Family Practice Forum

A Family Practitioner Teaches on an Internal Medicine Service

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When the Director of Medicine invited me to serve as visitant on the medical service at University Hospitals of Cleveland, where our family practice residents receive training in internal medicine, I eagerly accepted, with some anxiety about my ability to undertake this task. I had been practicing community based family medicine for ten years and for the past four years had been involved with family medicine education programs which had taken me further away from the care of hospitalized, seriously ill patients.

The visitant on this service assumes the responsibility for the care of those patients who do not have private physicians. During visitant rounds, each of these patients is presented in detail and discussed as one of the major teaching exercises on the medical service. The month-long tour of duty turned out to be a most rewarding and satisfying experience that provided new insight concerning the role of family medicine in contemporary medical education.

The heavy demands on this busy university medicine ward left little time for the house staff to deal with anything other than the most pressing and immediate medical problems. Although each house officer had a continuity clinic, they cared for many patients that they had never seen before the present admission and would not follow after discharge. This made it difficult for the medical house staff to obtain an appreciation of the broad impact that illness has on the patient and his/her family.

Two Teaching Examples

1. A Terminally Ill Man

One of the first cases to be presented to me was an elderly gentleman who was terminally ill with mesothelioma. The intern who did the work-up on this patient had had no previous contact with this individual; in fact, this patient's previous medical care had been provided by another hospital in the city. Following the case presentation, there was a discussion led by the assistant medical resident of the chemotherapy for this rare neoplasm. I had nothing to add to this discussion, but afterward asked how the family was coping with this man's approaching death. The intern had little contact with the family and could not really answer the question. I then suggested that we gather the family together for an interview. Accepting this suggestion, the intern arranged for the family members to meet with us later that afternoon. The intern, the resident, and I met with the son, daughter, and brother and sister-in-law for approximately 45 minutes. The house staff appeared somewhat unsure of how to proceed with such a family interview, which prompted me to direct the conversation.

The interview produced historical data and emotional responses that appeared to have a major impact on the house officers. The 28-year-old son, who was currently separated from his wife, had experienced a significant depression three years earlier, following the death of his mother. For the past month, the son had not been working so that he could care for his terminally ill father at home. Two weeks prior to the patient's admission, the son himself had been unable to cope with the situation, had simply ceased to function and was in a hospital where the physicians were unaware of the terminally ill father. When the daughter was asked to discuss her feelings about the impending death, she became visibly upset and had to leave the room for a few minutes. The family realized that there was nothing more that could be done for their father, but seemed pleasantly surprised to hear that the medical staff were also concerned about their well-being. We extended an invitation for them to contact us if we could be of any further

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help during this difficult period. The daughter did contact the intern and with some encouragement and supervision from me, he provided short-term supportive therapy for the woman. He saw her on one occasion prior to the patient's death and on a number of occasions following the death. He willingly provided this service despite other heavy demands of this busy medical service. The intern learned the therapeutic value of giving the bereaved an opportunity to express feelings to a concerned professional, and learned that a physician need not have particular in-depth training to provide this essential form of care.

2. Ketoacidosis in a Young Woman

A 22-year-old woman was admitted to the medicine ward with mild ketoacidosis, which was corrected during the night before morning rounds. Since this was the end of the academic year and the house staff had already managed several patients with ketoacidosis, there was little to discuss in the medical management of this particular patient. However, during the presentation, the intern stated that the patient had a character disorder. When questioned further, she really meant that the patient was hostile and difficult for the house staff to manage. The intern remarked that after 17 years with known diabetes, the patient should have learned how to cope with her illness. There was no explanation why she had gone into acidosis at this time, and it was assumed that she had not followed the prescribed medical regimen. This provided an opportunity for a discussion of patient compliance. I was able to refer to studies that demonstrate that the more the diabetic knows about the illness, the poorer is the control, and that the longer a patient has diabetes, the more likely he is to make an error in insulin dosage.

When I interviewed the patient, the house staff gained some additional insight into the life of a juvenile onset diabetic. The patient was one of 11 children. Her father died when she was five years old. Shortly after this, the diagnosis of diabetes was made. The patient felt odd or different because she could not have candy as a child. Conflict and turmoil developed between the patient and her mother during the teenage years. The patient was hospitalized several times each year, and she fell further and further behind in her school work. Her school failures worsened her self-image and she became markedly depressed. There was no one in whom she could confide during those difficult years. She had problems dating boys because of her diabetes. On her first date with one male, she had a hypoglycemic reaction which terrified the lad. Finally, at age 17, she developed a strong relationship with a man by whom she eventually bore a son. During the next four years, she was not hospitalized.

I repeatedly probed for some explanation for her present poor control. She insisted that she maintained an appropriate diet and took the prescribed dose of insulin. Finally, she told us that two weeks prior to her admission her mother had been hospitalized for a serious illness and that this experience had stirred up all her feelings and past conflict with her mother. After we left the patient, I asked the house staff if they thought psychosocial factors could influence the control of diabetes. Their response was a polite yes, but they did not seem truly convinced.

Reflections

This personal experience has provided a greater understanding of the role of the model family practice unit and family medicine faculty in a university hospital based family practice residency program. An average curriculum provides a total of two years of rotation on specialty services and one year's experience in a family practice unit. In the model practice, the resident is exposed to an environment in which there is adequate time to deal with patients in the context of their families and the broader environment. The family practice residents are provided with experienced teachers who demonstrate an interest in the psychosocial factors that influence health. This faculty may include family physicians, psychiatrists, social workers, nutritionists, nurse practitioners, and others.

It seems obvious that departments of family medicine cannot provide acute inhospital training equal to that available in some other specialty services. Other specialty inpatient services, as presently structured, have difficulty providing sufficient training in some of the broader aspects of medical care. The combination of experiences on high caliber teaching specialty services and in the model practice has the potential for producing primary care physicians with a balanced perspective of the health needs of the population.