Carving a Predoctoral Curriculum In Family Practice

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A major issue facing all developing family practice departments in medical schools is the definition of curriculum and teaching responsibilities within the overall teaching mission of the institution. There are many areas in which such departments can make important contributions, complementary to the teaching efforts of other departments, in predoctoral medical education. This article describes the philosophy, goals, and course offerings which have been developed by the Department of Family Practice at the Medical University of South Carolina.

Most curricula which have been developed in medical schools over the years have closely followed departmental lines. As departments of family practice have taken their place in a growing number of medical schools in this country, we have been faced with the task of determining how family practice can best contribute to the overall curriculum. Since family practice is a "horizontal" specialty in terms of its synthesis of many disciplines, and since most medical school curricula are relatively full and well-established, the additions made by family practice can be visualized as a "carving out" process. The purpose of this article is to describe our efforts at the Medical University of South Carolina in response to this issue in the hopes that our approach and experience may be of value to developing family practice programs in other medical schools.

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Background

The Department of Family Practice was started at the Medical University of South Carolina in 1970. Since that time, we have based the development of our curriculum for medical students on three basic premises. First, we have felt that family practice should become a *citizen of the university,* and not be painted into an isolated corner. Our initial step in the development of the predoctoral curriculum was a probing and searching one – beginning to know and be known by other faculty members involved in the teaching of medical students. We have taken an active part in campus affairs, committee work and as teachers in interdepartmental programs.

A second premise has been to accept and build upon what has been called the *lead learner* concept. Teachers who are lead learners are accepted very well by today's medical students. The electricity of going into a classroom when everyone expects to learn is exciting. The day when lectures were recited from crisp, neatly typed notes with mimeographed handouts is falling into some disfavor. The student likes to feel that he is a part of the action. He will not fall asleep if he expects momentarily to be part of the discussion. The lead learner role is more appropriate for a practicing physician than the detached role of a lecturer protected by the lectern and prepared texts. It involves putting the questions in context with the answers. The mildew of often repeated and sometimes boring and "broken-record" performances elsewhere in the curriculum makes the spontaneity of lived-out experiences and tried and true facts like a breath of fresh air.

Our third premise has been to accept the importance and necessity of overall goals for our predoctoral curriculum. Following a careful review of course offerings within the existing curriculum of the medical school, the Department of Family Practice formulated these five major goals for its own contribution to the learning experiences of medical students:

1. To make the cadaver live.
2. Fill in the common diseases (Gapology).
3. Problem solving techniques.
4. Medical vocabulary building.
5. Attitudinal development.

These goals will vary from institution to institution since it is necessary for family practice teachers to know the curriculum in their particular school before they can define their own goals. Our goals are intended to complement, not compete with, existing curriculum offerings of other departments.

Curriculum Based on Goals

The teaching efforts of the Department of Family Practice can be briefly described in relation to each of our five major goals.

1. To Make the Cadaver Live

A course called *Diagnostic Anatomy* is offered to freshmen at Charleston after they have had Gross Anatomy. It is cosponsored by the Departments of Anatomy and Family Practice. An anatomist presents anatomical slides representative of specific disease states. Then the family physician draws from his own experience in treating people with such afflictions. He attempts "to make the cadaver live" by painting word pictures of what such patients say, what they look

like, what they act like, and sometimes even how they smell. These word pictures add a dimension to gross anatomy that indeed is refreshing as well as innovative. At this time anatomy is still very vivid to the students. It is hoped that this elective makes later recall of body structure more effective.

The class is not limited to freshmen; it is open to all classes. Some sophomores and seniors use it as a refresher for Boards and for sharpening their memory. The participation of the basic scientist, the family physician, and representatives of all classes assures a variety of comments and observations. The relaxed atmosphere makes it natural for discussion to take place. Our feedback on this effort has been most gratifying. Each succeeding quarter finds the room more crowded. This quarter there are 63 enrolled and they *attend.* They are afraid if they do not attend they will "miss something" as they put it. Sometimes the freshman medical student assumes from his seat the role of teacher when a senior asks for a forgotten anatomical fact. At other times, the senior becomes a teacher when a freshman asks a clinical question.

2. Fill in the Common Diseases (Gap-ology)

"Gap-ology" is a term coined to denote the second goal – that of addressing the more common and practical aspects of the family physician's practice, thereby attempting to fill in the gaps in the curriculum. A course called *Medicine with Continuity 1* was developed. It is a topic conference in which diseases and entities that will make up a large percentage of the family physician's practice are discussed. It is hoped that these common and frequently seen conditions will be brought into perspective (in the total picture of medical education) and will be given the important place that they will later occupy in the physician's practice. Audio-visual aids such as films or slides are utilized with appropriate interplay in the discussion period.

This course addresses itself to that group of diseases that a physician is likely to see several times a day in a busy practice. The elective is open to all classes, beginning with freshmen, and it can be chosen for as many quarters as the student wishes. Patients are discussed in this elective but no patient responsibility is required. Students are allowed to participate in the choice of subjects. If a large portion of the class wishes to have a session on a given subject, it is included in that quarter's work.

It is best to limit these classes to not more than 25 students, since small groups interact better. This elective has proved so popular in Charleston that the Department has had to increase the size to 40 and add an extra session so that two such sessions are offered each week.

Another elective called *Health Care for the Family* provides an opportunity for personal tutelage on a one-to-one basis. It is limited to six students per quarter because of the faculty time it requires. Those students who elect this course are assigned a family. Each student visits the family's home with a social worker. The student later discusses problems present in the family with the family practice resident who is the family's physician. He explores the environmental and sociologic histories of the family which might have bearing on the medical problems and discusses his findings for an hour each week with the assigned faculty member. Medical factors as well as feelings are discussed during these sessions. The student is then required to write a paper describing his own feelings, attitudes, and changes in his own feelings as a result of his visits.

This elective provides an introduction to the doctor-patient relationship and what this relationship means in the context of the home and family circle. The course is over-subscribed each quarter, and a great deal of cross pollenation takes place. The student uses other elective experiences in seeing his family, and enhances his understanding of these other electives by placing his scientific knowledge in the context of family life.

3. Problem-Solving Techniques

At the sophomore level while students are engrossed in the study of General Pathology and Physical Diagnosis, the Department of Family Practice offers an elective called *Medicine with Continuity II.* Patients are presented at weekly conferences. Each student is assigned a family he visits in the home. He is also called whenever a person in his family is sick and sees that patient with the resident. At weekly conferences a student and a family practice resident present one of their families and the student is invited to participate in the presentation. No topic is announced, and the diagnosis is unknown to the class. This factor adds to the enthusiasm of the participants, who are actively involved as the presentation unfolds. At these weekly conferences with the family present, we generate a problem list, thereby introducing the Problem-Oriented Record System. The students watch the resident develop his history and then are allowed to ask whatever questions they deem necessary to make a diagnosis.

The problem list is generated in the language given by the patient and understood by all. After the patient is dismissed, the problem list is interpolated into a differential diagnosis. There is lively action in the process. There are residents, several faculty members and students participating in this "stereo effect." Rarely have the proper diagnoses not been included on the differential diagnosis list. By the process of elimination, the class usually arrives at a reasonable diagnosis. In the meantime many reasonable considerations have been discussed and ruled out. Most students say that this exercise makes them appreciate pathology more than ever. We generally correlate these patients with topics being given in the Pathology course at the time. These exercises prepare the student for the hospital wards by introducing him to the problem solving methods used by clinicians.

4. Medical Vocabulary Building

All of the Department of Family Practice electives are directed toward explaining and defining clinical terms so these terms will not be totally foreign to the students when they hear them on the wards. Here again, it is the hope of the department that this effort will help bridge the transition from the preclinical to the clinical years. Thus far, the feedback has been good. It is realized that repetition is the father of all easily recallable facts. During each session an effort is made to encourage each student to feel free to ask the meaning or significance of a new word or concept in his vocabulary.

5. Attitudinal Development

All students of medicine need to possess certain qualities. They need to possess a high degree of determination. They need to care about patients. Family physicians should care and be concerned for the welfare of others, but all other physicians share this same responsibility. It is felt that all students who take our electives, regardless of their final career goals, should be provided with role models of dedicated physicians who care about patients and who care about students. A standard of excellence and honesty is presented so that the future effect will be a positive one.

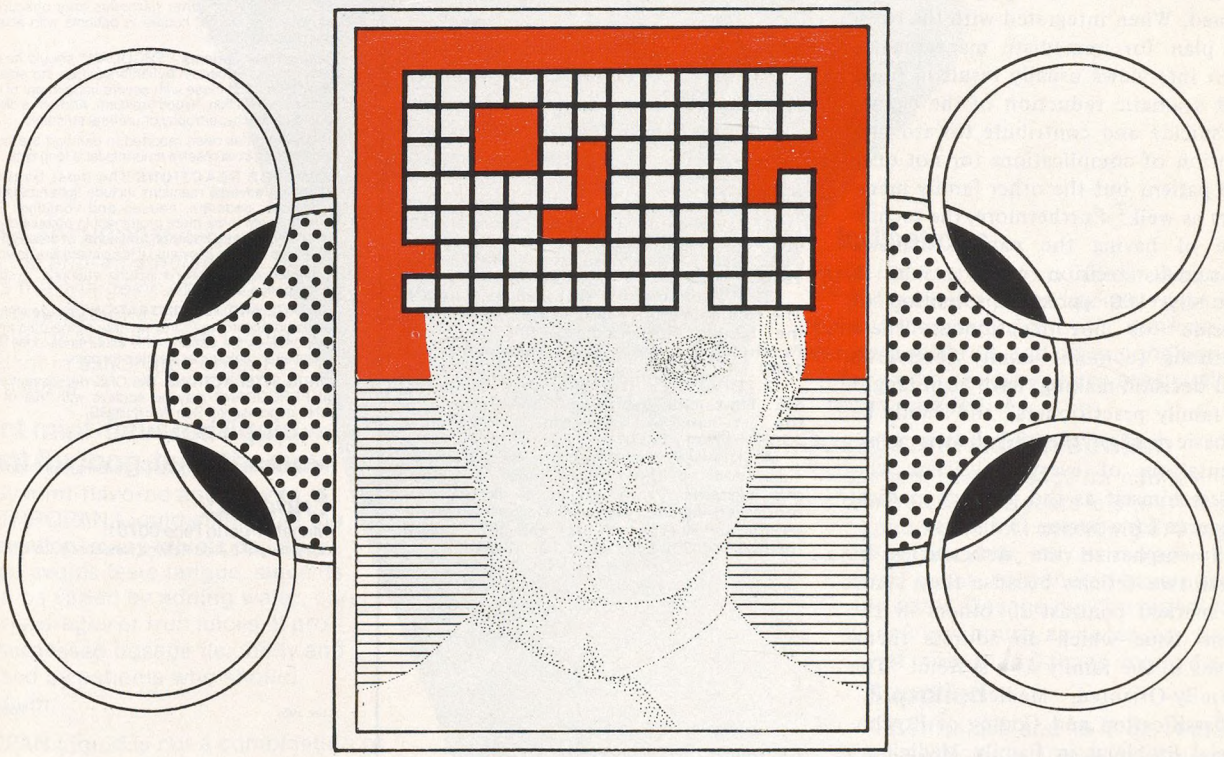
Departmental electives are not conducted for the recruitment of involved students into the ranks of family practice. Certain facts, techniques, principles, and standards are common to the making of good physicians in every area of medicine. It is our purpose to make a contribution to the education of every student who takes an elective in this department. The practice of helping one realize his capabilities while understanding his limitations is uppermost in this department's list of priorities. We feel that the discovery of what one does not know is a vital part of curriculum assessment and attainment.

Electives in behavioral science are offered in the department to help students understand patients as whole persons and parts of families and society. The physician's role in society is considered in these electives. Emphasis is placed on the feelings of patients and physicians. The student is alerted to his own reactions to patients and their diseases. These electives are taught by teachers qualified by special training in this field.

Electives in Ethics are also offered by the Department of Family Practice. One such elective is entitled *Value Conflicts in Medicine and Society*. Making one face his responsibility to use his knowledge and skills wisely and in harmony with the value system in our society is one of the objectives in this elective. One faculty member is an ethicist who is competent to pursue this objective.

Preceptorships and clerkships are offered to add real-world flavor for juniors and seniors. All of these electives together with those discussed earlier are addressed to attitudinal development and career choice. A preceptorship in family practice is often very helpful in making an informed career decision. This is needed to place the many hospital rotations in perspective. Our ultimate goal should be to help each student find a place in medicine where he or she can be happy and productive in society. Family practice should contribute to the teaching mission of the medical school of which it is a part, not simply try to produce family physicians.

The one thread that runs consistently through all of the electives in our curriculum is the unique way that a family physician feels, acts, performs, and involves himself with his patient. In developing a curriculum in a medical school there could be no better advice than that given by Arnold Bennett when he said "the way to write a book is to write it through the eyes of a child who is seeing the thing for the first time."



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the case. The article could be addressed without editing to an audience of internists, old-fashioned general practitioners, or surgeons. It is not geared specifically to inform family practitioners and fails to take into account that in the treatment of puzzling and persistent psychogenic pain "changes in the structure and functioning of the family are vital to the outcome of therapy and the prevention of recurrence of symptoms."[1]

Another article in the same issue ("The Immediate Management of Suicide Attempts in Children and Adolescents: Psychological Aspects") does relate the suicide attempt to psychopathology in the family. However, neither of the case studies describes any therapeutic work with the family. In the discussion of treatment much space is devoted to hospitalization and psychotherapy of the patient, while parents "may seek help for their own emotional disturbances or advice regarding family interpersonal relationships." The concept of the suicide attempt as a partial manifestation of a larger, interwoven network of family relationship problems is not made explicit. Thus, the technique of conjoint interviews with the adolescent, his parents, and his siblings goes unmentioned. When integrated with the overall plan for immediate management, such interviews usually result in rapid and dramatic reduction of the danger of suicide and contribute toward prevention of complications for not only the patient but the other family members as well.[2] Furthermore, the technique of having the patient make a no-suicide decision which results in virtually 100 percent prevention of suicide[3] is not mentioned. These methods (conjoint family interviews and decision making) have been taught to family practitioners[4] and should be a basic part of the therapeutic armamentarium of every physician who offers himself as the primary medical resource for a person in distress.

I emphasize the deficiencies of these two articles because they stand in marked contrast to others in the same issue which do address themselves to the family as a system: "The Family-Oriented Medical Record," "Classification and Coding of Psychosocial Problems in Family Medicine," and "Chronic Invalidism in a Young Woman: A Study of Family Dynamics."

The concept of the family as a relationship system and the intervention techniques which logically follow is difficult to get across to anyone thoroughly imbued with an individualistic orientation. It is more than psychotherapy of the patient, more than help with problems of the parents, more than advice about family relationships. It is not simply the engrafting of traditional one-to-one psychiatry onto a general medical practice. It involves direct observation of the pathologic relationships among family members and direct intervention and modification of those relationships. It is an efficient way of helping and may often be effective after individual therapy has been only partly successful.

The family physician has an opportunity to know all the family members in a way which is seldom possible for other health-care providers. This knowledge gives him unique leverage for therapeutic management, whether this be performed by the doctor himself, by co-interviewing with his family-oriented nurse or social worker, or by referral to a family therapist. And this knowledge base supports the delineation of family medicine as a specialty in its own right.

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Dr. DeVaul responds to the preceding letter as follows:

We appreciate Dr. Kramer's comments about the importance of an understanding of family relationships in managing patients with psychogenic pain. Our article focuses on a primary function of the physician: defining the problem for the patient as a prerequisite to a strategy for effective intervention. This issue is critical in patients presenting with psychogenic pain as they frequently insist that they have an acute treatable medical problem and adamantly deny any other difficulties. These patients appear to have unusual success in getting the treating physician to focus on the pain complaint and thus run a dual risk. They are at high risk for inappropriate medical and surgical treatments aimed at pain relief and often run the risk of having an unidentified and non-pain related disease process. The article describes characteristics of patients who are likely to be successful until the problem is adequately redefined as a chronic and emotional one.

Once the psychological nature of the pain is recognized and defined for the patient, management strategy must certainly consider the family relationships. As Dr. Kramer points out, the family system frequently plays a role in the origin of psychogenic pain (conversion pain in an effort to resolve interpersonal conflict) and in the perpetuation of the psychogenic pain (secondary gain of being taken care of and avoiding other adult responsibilities). An understanding of the family system is essential for adequate management as it is in most medical problems.

We would assume that family practitioners are not only more likely to see these syndromes but hopefully because of their understanding of the family would be more effective in their management. It is worth pointing out that the early recognition rather than referral for more specialty evaluation of pain complaints will make the intervention easier.

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