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ABSTRACT

This is the preliminary report of a demonstration project in continuing education of the physician in his own community. Members of the University of California San Francisco Medical Center went into residence in 14 communities in Northern California and Nevada for periods of three days. Choice of specialities and the programing were developed by the local community in close liaison with the University and related to specific areas of current interest and needs. Although final evaluation has not yet taken place, many achievements can be identified in the field of patient care and development of facilities, and there has been a real expansion of continuing education for the practicing physician. New community development and community-university relationships of great potential value have resulted from the program. An unexpected result of the program was that it provided medical school faculty with the opportunity to observe practice and problems in ways not otherwise available, pointing up the importance of continuing education and the leadership role to be assumed. The Physicians-in-Residence Program suggests that manpower projections must be community-based, tied to work function and serving delivery systems. Cooperative regional arrangements would maximize resources and improve services. (MF)

A PHYSICIAN MANPOWER PUBLICATION

PHYSICIANS-IN-RESIDENCE

A Demonstration Project
in Continuing Education

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service National Institutes of Health

PHYSICIANS-IN-RESIDENCE

A Demonstration Project in Continuing Education

Department of Health, Education, and Welfare
Public Health Service, National Institutes of Health
Bureau of Health Professions Education and Manpower Training
Division of Physician Manpower

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Foreword

The rapid acceleration of medical knowledge has created new and extraordinary needs in continuing education. This preliminary report of a demonstration project conducted by the Department of Continuing Education at the University of California San Francisco Medical Center under contract with the Division of Physician Manpower, National Institutes of Health, presents some new approaches towards the greater involvement of physicians in solving the problems of their own continuing education. We are grateful to Dr. Seymour M. Farber, Dr. L. S. Kimbrough, and Dr. Roger H. L. Wilson of the Department of Continuing Education for the Health Sciences at the Medical Center for their pioneering work on this project.

The Division of Physician Manpower provides a Federal focus for activities concerned with increasing the supply and enhancing the effectiveness of physician manpower. It awards contracts and research grants to accelerate research and demonstrations directed towards developing new concepts that improve the quality of educational programs. DPM support for innovations in continuing education is part of a larger effort to alleviate the shortage of physicians.

Dr. Frank W. McKee, Director
Division of Physician Manpower

BACKGROUND OF THE PROJECT

For many years the San Francisco Medical Center Continuing Education Department has conducted an expanding program not only for physicians but also for allied health professionals. Beginning with traditional courses of a didactic type, the department has expanded into many other activities including investigation of radio, television, seminars held outside the University, and other techniques. Yet it is common knowledge that traditional methods do not reach the majority of the physicians. Some of the most salient reasons for this are:

1. The factors of time and distance combined with the need to leave practice to attend programs or participate in university activities.
2. Inadequate communication and mutual involvement between the physician in the field and university faculties.
3. Failure to provide for the total needs of the community and individual practicing physicians.

These were also some of the factors which led to a demonstration project planned in cooperation with local California communities at a distance from major medical centers and from the University.

This is the preliminary report of this demonstration project in continuing education of the physician in his own community.

Members of the faculty of the University of California San Francisco Medical Center went into residence in fourteen communities in Northern California and Nevada for periods of three days. Choice of specialities and the programming were developed by the local community in close liaison with the University and related to specific areas of current interest and needs. Though final evaluation has not yet taken place, considerable achievements can be identified in the field of patient care and development of facilities, and there has been a real expansion of continuing education for the practicing physician. New community development and community-university relationships of great potential value have resulted from the program.

METHOD

The plan was to send members of the University faculty to fourteen separate communities for a period of three days each. Three such physicians would be chosen after intensive consultation between Continuing Education staff and the chiefs-of-staff, medical society leaders, and others concerned with the problems of health care within the community.

Areas selected ranged from metropolitan to smaller urban centers providing medical care for large rural populations and to small communities in a more rural setting adjacent to similar small towns. The specific areas used were Eureka and Ukiah in the North Coastal area; Redding, Chico, and Marysville-Yuba City in the Sacramento Valley; Stockton, Modesto, Merced, Tulare, and Exeter in the San Joaquin Valley; Salinas, Watsonville, and San Luis Obispo in the South Coastal region; and Reno, Nevada.

The staff began by meeting with local medical leaders to find out from them what type of specialized physician it would be most helpful to have in residence. Ample time was given for discussion within the community before implementing the preferences. In each case it became apparent that very specific areas of medicine were needed. In Reno orthopedic surgery is of great importance because of the large number of skiing accidents that occur. In Redding a major problem of neo-natal morbidity and mortality needed solution. In Marysville a wide range of psychiatric problems needed resolution. In Exeter the indications for hysterectomies were a matter of concern. Other areas requested by communities included pulmonary disease, intensive care units, gynecology, general surgery, psychiatry, to name but a few.

The member of the faculty who was considered the most appropriate for the specific need was put in touch with the key community hospital staff member and went into residence for a period of three days. This cycle was repeated twice at approximately three month intervals. The physician-in-residence was interviewed by the staff on his return, and liaison visits were continued with the local communities.

The format of each residency visit varied considerably according to the community. In some cases a full program of lectures, grand rounds, and individual discussions was pre-planned. In other cases a more limited program was designed with the idea that more individual consultation and informal discussion would be more useful. Thirty-six faculty members have participated in this project over the last year.

At the end of January, 1969 a conference was held of representatives from the medical communities and the Medical Center faculty to discuss the merits and potentials of the project.

RESPONSE

While formal evaluation of the program and changes in its structure still remain to be accomplished it has been

completely evident that the communities have welcomed it. It is also of particular interest that the faculty members who went out considered that they themselves had had a valuable educational experience.

When the communities were first approached, the response was somewhat varied. In some places it was felt that although the idea was good, the busy physician simply would not be able to find time to profit by it. In others the plan was very enthusiastically seized upon. Now all of the fourteen communities involved have expressed a very strong desire to continue with the program. New groups have also asked to be included in the project. As the program progressed it became apparent that the personal contact in matters that concerned them provided physicians with motivation sufficient to overcome the obstacles originally raised.

Despite a real personal warmth, the first visitor in some cases was received somewhat tentatively. By the third visit, however, it became clear that many physicians who would normally not be involved in continuing education projects were participating freely and developing concepts of their own needs far beyond their previous realization. Many physicians not affiliated with the institutions concerned came from surrounding areas and

participated. In many cases adjacent facilities drew upon the physician-in-residence as did county medical societies. Where the subject was particularly appropriate, as with psychiatry, epilepsy, and pediatric problems, the use of the program was extended widely into the involved community. In only one community, was the comment made, "I could have written down who would attend." In all more than 3500 physicians ranging from 40-50 at Exeter to several hundred at Stockton were involved at one or another time. To this must be added a considerably greater number of allied health professionals and a significant group with special interests outside the field.

ACHIEVEMENTS

Despite the early phase of evaluation in this program, it is possible to identify certain definite accomplishments:

1. The recipients of this program are unanimous in their desire to maintain and extend it.
2. The local community has shown that it will accept and welcome physicians from the University.

3. There are a number of examples where patient care has been improved as a result of the program, such as surgical criteria and performance, pulmonary investigation and management, reduction of neo-natal morbidity, and improvement of autopsy rates and attendance.

4. Local community physicians have begun to reexamine the problems of improved use of facilities, ranging from laboratories to intensive care and infectious disease units. New programs are developing on even broader bases where community responsibility is wider as in epilepsy, learning disorders, and mental health.

5. There is definite evidence that increased cohesiveness of medical practice has occurred, with a halo effect upon the whole medical community including trustees and administrators. This is not confined to physicians and other members of the host institution but in some cases was countywide and also involved adjacent counties.

6. Enthusiasm for additional locally directed inservice programs has increased markedly not only for physicians but for allied health professionals.

7. There are beginning efforts at local financing for this type of program.

8. Closer inter-relationship between physicians in the community and academic faculty has developed.

9. New facilities and techniques previously not contemplated by the local medical community have emerged, such as washout techniques for IVP's pulmonary function testing, and newer biopsy techniques.

10. The medical school faculty members involved in the program have indicated that their experiences in these communities may modify their approach toward students, residents, and fellows at the University. This, in turn, may favorably affect graduates going into the practice of community medicine.

An unexpected result of the Physicians-in-Residence program is that it provides medical school faculty with the opportunity to observe practice and problems in ways which are not otherwise available. This has had a profound effect in arousing the faculty to the importance of continuing education and the leadership role a major medical center must assume. The Physicians-in-Residence Program provided the first relationship with a teaching facility for many physicians in the areas visited. The opportunity to observe, listen, talk over problems and to ask questions proved a stimulant to physician interest. The chance to react and transact with visiting faculty indicates that this technique could be the nucleus for developing continuing efforts which would make the use of television, radio, preceptorship, staff development, and technical assistance programs more effective. The Physicians-in-Residence sessions have clearly opened new channels of communication among and between individuals and institutions.

These conclusions are drawn from the interviews, liaison discussions, and the evaluation conference. At the California Medical Association Second Planning and Goals Conference in Continuing Medical Education held on February 22-23, 1969, at

which a preliminary report on the Physicians-in-Residence Program was presented, the following was recommended by the CMA:

> "In order to coordinate continuing education to meet physician needs in rural and urban areas, it will be necessary to work closely with the representatives of the local community, the medical society and hospital staffs. The programs presented have to be made relevant to the local problems. Time is a great problem for the rural and central-urban doctor. Therefore, the programs must be presented locally and conveniently. In the disadvantaged areas the money required for the fee to take the course is often a deterrent. The courses are most effective when the demand for them is self-generated by the local physicians."

COMMENT

In considering the whole question of utilization of manpower, it is essential to relate two separate problems in the development of medical services:

1. The concept of the patient receiving the best possible care within his own community or relatively near to it.

2. The availability of personnel.

While it is clear that very complicated problems in diagnosis and treatment may require a patient to travel to a major regional medical center (Fresno, Sacramento, San Francisco) for a short period of time, his long term management must be within his community. Moreover, most clinical problems need to be resolved within a local clinical area with occasional consultation available from smaller regional centers. The evidence is accumulating, as a result of this program, that this objective is not being achieved to the extent possible.

There appears to be a shortage of skilled allied health professionals at the regional level but ready availability of the less skilled. Consequently, considerable fluctuations in salaries are found.

All of this reflects on patient care. Also to be considered are the wide variation of clinical problems together with more limited facilities for their solution that impose a need for greater flexibility, breadth of skill, and

understanding on the part of all personnel and the skilled group in particular.

This applies equally well to physicians themselves. With a shortage of well-trained specialists in some rural areas, specialized services simply cannot be provided at an optimal level in many cases. The young medical graduate too often considers practicing in major urban areas first and may be reluctant to move to a small community. The problem is compounded by difficulties in critical review of patient care in smaller institutions. This is partly due to increased patient load, distance, and also limited availability of consulting opinions. "Death and Complication Rounds" are commonplace in large urban centers. Consultation with one's peers is a way of life in hospitals with a highly specialized staff. This does not obtain in many smaller institutions. Thus, in many situations, there is not only a shortage of physician manpower but also a difficulty in achieving the best utilization of what is available.

Even the language of medicine is changing as a result of the rapidity of development of new concepts and approaches. This indicates that research is needed to develop communication

skills among [illegible] [illegible]een [illegible]sicians and this may require the development of new teaching methods utilizing a variety of techniques. Intensive efforts are needed to build a strong and on-going continuing education program involving not only physicians but allied health professionals as well.

The Physicians-in-Residence Program suggests that manpower projections must be community based and tied to work function and serving delivery systems. Evidence indicates that cooperative regional arrangements would maximize health resources and improve patient care. In some instances one hospital could become the neo-natal and pediatric center for an entire area; another could be the center for intensive coronary care, etc. This is an important potential in the areas of Northern California that were visited. Training resources must be developed through community college, state college, and university cooperation.

RESULTS, CONCLUSIONS AND RECOMMENDATIONS

A close look at this demonstration project indicates that it proves that a number of clearly defined problems in continuing education are amenable to solution. Already detectable at the present time are a pattern of enthusiasm,

some definite evidence of change in medical practice, and a new cohesiveness between physicians in the community and the faculty of a medical school. The greatest rewards will come with the follow-up, evaluation, and further development of the concept. While the project represents good progress in gaining acceptability for continuing education, it is not the only method of achieving it and exploration of other avenues should be pursued. The findings to date follow:

1. Initial anxiety that criticism of practice might result can be overcome. This is particularly relevant to older physicians who are not regularly in contact with the University and who are less actively engaged in their own continuing education. Consequently, in some communities there was a dearth of case material, particularly on the first visit. This seemed to be readily dispelled in each community, and by the last visit an entirely different attitude appeared to develop.

2. Local responsibility can be effective when a single person acts as liaison, with appropriate designated members of the staffs assigned to prepare the actual material. Under this arrangement an active program can be more easily achieved than when primary responsibility is fragmented. Local continuity of responsibility for a reasonable period of time seems essential to avoid repetition of preliminary groundwork.
3. Communication between the Physicians-in-Residence and their local colleagues is essential prior to the visit. In places where this was done, a program resulted that was varied and well-oriented to the community needs; it also considerably eased the task for the Physician-in-Residence.
4. Increased involvement of the local medical societies is necessary, not only to ensure greater interest and possible further development of the program but also to ensure the most active participation by local chairmen.

5. In communities where there is more than one institution, there may be wide ranges of cooperation between staffs, ranging from full cooperation to complete separation. It seems most desirable, in rural areas as well as in certain more urbanized communities, that more than one institution be utilized.
6. The duration of the visit should be two or three days, depending on the needs and desire of local physicians.
7. Advanced scheduling (which is only possible with a long term arrangement) is most desirable so that visits will coincide with county medical society meetings and other local educational functions.
8. Where allied health professionals were involved, there appeared to be a distinct increase of value in the program to the communities. This is important since in-service training in most hospitals is often still at a rudimentary stage of development.

9. It is essential that the local liaison personnel be given real responsibility and that they should also be energetic, well liked, and respected members of the community. In two communities considerable difficulty in scheduling resulted from a simple delay at the local level.

10. It is essential that a system be designed to ensure the availability of alternate physicians in the event of unavoidable cancellations. One particularly well planned visit, for example, was cancelled because of last minute scheduling changes.

11. It seems best for only one man to go out at a given time. This does, however, produce some stress on certain faculty members because of conflicting responsibilities.

12. It does not seem feasible for such highly specialized areas as ophthalmology to be represented in this program. However, it is interesting that plastic surgery provided a

most successful session, possibly because of the actual practical clinical work accomplished.

13. The most successful visits were accomplished with a variety of methods of presentation. Identification with clinical practice is an important criterion in choosing the Physician-in-Residence. Basic science and current research are best discussed with physicians in the context of their actual clinical needs.