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# Communications

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## Interdisciplinary Family Practice Rounds

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Modern comprehensive health care is frequently provided by a team of health-care professionals representing different disciplines working closely together. Various schemes to teach team interactions have been developed but often appear stilted and artificial to students. At the University of Washington a team has been developed which provides patient care within the family practice residency while teaching the essentials of team interactions and providing a high level of participant satisfaction.

### Method

As part of the Department of Family Medicine's ongoing efforts to achieve the objectives of this family practice residency, an inpatient service was developed at the University of Washington Hospital in July 1975. Patients admitted from the Family Medical Center at the University Hospital were admitted directly to the Family Medicine Service and cared for by family medicine residents under the direct supervision of departmental faculty. Initially, the traditional approach to academic rounds was instituted, with the residents and attending physicians meeting on the wards each morning and discussing each clinical problem as they moved from room to room.

However, it was apparent that family practice residents needed to have a broader view of patient problems and solutions than is usually provided by the typical inpatient rounds. The traditional style of making "teaching rounds" was not satisfactory for the goals of the residency program in comprehensive and continuing care.

The initial change was to begin rounds in the Family Medical Center with a discussion of the

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ambulatory patient problems presented to the resident on call the night before either by telephone or in person. Following presentation and discussion of those clinical problems the faculty and residents then discussed fully the current problems on the inpatient service prior to going into the hospital to see the patients.

### **Medical Social Worker**

The medical social worker who practices within the Family Medical Center was the first other health-care professional invited to join the morning rounds. The participation of a medical social worker was extremely appropriate in providing the physician group with better understanding of the psychosocial aspects of the patient's problems, the effect that the problems had on the family unit as a whole, and in helping determine appropriate community resources for the use of the patient and the family.

### **Clinical Pharmacist**

In July 1976, the program became involved in an interdisciplinary health team project which provided the residency program with the services of a clinical pharmacist. The pharmacist improved patient care by offering skill and expertise in drug use and drug education to our patients and, at the same time, served as a valuable teacher in the areas of drug therapy, assessment of drug needs, appropriate use of pharmaceutical agents, prevention of drug interactions, and cost effectiveness in the use of pharmaceutical therapeutic modalities.

### **Nurse**

Because of the essential role of the nurse in health care, our nurses were then invited to join the morning group. On a rotating basis one registered nurse agreed to be present at morning rounds once or twice weekly. This provided the physicians with insight into any previously identified relationships between the patient and the Family Medical Center. In addition the nurse provided direct linkage between the medical staff caring for the patient while hospitalized and the primary physician who normally took care of the patient.

### **Librarian**

The group soon recognized the need for access to the ongoing developments in medical literature and invited a member of the hospital library staff to join the group weekly for rounds. Having the expertise of the hospital librarian not only gave ready access to acquiring reprints of appropriate literature based on the clinical problems seen, but provided the group with many suggested references that were known to the librarian as having recently been published.

### **Nutritionist**

Having established liaison for the Family Medicine Service patients with the hospital dietary staff, it seemed appropriate to invite a member of that staff to attend rounds on a weekly basis. This has been accomplished, providing an additional area of expertise in the management of the nutritional needs of our patients both while they are hospitalized and as part of their discharge planning.

There are plans at this time to add to the rounds a member of the community's Visiting Nurse Association as well as a patient health educator. This will provide the physicians with the expertise of these other health-care professionals in order to better make use of available community resources and to provide better patient education as appropriate.

### **Results**

Utilization of a team of health-care professionals in the concept of inpatient rounds has expanded the understanding of the resident group in the delivery of comprehensive health care far beyond the traditional one of the physician's relationships and responsibilities. It is felt that through this interdisciplinary health-care team the management of patients admitted to the University of Washington Family Medical Center is improved and the educational program expanded.

Residents are unanimous in their praise of the system. Initially there was apprehension lest the addition of more people dilute the responsibility residents feel for their patients. But all residents who have had the experience feel it has increased their understanding and appreciation of the roles

of the other professionals as well as made patient care easier and more satisfying.

Equally important in the process of developing this team have been the benefits derived by the other health-care professionals. The medical social worker has indicated the development within her thinking of a much clearer relationship between the skills that she possesses and the process of health care as provided by a physician. The clinical pharmacist has achieved an expanded knowledge of clinical skills beyond that which his training provided him which has given him a better understanding of the pathophysiology and natural history of diseases as they affect the utilization of pharmaceutical agents. The librarian has been able to improve her judgment in selecting appropriate

library materials to send to practicing physicians as well as having become acquainted with physicians' jargon. The nutritionist has seen how dietary problems and dietary plans fit into total patient care. Each of these professionals feels the experience has been a valuable source of professional growth and satisfaction.

Within the commitment that family practice residency programs have in both continuous and comprehensive health care, the authors highly recommend the inclusion of members of other health-care professions to the inpatient services of the family medicine residency programs in an effort to expand the availability of knowledge and expertise under the umbrella of comprehensive care.

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## Hypertension Screening Program Follow-Up of Previously Identified Children with Elevated Blood Pressure

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A hypertension screening program was conducted on 4,329 grade school and high school students in the Delta-Menominee District Health Department area in 1975. This was followed in 1977 with a repeat screening of those who had had an elevated blood pressure on the original screening. The majority of the students in the first screening were in the 15-to-18-year age group. This made the follow-up difficult because a large proportion had graduated from high school.

### Methods

In the first screening, 3.7 percent or 160 of the 4,329 students had an elevated blood pressure based on standards set up in the first screening. The referral screening levels on both programs were any readings above the following: 120/79 mmHg for ages five through eight years; 126/82 mmHg for ages 11 through 14 years; and 139/93 mmHg for ages 15 through 18 years. For students with elevated blood pressure, a minimum of three readings were taken, either with a rest period between readings or with blood pressure readings repeated on a different day. Urinalysis for glucose, albumin, and occult blood was performed for each student. Height and weight were also determined. Those who were more than 15 percent over ideal

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Table 1. Blood Pressure Screening Results

Age (Years)	Level for Referral	Total	Normal	Systolic Elevated	Diastolic Elevated	Both Elevated
5-8	120/79	1	1	0	0	0
9-10	126/82	5	3	2	1	1
11-12	134/89	16	13	2	2	1
13-14	134/89	9	2	6	3	2
15-16	139/93	14	7	6	1	0
17-19	139/93	14	5	8	3	3
	<b>Total</b>	59	31	24	10	7

weight for age and height were considered obese.

Of the 160 students who had had elevated blood pressure in the initial screening in 1975, 67 students were still in school. Parental permission was given on 60 students and 59 of these were screened in the current program. These were mainly from those students who were 15 years and under in the original screening. The 59 students screened revealed 28 with an elevated blood pressure. The breakdown of the types of elevation is seen in Table 1. The urinalysis revealed only one child with a positive urinary glucose. Ten of the children rescreened had a trace or more of urinary albumin and seven, or 25 percent, of those had an elevated blood pressure. The average in a similar normotensive population is approximately ten percent positive urinary albumin. Of those who had an elevated blood pressure, 15 of the 28 were obese (weight 15 percent above the ideal for age and height) compared with six of the 31 with a normal rescreening blood pressure.

Concerning family history, it was found that hypertension, obesity, and stroke were much more frequent in the families of students who were hypertensive than in the families of students who were now normotensive.

After the 1975 screening program, 67 percent saw their family physician and 35 percent of these

were diagnosed hypertensive. In addition, many others continued to have periodic checkups. Seventeen percent of the original group had some type of treatment regimen instituted. One of the original group of students was found to have polycystic kidney disease, but little else was found in the way of organic cause in either screening program.

## Conclusion

In a rescreening program of children who at a previous screening had had an elevated blood pressure, it was found that nearly one half continued to have elevated blood pressure in spite of periodic medical follow-ups, and an additional number were in the high normal range.

Simple urine tests on the hypertensive group revealed little except for a higher number of children with urinary albumin. Most of the hypertensive children had a family history of hypertension and over one half of the children were obese.

It is advisable that physicians regularly check blood pressure in children and young adults, especially in those who are obese and who have a family history of hypertension.