

A Predoctoral Curriculum in Family Medicine

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Development of a new discipline, such as family medicine, requires careful definition of scope and purpose. This must be followed by delineation of specific educational objectives. The teaching program is often carried out by people experienced as clinicians but not as teachers and requires selection of methods most natural to this kind of faculty.

This article describes the current stage of curricular development at the institution with the longest experience in predoctoral family medicine in the United States. Based on seven years' experimentation, this paper provides an overview of the philosophy behind this particular curriculum and describes, in brief, four educational methods which have proven useful. These methods will be discussed in greater detail in subsequent articles focusing on specific educational objectives, illustrative examples, and evaluative methods.

The College of Medicine of The Pennsylvania State University in Hershey, Pennsylvania, is a new medical school which accepted its first class in 1967. The Department of Family and Community Medicine was started in this new school at a time when there were no other similar departments in the United States. No satisfactory definition of family practice had been developed and there were no preexisting teaching programs to copy. This paper will describe our approach to curriculum development, teaching methods, and evaluation during a seven-year period.

Curriculum Development

It appeared to those of us who developed this program, that the basic strengths of the family practice style were the close patient-doctor relationships, the opportunity for continuity

of care, and the understanding of families. Clearly, the teaching of these concepts requires interaction with patients over a long period of time. We concluded that family medicine ought to be introduced to medical students early, and consequently we made it a required course for all first and second-year medical students. The course covers all aspects of family medicine which might be important for every graduate to understand. For those students who anticipate entering family practice as a career, the core curriculum is supplemented by a series of electives. These allow for in-depth study of any of the areas introduced in the basic core course.

In order to develop a good curriculum, it was first necessary to define the subject. Family medicine is defined in different ways in different cultures and under different health care systems. We have chosen to define it by listing its functions; some are unique to family medicine and some, although not unique, are characteristic. We teach only those aspects of family medicine which are either unique or characteristic of family medicine, and let the other clinical departments teach those areas in which they are most expert.

Our definition of the family physician includes the following:

1. Primary care — the physician of first contact, able to provide initial care for any disorder. Readily accessible.

2. Comprehensive care — provides care for 90 percent of people's health care ailments, for either sex, and for any age.

3. Health maintenance — emphasis on keeping people well through any means at the physician's disposal.

4. Common diseases — must be an expert in the common and chronic diseases which make up a large part of family practice.

5. Intrafamily psychodynamics — must understand how family members relate to each other. Helps families to anticipate and cope with crises.

6. Community concerns — is interested in how the community ecology affects patients and is aware of community agencies available to help them.

7. Home care — provides care at home whenever it is in the best interests of the patient.

8. Continuity of care — provides health maintenance and health education while the patient is in good health. Offers care during illness and convalescence, and, when necessary, terminal care and assistance to the family through their period of grief.

9. Close patient-doctor relationship — through prolonged contact under many and varied circumstances, the family physician learns to care for his patients as individuals.

Having identified our goals, it next became necessary to develop the educational objectives to meet them. Within the limits of our capabilities, a number of teaching modes were developed. Those which we have found most useful will be described briefly here.

Teaching Methods

The majority of the ten physicians who comprise the faculty of the Department of Family and Community Medicine are family practitioners who had previously been in private practice. We had to learn to become teachers. We sought teaching methods which fulfilled our educational objectives and with which we also felt comfortable. Most of the teaching areas we

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identified did not lend themselves well to lecture room format nor to programmed learning methods. They involved interpersonal skills and attitudes rather than cognitive data. The methods which have proven most helpful and which we continue to use include small group seminars, correlation conferences, preceptorships and family assignments.*

Seminars

Most of the core curriculum fits well into this mode. The class is divided into groups of ten or 12, each with two instructors. One instructor accepts primary responsibility, but the second is available either for dialogue or to serve as a substitute. A selected list of references is presented a week in advance of each class. Educational objectives for each session are carefully defined and handouts are provided to augment each presentation. Usually the presentations are patient-centered. They often include recently made video tapes featuring real patients or actors who are interviewed or examined by one of the staff members. The format is informal and there is always ample time for discussion.

Correlation Conferences

This conference is conducted either for the entire class or for small groups. A patient is interviewed in front of the class. He or she is presented as a whole person whose problems are discussed from many points of view including clinical, basic science, and clinical medicine, with the emphasis always on the patient and his or her situation in the family unit and in the community.

Preceptorships

Members of the department continue to practice in several family practice centers. Either as part of the core course or as an additional elective, students frequently accompany them in care of patients. This is undoubtedly the most enjoyable and natural way to teach family medicine. It is most effective when both student and preceptor are thoroughly familiar with the educational objectives for which this exercise was designed. It is not enough just to show things to students; one must

also clearly identify the educational objectives behind one's teaching methods.

While most of us who work in a medical center setting would like to feel that we practice much as we did as private physicians, we realize that we have gradually become institutionalized to some extent. Our offices are not realistic reproductions of the private practitioner's setting. To compensate for this, we have developed a series of preceptor arrangements with physicians throughout the state, permitting students to spend from one week to three months with selected physicians in their natural settings.** Structure is provided by specific delineation of educational objectives for both preceptor and student, and by careful evaluation afterward.

Family Assignments

During the first few weeks of medical school, each student is introduced to a carefully selected family by the physician who serves as their family doctor. The student is given an opportunity to visit the family in their home often, and to see them when they come to the office or are hospitalized.

The objective is to provide an opportunity for students to observe a patient-doctor relationship and to begin to develop such a relationship on their own. They have an opportunity to follow patients over long periods of time under many circumstances and to see them both when ill and well. The students also begin to develop an understanding of intrafamily psychodynamics and of the family's role within the community. All of these objectives become possible through the prolonged association and through the personal introduction by the family doctor and regular interactions with him.

Electives

Elective courses permit deeper exploration of almost any topic covered in the core curriculum. These include interviewing techniques, emergency care, community medicine, research projects, further preceptorships, and study of the family, geriatrics, nutrition, or human sexuality. The teaching modes vary, of course, but are general-

ly in the small group style and patient-centered whenever possible.

Evaluation

Our primary purpose in evaluation is to determine the effectiveness of teaching. This determination needs to be made quickly and accurately enough to permit both short-term and long-term changes in the teaching format. After most class sessions a small sampling of students is asked to complete a brief questionnaire. The results become one of the inputs in a regular feature originated by Dr. Hiram L. Wiest, which he calls a "Review-Preview Conference." These sessions are weekly meetings of all persons involved in the teaching program plus student representatives. The evaluations by both students and faculty of the teaching activity of the preceding week are summarized. This is followed by a planning session for teaching activities for the following week. This rapid feedback permits prompt adjustments in the program whenever indicated.

The second purpose in evaluation is to determine the degree of student achievement. Since much of what we are attempting to teach is attitudinal, involving interpersonal skills and integrative concepts, we have generally found that an oral examination has been most effective. It is also most enjoyable for us since it provides an opportunity for further teaching and for close student-faculty interaction.

Principles Evolved from this Teaching Experience

During the past seven years, a number of principles have been evolved which have been helpful to us. While there is no reason to believe that these concepts have universal applicability, we would like to share them in the hope that they may prove useful for others.

1. The overall goals of each segment of the teaching program need to be defined and clearly stated. From these, specific educational objectives should be carefully delineated and emphasized repeatedly — both to students and faculty. We feel that instruction ought to be in those aspects of family medicine which are either peculiar to or most characteristic of our

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style of practice. Each of the other clinical specialties should teach those particular aspects of practice in which it is most expert.

2. After educational objectives have been developed, a teaching mode should be selected which effectively achieves these objectives and is also comfortable and appealing to both faculty and students. We have made some of our most spectacular mistakes by attempting to teach in ways which were uncomfortable for us.

3. Some means of continuous evaluation is essential. This evaluation should include assessment by both faculty and students. It should be a measure of achievement of objectives and not of the popularity of the teacher or his teaching method.

4. Teaching methods ought to be readily adaptable in response to needs expressed in the course of the continuous evaluation process.

5. Examination techniques can be used to supplement the evaluation of the course, to reinforce learning, to help students understand their own achievement, and to help teachers know students better. It is especially important to keep in mind the limits

of examination techniques, particularly in teaching which involves attitudes and interpersonal relationships.

6. The heart of family medicine is the development of interpersonal skills — the ability to communicate, and healthy attitudes and interactions among people. Our teaching can emphasize this by permitting students to observe our interactions with patients and by providing an opportunity for students to develop their own skills. The whole process is greatly enhanced by permitting the student and the physician preceptor to get to know each other on a close personal basis.

7. The responsibility for what happens in a teaching-learning situation should rest on the student. The faculty's responsibility is to provide direction, point toward goals, offer means for learning, and assist in evaluation.

8. Representative student participation must be sought in all decision-making sessions. There is usually a wide diversity of viewpoints within a student group, so it is important that the students select their own spokesperson. They need ample opportunity to be heard, to express their views and to have their questions answered. It is

not necessary that the faculty follow their recommendations — but it is essential that these recommendations be listened to and that rational responses be made.

9. Students should be led to see that one always needs to learn, and that the most important skill one can acquire is the ability first to define what one needs to know and then to be capable of finding out where and how to learn it.

10. While there has been much emphasis on student needs and student rights, it is equally vital that a department be responsive to the faculty's needs and feelings, and that both faculty and students recognize each other's requirements.

11. Curriculum must be seen as living, growing and dynamic. As teachers we often feel that we ought to strive to develop the perfect curriculum — and having achieved this, be able to repeat it each year with great ease and simplicity. However, such a curriculum is neither achievable nor desirable. The teaching process should be under continuous review and able to respond quickly to changing needs, changing knowledge and changing resources.

