as planning learning objectives, clinical supervision, assessment,

feedback and teaching methods in the workplace, can transform experiences that currently occur spontaneously into intentional training opportunities.

It is concluded, therefore, that the preceptorship experience during residency can function simultaneously as a teaching strategy for the intern and as a professional development device for the resident. More than preparing the apprentice for specific clinical situations, teaching allowed the resident to reflect on how she learned, how she was taught and how she wants to teach in the future. In this sense, the "preceptorship mirror" represents a continuous process of recognition and transformation, in which the experience of teaching contributes to the training of the future preceptor and to the consolidation of the educational dimension as an integral part of the identity of the family and community doctor.

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