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ABSTRACT

This is the final report for a three-year contract in health manpower development. The contract, awarded to Howard University in 1969, was actuated in January 1969 and extended to August 1972. The contract period has been marked by a large variety of progressive activity and creation of programs. These include the development of an attractive community physician continuing medical education program, American Academy of Family Practice memberships for community physicians, a Family Practice Residency, a Department of Family Practice, a progressive educational program for family physicians including an intensive review course, multiple successful candidates for the Board of Family Practice, a student teaching program in Family Practice, and a community physicians preceptorship for freshmen and sophomores. This report describes the further development of these activities and illustrates the mechanism by which they have become expected functions of the Howard University College of Medicine, its hospital training program, and its community physician support. The last year's activities are described in three categories: Neighborhood Physician Education, Family Practice Resident Training, and Predoctoral Student Teaching. (Author)

FINAL REPORT
NIH 71-4019(P)

August 30, 1972

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Final Report
Training Program for Neighborhood Physicians
Howard University
College of Medicine

This is the final report for a three-year contract in health manpower development. The contract, awarded to Howard University in 1969, was actuated in January 1969 and extended to August 31, 1972.

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These activities are well described in the first and second annual reports in the accompanying manuscript.

This report will describe the further development of these activities and illustrate the mechanism by which they have become expected functions of the Howard University College of Medicine, its hospital training program and its community physician support.

The last year's activities will be described in three categories: Neighborhood Physician Education, Family Practice Resident Training, and Predoctoral Student Teaching.

NEIGHBORHOOD FAMILY PHYSICIAN

The base of activity for the community physician is in the Department of Family Practice and in the closely allied Howard University Continuing Medical Education Program. The Department's activity includes clinical responsibility in Ambulatory Care, a training program for Family Practice Residents, and a predoctoral teaching program for medical students.

The community physician's activity is summarized as follows.

Attending Staff

An increasing number of community physicians have been given appointments in the Department of Family Practice. Some participate in all teaching conferences and a large number of physicians serve as preceptors to freshmen and sophomore students. Some are awarded instructoral or professorial rank, with or without compensation. Those receiving compensation receive a token part-time salary contracted by non-federal funds. They are encouraged to participate in all of the department's activities including patient care, resident and student teaching, and in program planning.

Educational Activities

Intensive Review Course

The second annual intensive review course was given in January 1972. (The first was given in January 1971). This program, approved by the American Academy of Family Practice, was supported partly by funds from this contract and presented by consultants from among our specialty faculties. The course was evaluated by the student participants and by

instructional personnel. Aspects of these evaluations will be used in the development of future intensive review programs.

Summer Demonstration Program

Summer clinic demonstrations and supervised patient management were presented for the third annual period. This popular activity served to bring the community physician into direct involvement in hospital patient care and allowed for peer review.

Regional Involvement in Family Physician Education

The administrative staff of our Family Practice and Continuing Medical Education program continued as active members of the District of Columbia Medical Society's Committee on Continuing Medical Education. Plans are being introduced to require continuing medical education participation for family physicians and all other specialties as a criteria for medical society membership. The guidelines for this requirement and its acceptance is being debated thoroughly in this committee.

The administrative staff was invited to help develop a scientific program for the national meeting of the Interstate Postgraduate Medical Association of North America which will be holding its annual meeting here in November 1972. Key members of our supportive staff have been designated to participate in the program.

National Involvement in Family Physician Education

The Howard University Department of Family Practice developed a national organization for Family Physicians within the National Medical Association. By this means, it expanded to national responsibility for the continuing education for black family physicians.

The educational program has been developed by our staff. To enhance this program we have produced a series of motion pictures. Sponsorship for these films was obtained from The Veterans' Administration and Davis and Geck American Cynamid Company. They are listed below.

Films Produced by Howard University, Continuing Medical Education and Department of Family Practice

Clinical Evaluation of Thyroid Disease
W. Lester Henry, Jr., M.D.

Diabetic Foot
W. Lester Henry, Jr., M.D.

Sickle-Cell Disease: Review and Update
Roland B. Scott, M.D.

Common Dermatological Conditions: Their Diagnosis and Management
Betty Fischmann, M.D.
John A. Kenney, M.D.

Movement Disorders of Extrapyramidial Origin
Don Wood, M.D.
Robert Cohn, M.D.

Endoscopy
Victor Scott, M.D.

Diagnosis and Surgical Treatment of Coronary Artery Disease
Louis A. Ivey, M.D.
Charles L. Curry, M.D.

Hiatal Hernia Repair
William E. Matory, M.D., F.A.C.S.

Portacaval Shunt
Edward Cornwell, M.D., F.A.C.S.

Correction of Epstein's Malfunction
Robert L. Simmons, M.D., F.A.C.S.

Diagnostic Concepts in Abdominal Trauma
William E. Matory, M.D., F.A.C.S.
Macy G. Hall, Jr., M.D.

Resection of the Parotid Gland
LaSalle D. Leffall, M.D., F.A.C.S.

Surgery for Hyperparathyroidism
Jack E. White, M.D., F.A.C.S.

Gastrectomy for Gastric Carcinoma
LaSalle D. Leffall, M.D., F.A.C.S.

Contrast Mammography and Nipple Discharge
William W. Funderburk, M.D., F.A.C.S.

Modified Soave Procedure for Hirschsprung's Disease
Charles H. Clark, M.D., F.A.C.S.

Repair of Tetralogy of Fallot
Robert L. Simmons, M.D., F.A.C.S.

Liver Biopsy and Appendectomy
William E. Matory, M.D., F.A.C.S.

Renal Bi-Valve for Stafhorn Calculus
George W. Jones, M.D.

These films will continue to be used as the basis for teaching sessions for community physicians, residents, and students.

Future plans for community physicians include progressive participation in the Department of Family Practice activities and documentation of this participation.

American Medical Association Accreditation of Program

A survey for accreditation of the Continuing Medical Education Program was made by the American Medical Association's Council on Medical Education in January 1972.

The survey was made at the time of the Intensive Review Course for Family Physicians. Sessions of the course were observed, and members of the teaching faculty, the Director of Continuing Medical Education and Dean of the College of Medicine were interviewed.

The program was granted approval for two years.

FAMILY PRACTICE RESIDENCY PROGRAM

The Family Practice Residency Training Program is in its third year. It was given provisional approval for three years graduate training by the Council of Medical Education of the American Medical Association in August 1969. Re-evaluation is scheduled within the coming academic year.

The present residency training program began through the support of this contract. The grant assistance helped to establish a Department of Family Practice in the College of Medicine.

The initial approval included a request for six residency positions. A subsequent request for approval for training of sixteen residents was granted in June 1971. We hope to expand to a capability of thirty six residents within the next three years.

Objectives

The objectives of the program are as follows:

To develop physicians skilled in primary and comprehensive health care in continuity for men, women and children.

To impart to physicians the skill of the proper use of consultants in the delivery of optimum health care.

To develop physicians, medical students and paramedical personnel skilled in the care of ambulatory patients.

To reinforce the neighborhood family physician now in practice and provide peer group development and review.

To involve the family physician, his community practice and his image in the predoctoral curriculum for training in comprehensive care.

To serve as a base for learning, development and teaching for the community physician.

Description of Rotations

The resident rotates through all of the major specialty services for approximately thirty of his thirty-six months of training. He is fully involved in the activities of the department through which he is rotating. This includes special assignments, participation in case workup, night and weekend rotations, case presentations and responsibilities to the attending physician(s) of that service. He begins his involvement in the Model Family Practice Office during his first month and develops progressive responsibility during the following thirty-six months.

He is required to attend a weekly Family Practice conference in comprehensive care. He is required to participate actively in the conference through regular assignments and through spontaneous interest.

Model Office involvement is required during all thirty-six months. During the first twelve months, the resident will spend an afternoon an evening in the Model Office. At this time, he will develop his family patient clientele. Those first year residents who served their senior elective in medical school in the Model Office with Senior Family Practice residents will be encouraged to keep the families which they acquired for care.

In the second and third years, the resident will serve in the Model Office two afternoons and evenings weekly. He will develop a progressive number of families to which he will be responsible for comprehensive care.

His experience in the Model Office is distinguished by his serving as part of a team rendering total patient care. The team consists of the resident, his attending family physician, a medical social worker, a public health nurse, a family health worker and medical students. Team conferences form a significant contribution to his training.

The resident rotates through all of the major specialties during his three years of training. Sub-specialty involvement is encouraged during the senior year. At least six months of Pediatrics is also required.

During the first three years of the program it has been difficult to define the experiences according to the year. The allocation of time described in the following table has been generally followed. A more exacting time assignment is being developed as the number of residents increases and as the training program is strengthened.

Beginning July, 1972, the senior residents were assigned to one of the Department's major ambulatory units for twelve months. Any in-hospital service is confined to the first half of the day. With his team, which consists of a rotating resident, public health nurse, social worker, etc., he will be responsible for the continuing care provided in his ambulatory unit.

Standard Rotation Schedule

Rotation	Year of Resident		
	First	Second	Third
	Length of Time (Months)		
General Medicine	2	4	-
Medicine (Subspecialty)	-	-	(4) Concurrent with Ambulatory Care
General Surgery	2	-	-
Pediatrics	2	2	(2*) Concurrent with Ambulatory Care
Ob-Gyn	2	2	-
Psychiatry	2	-	-
Ambulatory Care (Emergency & O.P.D., Community Clinics)	2	2	12
Elective	-	2	-

*Mostly ambulatory Pediatrics

Description of Type of Experience and Training Environment

The resident experience is attained in the University Hospital's major specialty services and in the Ambulatory Care Services (including the Emergency Care Area), in the Model Office and in a community health clinic. A rotation through Medicine, Pediatrics, and Ob-Gyn in an affiliated community hospital is to begin in July, 1972. Training in other community health clinics is being planned for the future.

Model Office

The Model Office is now in the hospital ambulatory care center. In July, 1972, it will be located in a housing project located one block from the hospital and extending for an area of two large city blocks. The Family Practice residents will have full responsibility for the care of the approximately 2,000 inhabitants of this project (106 elderly patients and approximately 600 child bearing families).

Middle income families of the surrounding community and faculty families will be encouraged to participate as the new office organization matures.

Community Health Clinic

Some residents will rotate through a community health clinic located in a densely populated black neighborhood (the site of rioting in 1968). Its design includes the health team approach utilizing the resident, public health nurses, medical social workers and family health workers. Its patient load is approximately 15,000 individuals. It is supported by classical specialists and a Board Certified Family Practitioner.

The Family Practice Resident is the primary physician trainee in this clinic. He is responsible for comprehensive care to families seen throughout his tour of rotation.

Community Hospital

The community hospital rotation planned to begin in July, 1972 will afford rotations in Medicine, Pediatrics and Ob-Gyn. The Family Practice Resident will be the only resident on Pediatrics and Medicine at this hospital. A senior Gyn resident will share the Ob-Gyn service. The rotation will be supervised by University faculty in Medicine, Ob-Gyn and Pediatrics with the full cooperation of the Department of Family Practice of the community hospital and the attending staff of the rotation services.

Family Medicine

The basic clinical units for the Department of Family Practice are the Ambulatory Care Department (Emergency Care Area and General Clinic) and the Family Practice Model Office. Under the supervision of the Family Practice faculty and attending staff, the resident develops training and responsibility in disease prevention, early diagnosis, treatment of symptomatic disease, rehabilitation and management of chronic disease.

Special emphasis is placed upon continuity in patient care. The broad range of services which can be rendered to the ambulatory patient is revealed. The importance of good primary care and the expanding capabilities of the well-trained family physician are incorporated into the resident's training.

Involvement with related health professionals is emphasized throughout the program. Patient care, program development, case discussion, conferences and evaluations are shared with staff and consultants including medical social workers, public health nurses, mental health technicians and physical therapists. Physician assistants will soon be added to this staff.

Social influences in the presentation of disease will be stressed more. The prevalence, incidence, distribution and natural history of diseases will be emphasized as we augment our staff with experts in these areas.

Research and health care programs are being developed along with the responsibility of the resident program for a defined community population.

Internal Medicine

The Department of Internal Medicine and its divisions have had an approved residency training program and student teaching program in Internal Medicine for several years. It has thus developed a strong staff in this discipline.

The Family Practice resident serves at least one year in general medicine or in medical subspecialties such as cardiology, chest, nephrology, EKG interpretation and infectious diseases. Special emphasis is placed on mechanism of disease, its early detection through history, physical examination and appropriate laboratory diagnostic assistance.

Hospital care capability is developed, but imphasis is placed on those aspects of patient management which can be readily done on an ambulatory basis.

The identity of the Family Practice resident is respected and encouraged. Whenever possible advanced training is given which will add to the Family Practice resident's limited rotation time.

Pediatrics

The resident develops experience in ambulatory pediatrics and in diagnosis of pediatric illnesses. This experience is gained on the pediatric wards, in the newborn nursery, in the pediatric and general clinics, in the emergency care area, in the Model Office and in the community health clinic.

On-going special projects in sickle cell disease, genetics and phenylketonuria are available for those residents with special interests in these areas.

Ob-Gyn

Management of normal obstetrics, detection of abnormal prenatal and natal factors, family planning and the diagnosis and management of gynecological problems are stressed. The delivery suite, gynecology wards and Ob-Gyn clinic serve as the medium for training.

Psychiatry

Experience in human behavior and psychodynamics is obtained in psychiatric wards and in the psychiatric clinic. A new psychiatric staff is being developed. This staff will emphasize ambulatory psychiatry for the Family Practice residents.

Surgery

The resident is being given experience in the diagnostic, resuscitative and emergency modalities in surgery. These include the use of the various laboratory techniques and office instrumentations. He is also given experience in resuscitation and the performance of minor operative procedures. These experiences are gained during his rotations through the emergency service, the various surgical clinics (tumor, diagnostic, surgical dressing), and in the animal laboratory.

On the tumor service, he sees a wide variety of neoplastic lesions and develops an acumen for cancer suspicions and diagnosis.

Wound care is stressed, especially those wounds he is likely to see in an office, clinic or emergency room. He is trained in cardiac and respiratory resuscitation. He obtains experience in passing endotracheal tubes, performing tracheotomies, cutdowns, central venous pressures and various critical venal punctures.

The recognition and management of low perfusion states are emphasized as concerns the ambulatory patient as seen in offices.

The above experience will be gained more fully through well supervised rotations through the emergency service, the surgical ward services and various surgical clinics as the training staff expands.

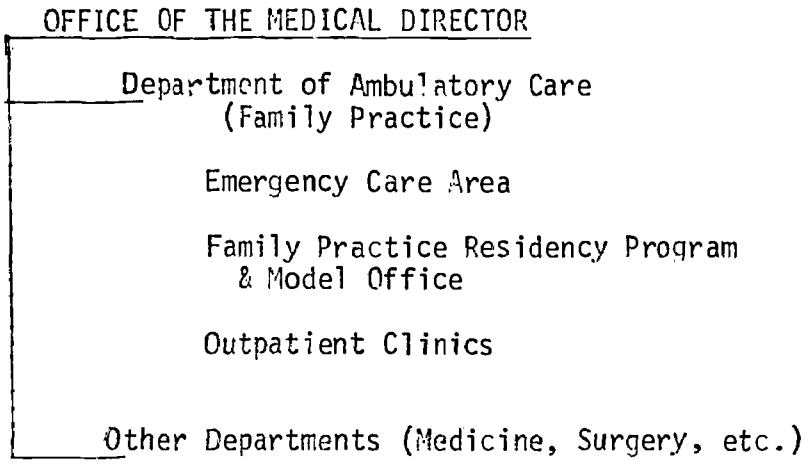
Commitment of Related Staff

Hospital

The Department of Ambulatory Care Developed along with the Family Practice training program. Its staff is devoted to the further development

of the residency program along with research and the introduction of advance principles of comprehensive care.

The Department of Ambulatory Care has the following organization chart:



The various outpatient clinic chiefs maintain full appointments and allegiance to the classical departments, but have taken a special interest in the development of the residency program.

The staff of the other divisions (Emergency Care Area, Model Office, etc) have full appointments in the Department of Ambulatory Care (Family Practice). All of these appointments are full time.

College of Medicine

The Department of Family Practice in the College of Medicine was adopted by the Board of Trustees with full and equal status with all other clinical departments. The effective date was January, 1971. It was shared with the Department of Ambulatory Care (Hospital) the full responsibility for the residency training program since its beginning. Student teaching responsibility began in July, 1971.

General Staff-Hospital and College of Medicine

On January 16, 1972, a faculty workshop was held by representatives of all Departments of the College of Medicine including the clinical faculty of the Hospital. All endorsed the Family Practice Training Program and offered contributions to its further developments. Some of their recommendations are included.

Community Health Clinic

One of the rotations is in a community health clinic in a nearby area (the site of burning and other violence in 1968). This comprehensive care clinic has adopted the Family Practice Residency as its primary residency support. Its staff contributes to the resident's training in community health care.

Affiliated Community Hospital

Cafritz Memorial Hospital is a 408 bed private community hospital based in a densely populated black community in Southeast Washington, D.C. The Family Practice residents will be the only residents on the service of Medicine and Pediatrics and will serve in Ob-Gyn with a senior resident in Ob-Gyn.

This mutual support of the residency and attending staff is expected to add an essential dimension and status to the residency program.

Model Office Description

Our residency program utilizes two areas as Model Offices. The first or classical model office is completely residency or hospital controlled. It is located within a block of the hospital and is a part of the Department's community health plan. All residents will have responsibility there.

The second model office is a community health center which serves as an area of family responsibility for rotating residents and a senior resident.

Primary Model Office

The primary model practice unit is located in the basement of a six year old multi-story housing unit. Its basic unit is a four-examination room suite with two other rooms, a waiting room and toilets. This unit will be renovated, equipped and leased with funds collected as patient fees.

There is an adjacent storeroom and another across the hall from this unit which will contain conference space and training staff offices. On the first floor a two-room office suite will be leased. Support for renovation, lease and equipment of these storerooms and the first floor office suite is being requested.

OEO Community Health Center

A community health center is located about nine blocks from the University. It serves as a site for resident's training and orients them to the advantages and disadvantages of clinic care.

Characteristics of Model Practice Units

Primary Model Office

The Model Office will serve as the base for health care to housing complex one block from the hospital. There are 106 elderly inhabitants and approximately 600 families with children.

Patient care will be rendered to the inhabitants with the assistance of related health personnel.

In July, the six junior residents and nine advanced residents will begin developing patient profiles with the assistance of health teams. The optimal number of families or patients for each resident has not yet been determined, but progressive involvement will be encouraged.

The resident will be required to provide the full range of ambulatory services. He must seek consultation and follow his patient with the consultant. He must be certain that the patient returns to him for continued care if consultation or hospitalization is had outside of the resident's service.

A special feature of this model office plan is that it lends itself very well to considerable home care. The proximity of the two-block housing complex to the hospital allows close repeated patient-physician encounter with reassurance while at home for treatments which otherwise might have required hospitalization.

OEO Community Health Center

This community health center is geared to serve a patient load of 15,000. However, in preparation for the future operations, the center will have the capacity to serve up to 25,000 patients.

Community Group Health Foundation is located and operated in the heart of a community that is plagued with the problems of:

1. Financial limitations of the population most in need of medical care;
2. A deficit in the availability of appropriate health care manpower;
3. Inaccessible facilities.

The Health Center helps to solve these problems for a segment of this inner center community. It is a private corporation administering a

comprehensive health program in a target area that comprises census tract 27, 28, 29, 30, 31, 32, and 39 in Northwest Washington, D.C. The majority of the patient population receives medical assistance in the form of Medicaid and/or Medicare and OEO support.

This center has more than 12,811 registered patients; 34% of this group are Medicaid eligible for D.C. Medical Services (D.C.M.S.). OEO picks up the cost for that 62% (plus the 2% D.C.M.S.) of the patient load that has no coverage. All patients receive the same high quality comprehensive care. The plan offered by the Community Group Health Foundation is a unique one.

A demographic profile of this Center's patient population follows:

Black	79.5%
White	5.8%
Non-White	14.7%

Under Age 5	14.2%
5-14 Years	18.5%
15-44 Years	51.4%
45-64 Years	11.7%
65 & Over	4.1%

The health care program at the Center is family oriented with the use of a team care concept in the management of patients. The teams are comprised of the following personnel:

Family Physician or Internist Pediatrics
Nurse
Social Worker
Family Health Worker
Public Health Nurse

Families are registered at the Center and the records system employs the problem-oriented family medical record. The average number of patient visits is presently 117.8 daily. The Family Practice residents have

participated fully in the medical program of the Center and have assumed the primary responsibility of the continuous medical care for families within the program. Under this arrangement, the Family Practice resident has provided on-going ambulatory care for families in the Center with a strong emphasis on health maintenance and prevention medicine while also providing hospital care for his patients when necessary. The Family Practice staff at the Center and the Howard University Hospital have provided close supervision and training of the residents in his care of his patients and families.

Percent of Time in Ambulatory Care

Resident	Model Office	Rotation	Average	%/36 Mos.
First Year	26-30 Days	60 Days	85 Days (3 mos.)	8%
Second Year	52-60 Days	60 Days	110 Days (4 mos.)	11%
Third Year	52-60 Days	365 Days	12 Mos.	33%
			13-19 Mos.*	35-52%

*Planned for beginning 1972 Senior Residents.

Beginning in July, 1972, it is planned that the senior residents will be assigned to one Ambulatory Care facility for one year. During this time, he may also take as much as 6 months of clinical specialty rotation so long as he can begin his Ambulatory Care responsibility by 12 Noon.

Health Maintenance and Preventive Medicine

The general plan of the program includes continuous association between families or individuals and the resident. Through this long association, the resident and his team establishes and maintains a record of evaluation and management which includes health maintenance, procedures, medications (vaccinations, etc.) and re-evaluation.

This will be more completely affected with augmentation of the Family Practice attending and supportive staff requested in this proposal. By this means, family assignments will be more extensively maintained by each resident and his team.

Indeed, the Model Office now being developed will lend itself ideally to resident involvement in continuous health maintenance, preventive medicine, environmental sanitation, epidemiology, and family and community disease control.

Relative Experience Indicative of Ability to Provide Training

Hospital

Howard University-Freedmen's Hospital was established in 1867. It has always served as the primary teaching hospital for the Howard University College of Medicine. It has approval for residency training in all of the major classical specialties (Internal Medicine, General Surgery, Obstetrics-Gynecology, Psychiatry, Pediatrics, Dermatology).

It has served as the oldest hospital completing training of a significant number of black medical specialists.

The various classical department heads have contributed to the establishment and maintenance of the Family Practice residency.

The present Family Practice residency is completing its third year. During these three years, it has experienced momentum toward maturity and is progressively gaining staff support so vital to such an innovation in medical education.

Department Chairman

The present chairman of the department enjoys favorable positions among the faculty th s predisposing the residency to the likelihood of fair appraisal. The Chairman is professor of surgery with board certification in general surgery and in family practice.

He is a member of the Executive Committee of the Hospital and of the Medical School and Director of the Office of Continuing Medical Education.

Dedication of Staff

The Department of Family Practice (Medical School) and the Department of Ambulatory Care (Freedmen's) are staffed by a group of young v'jorous full time personnel.

Although the number is limited their individual contribution over three years has formed a good base for continuous growth. The staff is fully respected by other clinical departments.

Neighborhood physicians support the residency program. They are being attracted to this program of training as a university base with which they can identify and to which they can contribute.

Three fellows and associates have taken and passed the American Board of Family Practice. All are now a part of the staff. Four of our immediate staff will take the board examination on April 29, 1972.

Trainees

Trainees are recruited mainly from among our own student body. Three of our present residency staff are from other schools; Jefferson Medical College, Meharry Medical College and Royal College of Physicians and Surgeons (Ireland).

Two of these incoming residents of July, 1972 will be from other medical schools, (University of North Carolina and Christian Medical College, Punjab, India). Most of the residents are black.

We presently have eight residents. A total of fifteen will be in training in July, 1972.

The recruitment has been limited because of uncertainty of source of funding. The Hospital has been able to fund only nine residency positions. Temporary funding has been obtained for the remaining six.

Applicants are expected to have an above average performance as medical students. They must have demonstrated an interest in community health care. Priority is given to those applicants who have served an elective in the Department of Family Practice or a recognized equivalent at another medical school. The students expressing desires to practice in communities in need of health care are strongly considered. Special attention is to be given applicants who were reared in low income communities with the supposition that they are likely to return to practice in that or similar communities.

Past Residents and Fellows

Resident	Age	Previous Experience	Current Position	Location
Clarence Davis U.S. Citizen 1969-71	35	Med. Student	Med. Officer Dept. of Ambulatory Care (Taking Board, April, 1972)	D.C.
Eugene VanHorn U.S. Citizen 1969-71	36	Peace Corps	Med. Officer State Dept.	Nigeria
Constance Holt U.S. Citizen Resident-Fellow 1969-71	37	Cl. Physician	Instructor Dept. of Family Practice (Taking Board, April, 1972)	D.C.
Robert Williams U.S. Citizen Fellow 1970-71	36	Med. Officer U.S. Army	Ass't Professor Dept. of Family Practice (Board certified, 1971)	D.C.

Broad Health Objectives

The residents are accepted primarily from among those applicants reared in rural or Southern United States and dense urban communities. Most of the residents are black and have chosen the specialty because of their desire to return to black and needy communities.

The Model Office is located in a low income black housing project. The community health clinic is in a dense black ghetto. The base hospital serves predominantly black patients, most of whom are under priviledged in education and health awareness.

The team approach is emphasized so as to train the resident in the utilization of related health professionals in the care of communities.

A physician's assistants training program is being developed in conjunction with the Department of Allied Health Professions and the Department of Community Health Practice. It is planned that the resident will train with the physician's assistant trainee and contribute to the finished product. The resident will develop the ability to multiply his own capability to serve a large number of patients.

New Knowledge to be Introduced

The following features will be incorporated into the residency:

1. Problem oriented records
2. Physician encounter form evaluation of practice patterns
3. Team approach to patient and family care
4. Utilization of related health professionals including physician's assistants
5. Computerization of health activities
6. Partnerships in training

Comprehensive Health Planning

The Director of the Office of Comprehensive Health Planning, Mrs. Marguerite Dalton, has stated that the District of Columbia is badly in need of more practicing family physicians. The training program at Howard University's hospital will alleviate this shortage since many of the graduates will remain in the Washington area.

Staff Resources and Supportive Personnel

The following staff is devoted full time to the residency program:

-Edwin McCampbell, M.D.	Ass't Program Director
-Arthur Vincent, M.D.	Family Physician
-Hilda Rhines	Secretary

The following staff are hospital salaried for service but maintain major responsibilities in the residency program:

-Norcliffe Brown, M.D.	Director of General Clinic
-Horace Laster, M.D.	Director of E.C.A.
-Diosdado E. Ulep, M.D.	Ass't Director - E.C.A.

The following staff are medical school salaried for predoctoral teaching, but make major contributions to the residency program:

-Robert Williams, M.D.	Family Physician, Community Clinic
-Constance Holt, M.D.	Family Physician
-Verline Ager	Public Health Nurse
-Marian Secundy	Medical Social Worker
-Sterling Lloyd	Medical Care Administrator

The following Department Chairmen and their staff give support to the rotation of the Family Practice residents:

Department of Medicine	-W. Lester Henry, M.D.
Department of Neuro-Psy.	-Edward Rickman, M.D.
Department of Ob-Gyn	-John Clark, M.D.
Department of Pathology	-Marvin Jackson, M.D.
Department of Pediatrics	-Roland B. Scott, M.D.
Department of Phy. Medicine & Rehabilitation	-Alicia Hastings, M.D.
Department of Community Health Practice	-John T. Wilson, M.D.
Department of Radiology	-Harry C. Press, M.D.
Department of Anesthesiology	-Edward Briscoe, M.D.
Department of Surgery	-LaSalle D. Leffall, M.D.
Division of Cardiovascular Diseases	-John B. Johnson, M.D.
Division of Dermatology	-John A. Kenney, M.D.

PREDOCTORAL STUDENT TEACHING PROGRAM

The Department of Family Practice was established in the College of Medicine with the effective date of January 1, 1971. The subsequent months included rapid preparation for curriculum input and faculty development. In September, 1971, student teaching began. This includes freshman

and sophomore preceptorship and senior clerkship. Multiple electives are also offered. These are described as follows:

Freshman and Sophomore Preceptorship

The preceptorship program was designed to expose the student to direct patient care and to introduce him or her to elements of the health care delivery system. The program provides an opportunity for observation and evaluation of the role and function of the private practitioner, the hospital-based physician, the health care administrator, the public health physician, and the allied health professional.

Preceptors include private practitioners and physicians and allied health professionals of the District of Columbia Community Health and Hospitals Administration, Freedmen's Hospital, private out-patient facilities, and social service and volunteer health agencies.

The Preceptorship for Sophomore medical students was presented in two phases of six weeks each. Each of the 115 students involved had two different experiences. All students were required to spend a four-hour period once a week with their preceptor. Preceptors included 45 practicing physicians, three health care administrators, 13 hospital-based physicians, and the D.C. Community Health and Hospitals Administration.

Students were expected to gain skill and facility in the physician's approach to the patient; to be sensitized to the attitudes and behavior of patients, and to acquire familiarity with the entire pathway of the delivery of health care from the patient's initial complaint to the complete solution or control of that complaint.

All students were asked to evaluate their experiences in the program. An analysis of 110 student questionnaires returned indicated that 88% considered their experiences to be good or excellent.

Preceptors also were asked to evaluate the program. The overwhelming majority were very positive toward the program. All agreed that it served the important purpose of exposing the medical student to elements of the health care delivery system and to aspects of physician/patient interaction.

In the second semester of the academic year, 130 freshmen students began the preceptorship program. Like the sophomore student, the freshman student had two different experiences of six weeks each. Like the sophomore student the freshman spent a four-hour period each week with his preceptor. Preceptors included 40 practicing physicians, 15 medically related settings, seven hospital-based physicians, and seven health care administrators.

Thirty-six slots were developed at facilities of the D.C. Community Health and Hospitals Administration. The primary preceptors at these facilities were nurses. It was felt that the nurse could best familiarize the student with the pathway followed by the patient.

During the preceptorship experience the freshman medical student was expected to critically assess physician/patient interactions, allied health professionals/patient interactions, and the role, activities, and interrelationship of those who participate in the delivery of health care.

Like the sophomore student, the freshman was asked to complete a questionnaire evaluating his or her preceptorship experience. While the

overall response to the program was good, there was considerable variation in the response among the types of preceptorship settings. Most significant was the very high regard given by students to the practicing community physician's office as a preceptorship setting and the relative low rating given to the experience in non-clinical agencies.

Preceptors remained enthusiastic about the program and the preceptorship staff expects their continued support.

As with all new and innovative programs, there were several problems encountered during the year. There was some confusion in some students' minds regarding their role in the settings to which they were assigned. Many students desired to play a more active role in the delivery of health care than their capabilities allowed. Many students questioned the value of exposing medical students to non-clinical aspects of the health care system. Many of the preceptors indicated that the first and second year medical student did not have the necessary academic and clinical background to enable them to comprehend most of the concepts involved in direct patient care.

In an attempt to address some of these problems, the preceptorship staff has sharpened and redefined the program's educational objectives, given the students a more thorough orientation, and required the students to participate in more small group discussions. The students were also required to complete reading assignments.

Senior Rotation

The Department of Family Practice shared responsibility for a Senior Clerkship in Comprehensive Care with the Departments of Physical Medicine and Rehabilitation and Community Health Practice. The entire senior class was involved in the rotation. Each rotation was of four weeks duration.

The Department of Family Practice assumed coordinative responsibility for the rotation, developed all student schedules and a comprehensive care handbook. Significant time was spent in team teaching and in planning sessions.

The broad objectives of the Family Practice segment of the rotation were defined as follows:

> In accordance with the recommendations of the American Academy of Family Practice Commission on Education, it is intended that the clerkship will instruct the student in the intellectual demands of family practice and provide him with information on the practice style of the family physician. This is both educational and informational. During the clerkship the student learns methods of diagnosis and treatment of illnesses; develops plans for performing diagnostic studies with consulting physicians; utilizes available allied health personnel, gains understanding of the interaction of the socio-economic features of a community; learns the importance of continued comprehensive health care and learns the advantages of continuing medical education through weekly conferences and lectures conducted throughout the clerkship.

At any one time there were eight to ten students participating in the rotation. All students received clinical experience at Freedmen's Hospital's Evening Family Clinic and Emergency Care Area. Two students worked in an Office of Economic Opportunity sponsored comprehensive care center, Community Group Health Foundation, and were precepted by a designated member of our teaching faculty at this facility. Other students

were assigned to physician preceptors in clinical installations of the Department of Human Resources, Community Health and Hospital Administration. All students received significant exposure to allied health personnel.

Weekly seminars with students, faculty, and guest speakers focused on patient/doctor communication, ethical issues in the delivery of health care, political and legislative issues currently facing physicians and other health professionals, the roles of allied health professionals generally as they complement the role of the physician.

Comprehensive care reports were presented by all students to the entire teaching faculty at the end of the rotation. Students were asked to focus particularly upon questions relative to health care system evaluation and effective use of medical and non-clinical consultants.

There were some real coordinating difficulties encountered in scheduling, establishing joint philosophy, and in outlining course assignments with the two other departments involved. These were minimized towards the end of the rotation, however. Students had problems in following the complicated schedule and were somewhat resistant to the non-clinical aspects of the rotation when presented out of the context of direct patient care. Student evaluations and interest varied, dependent upon the career goals of the individual student.

The Department was handicapped somewhat in terms of limited physician staff available for more individualized student teaching and to serve as effective role models in family practice.

The Department has been able to undertake for the academic year 1972-73 total responsibility for the clerkship in Family Practice. All students

will serve in ambulatory care settings, either with the Department of Human Resources, Community Health and Hospital Administration, Comprehensive Care Centers, or the Freedmen's Hospital Evening Model Clinic. All students will have some clinical exposure to the Emergency Care Area as well.

Conference time has been expanded to allow for indepth clinical case presentations, students to research and to report on comprehensive care topics of interest to them, and for inclusion of guest consultants and discussants in areas of third party payment, health legislation, and group practice.

NEW PROGRAM PLANNED

Physician's Assistant Training Program

The Department of Family Practice, in conjunction with the Departments of Community Health Practice and Allied Health Professions, is planning the development of a program to train physician's assistants for primary-care physicians. The training program will be patterned after the MEDEX program developed by Richard A. Smith, M.D., at the University of Washington, Seattle, Washington.

The program will accept individuals with military training and experience, and will provide them with a three-month period of intensive university training followed by a twelve-month period of clinical training.

The physician's assistant trained by this program, under supervision, will be able to screen patients to be seen by a physician, take histories, perform aspects of physican exams, assist in the performance of certain surgical procedures, and assume certain administrative responsibilities.

A request for grant monies to support this training program has been submitted to the Bureau of Health Manpower Education, National Institutes of Health, Department of Health, Education and Welfare.