Tallahassee Family Practice Residency Program

Harry W Barrick Jr

Summary

The condition and situations nationally and locally at the time of establishment of this Program are given and the author's reasons for going into directorship. Goals of the Program: 1) to teach the practice of medicine 2) to establish a pattern of family life for the residency in the future, and 3) to establish patterns of learning for the residency in the future. Methods and techniques used to achieve these goals are described and the degree of success in reaching these goals is noted.

KEYWORDS: Family Practice; Education, Medical, Continuing; Vocational Education

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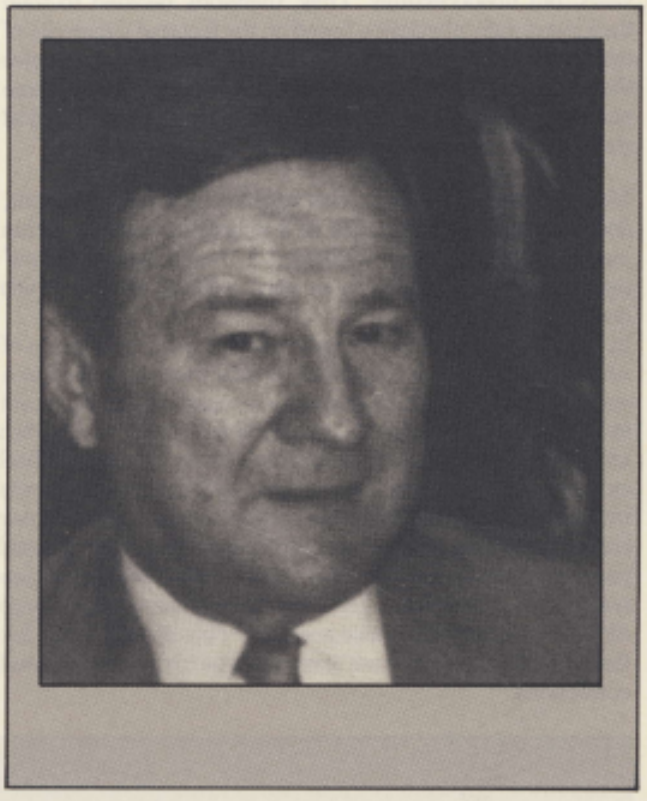


Curriculum Vitae

Dr H W Barrick Jr obtained the MD from Duke Medical School in 1956. He did postgraduate training at the United Mine Workers' Hospital in Kentucky and a one-year rotating internship at Rex Hospital, North Carolina.

After fifteen years of private practice in Raleigh, North Carolina, he was appointed Prof of Family Medicine at the University of Florida, Gainsville and Associate in the Program for Medical Sciences at Florida State University, Tallahassee. Since 1974 he is the Director of the Family Practice Residency Program, Tallahassee Memorial Hospital, Tallahassee, Florida.

Dr Barrick is a Fellow of the American Academy of Family Physicians and was appointed to the Family Practice Residency Review Committee in 1980. He has published a number of papers on family medicine.

A fighter pilot and flight instructor during the war, he is the recipient of several awards and medals. He is an active supporter of the Boy Scouts of America.

The Tallahassee Family Practice Program was created to fulfill a need and thus, from its inception, had a practical validity. In 1971-72 in addition to the *general* physician shortage, there was a more severe and accelerating shortage of family physicians. While the population in the United States had been increasing steadily, the number of family physicians in practice had been declining since 1931. At the same time, the demand for medical care was increasing because of increased medical knowledge, increased technology and expanding concepts of medical care.

Tallahassee had been recruiting in a co-operative effort between the city and the medical community for a number of years, but unsuccessfully. They, therefore, decided to train their own family physicians based on the fact that a majority of residents usually stay within 50 miles of where they receive their training. This decision had the support of the three necessary elements: the hospital administration, the medical staff and the community.

Medicine needed to, but was not responding to patients needs, and I viewed family practice as a reform movement, within medicine, that is valid because it is based upon patients' needs and is the best health care delivery system which does this.
In 1969, after more than twenty years of work by a group of very dedicated physicians, family practice was approved as a specialty and the first programs were started. This approval enabled family physicians to achieve board status, to establish criteria for the training programs and to attract medical students, many of whom for years had held the same concepts but had been unable to find adequate training. Many of our earlier programs were changed from a two year general practice training to our new three year family practice residencies. Therefore, when I was offered the opportunity to direct a program with these goals and objectives, I really felt that I had no choice if I were to remain true to my concepts and convictions.

Family practice is based upon patient needs, and patient needs must always be our guide.

When I started in this position in May of 1974, I visited several programs which were already underway (some had been underway four or five years). I then discovered that everyone was searching for answers just as I was. Having had these convictions and having practiced and carried them through for 15 years, I decided to base our program on what I knew practicing physicians needed to know to take care of the great majority of their patients. This has proved valid as family practice is based upon patient needs, and patient needs must always be our guide. These needs can best be perceived and determined by discerning, sensitive, practicing physicians.
The goal of our program as presented to me was to provide skilled, well trained practicing physicians for Tallahassee and for the surrounding area. Tallahassee has a large geographical referral area in which there are many small towns. I was surprised to find that it is located in one of the least populated sections of the country.

As our program developed we evolved three main goals in regard to our residents: *Firstly* we want to help our residents learn to practice family medicine, learn to deliver health care to their patients in an acceptable, accessible manner considering the total needs of the patient, the patient's family and the community.

Secondly, we want to help our residents make the transition from a medical student to a practicing physician and in the

The family physician is basically a problem solver.

process to develop a reasonable life style balancing his family, his practice of medicine and recreational and community interests.

Thirdly, we want to help our residents to establish their own learning patterns for the future so that they will continue to learn, continue to develop and broaden their knowledge, expertise, and service to their patients.

To have a good program you must have good people, both good residents and good faculty. They should be intelligent, be people oriented with a pleasing personality, be empathetic, have a desire and willingness to serve patients and have moral and intellectual integrity. They should have acquired a broad range of interests and have persued these interests and have acquired appreciation of the range of interests that their patients will have. Educationally, they should have acquired both good premedical and medical education. They need not be in the very top, academically, of their class but they certainly should not bein the bottom 5-10%.
In the early selection process we used a criterium of, 'inclination to live in Tallahassee' but when it became apparent early on that we were going to be very successful in retaining our graduates in town, we changed our criterium to 'some likelihood or inclination to practice in a small town in this area'.

Residents are going to learn in any residency program, but it is most important that they learn the things which will make them good practicing family physicians. As our program progressed we identified the items which we think are important for the residents to learn and have structured our program to give the desired outcome. I agree strongly with Dr Schweitzer who said, "The best way to teach is by example — or if necessary by deterrence". We do, therefore practice what we preach.

The residents must and do learn ***responsibility***. While we emphasize the resident's responsibility to his patients, and to their care and to their families, we like to stress that medical care is a mutual responsibility between the patient and the physician. The residents also learn responsibility towards other members of the medical staff,the faculty and particularly to their fellow residents. Our system requires that they depend upon each other and the peer pressure here is very effective.

Without an adequate center a good program is not possible.

Even before the residents start their residency, they place themselves under tremendous ***stress*** with their apprehension over whether they will be capable of assuming patient care responsibilities. Most have had only peripheral responsibilities in medical school but here the responsibility is theirs. The stress is tremendous and we continually seek ways of keeping this within tolerable limits. We cannot eliminate it, but we can

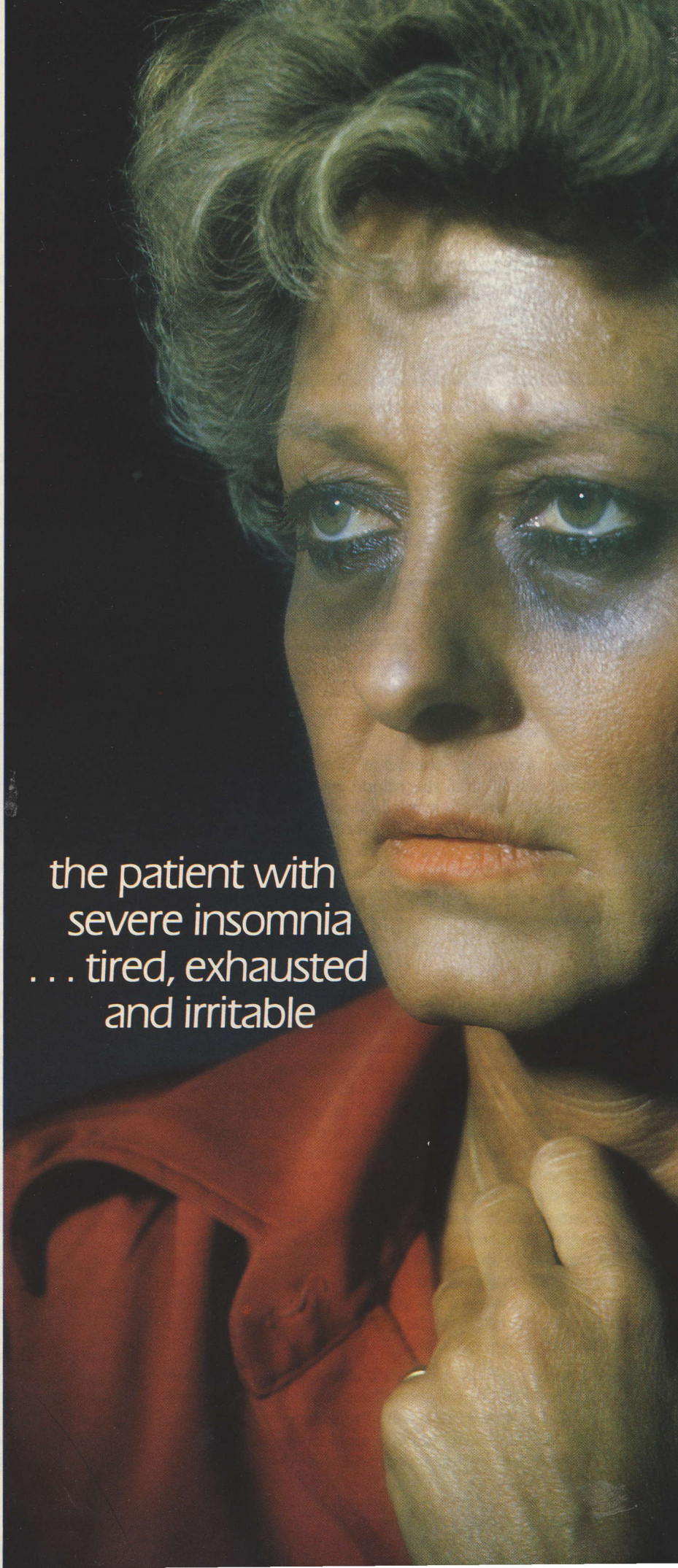
limit it, and after 8-9 months their self-confidence begins to increase and the tremendous weight of stress begins to lessen. The support which they receive from their fellow residents and the faculty is most important.

Early in their residency, the residents concentrate upon diagnoses, medications, dosages, etc. As a practicing physician knows, in time these become relatively simple in most cases and the real challenge in family practice is the managing and motivation of patients. This is where the residents have their greatest difficulty and this is where we place our greatest emphasis. No matter how knowledgeable a physician may be, unless he wins his patient's confidence and acceptance of his treatment plan, his patient will not follow it and will not benefit.

This ties in well with the ***patient-doctor*** relationship which in truth has changed from the traditional doctor/patient relationship, because we have now gone from a seller's market in which the physician has the advantage, to a buyer's market in which the patient may seek help from many different sources. We are in the midst of a changing relationship in which the doctor cannot arbitrarily dictate, cannot arbitrarily prescribe, cannot expect the patient to comply merely because he has so ordained. With each patient there must be a different relationship adapted to the patient's needs and personality in order to obtain the best results.

In all of medicine, but most certainly in family practice, physicians must learn to ***deal with uncertainty.*** In most cases we are faced with making decisions with an incomplete data base. We should always remember this. Very frequently residents come from medical school with a concept that 2+2=4 and when they are faced with a 2+1½ they are uncomfortable. They have been trained to take a history, do a physical examination, get some tests and come up with an answer immediately. When the data base is incomplete and they know it, they become anxious. Dealing with uncertainty is never pleasant. The residents must learn to deal with it in appropriate ways.

Similarly the residents must learn to ***use time*** in the treatment of their patients. Time is useful in making the diagnosis as the disease progresses or regresses. Time is useful in treating diseases and in watching patients' response to medications



and treatments. Time is particularly useful in establishing relationships with patients so that these relationships expedite resolutions of problems and in many cases enable problems to be solved which otherwise could not be. Time is of utmost value in learning the course and natural history of diseases and especially in the treatment of chronic or progressive diseases.

The real challenge in family practice is the managing and motivation of patients.

Residents must also learn that the patient, not the physician, ***sets the limit*** of treatment. Each patient decides either consciously or unconsciously how far he will carry out a treatment plan. Any physician can write out a prescription but the patient decides whether he will take it. A physician needs to determine the limits which the patient has set.

After a diagnosis, planning and prescribing, the ***evaluation of treatment*** is most important. Evaluation comes in both the subjective and objective modes. It is important that the physician separates the two and takes both into consideration in forming future plans. It is difficult to separate the subjective from the objective when there is not a test which can be performed or an X-ray which can be taken to see the results. Often the subjective becomes the criterium for treatment in the psychogenic and behavioral areas.

To learn ***follow-up*** treatment always presents some problems initially until the natural course and progression of disease processes is learned. Much must be learned by observation for there is little in the literature or textbooks to provide a young physician with follow-up guidelines. If the physician is somewhat anxious, he may see the patient too often and if the resident regards the condition as

In family practice, residents must learn to deal with uncertainty.

minor, the follow-up periods may be too long. The resident must learn to be sensitive to the perception of the patient regarding how serious the patient thinks the problem is, so that he may address this factor in setting the follow-up visits. He must also learn the pitfalls of using a prn return. He must give the patient criteria to make the judgement and he must, of course, be sure the patient is capable of making that judgement.

Communication with the patient is perhaps the most important function of the physician. He must communicate the problem to the patient in words which the patient can understand; even if these are scientifically inaccurate they are acceptable because of the patient's concept. On the other hand, the explanation can be quite scientific if the patient can appreciate such information.

Communication of the prognosis is always important. Patients want to know **if** they will get well and **when** they will get well and a slighly conservative time frame here is usually very helpful. We continually run into problems when the patient is uncertain of the total treatment plan. Many ingenious methods are used to ensure patient knowledge and compliance such as devising schedules, writing out instructions, handing out printed material, having the patient repeat the instructions and even sending nurses for follow-up to make sure the instructions are being carried out. Communication also means answering patients' questions and dealing with their anxieties; both may be either spoken or unspoken. When a woman presents with a breast mass, the question she wants answered is, "Do I have cancer?" The residents need to appreciate this and address the problem. Each problem has its own questions and anxieties and only by appreciating them and addressing them can the total care of the patient be accomplished.

In attempting any program certain resources are indispensable. We have been extremely fortunate in having these elements present.

We have an excellent hospital. It is well administered, well staffed and well run. It is basically a no-frills hospital but the standards of care are high, the technology is excellent and the equipment is constantly updated.

Element number 2 is excellent medical staff who support the program. This we have in more than adequate numbers. We have all specialties represented on the staff and the qualification of the staff members is excellent. Participation is truly superb.

The hospital administration has indeed been supportive of this program and regards it as an integral part of the total hospital. A self supporting, independent, community hospital

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will never have unlimited resources but we have had our share of these and this has contributed greatly to our ability to achieve excellence.

The Family Practice Residency Program evolves in and around the Family Practice Center. Without an adequate center, a good program is not possible. Our center when built in 1973 was one of the first and one of the finest in the country. As concepts, needs and usages have changed, expansion is necessary and we are looking forward to that.

Excellent faculty combined with excellent residents are most important. Here we have been extremely fortunate. We have been able to attract the best from this community to participate in the program. Although we have a relatively small full-time faculty, when the part-time and volunteer faculty are added together, we have been able to put together excellent support for the residents. All of our faculty are highly experienced in practice. We continue to feel that practice prior to becoming full-time faculty is essential.

The last most important element, of course, is adequate patients, and from the time of the start-up of this program we have had as many patients as we can treat.

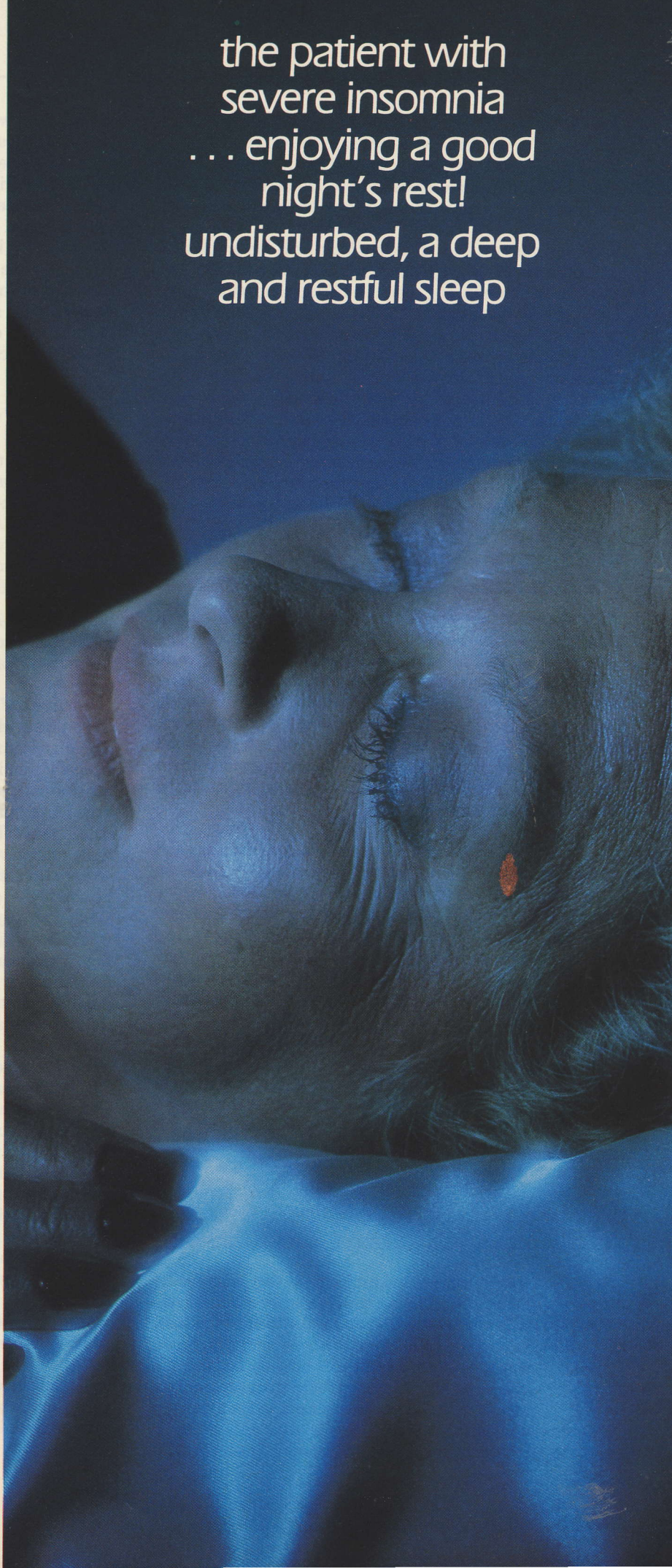
Financial support is always a concern. Hospital revenue comes only from the patients they treat. We, as a program, cannot place too great a burden on the hospital. We have been fortunate in generating approximately 50% of our budget through patient care. We receive another 25% from the state in support of family practice and the other 25% comes from the

hospital. It is important that, to ensure the financial stability of the program, not too much burden be placed on the hospital patients. As long as we maintain this ratio I believe we will be stable.

It has long been my thought that if a physician after internship went into practice and were sufficiently intellectually curious, an astute observer of what transpired in disease and patient care, were analytic of everything he saw and heard, were intellectually honest and dedicated to learning and sufficiently disciplined to pull everything together, he could, in 8-10 years, learn essentially what most family physicians should learn. We are attempting to reach this level of expertise for our residents in 3 years. Here is how:

Our curriculum is based upon patient needs. These needs have been well defined by a large study in England and another large study in Virginia. More recently the American Academy of Family Physicians through the Family Health Foundation has completed Project Merit which has further defined the scope necessary for family physicians and in this latest study has broken the care down into definitive care, shared care and supportive care. In the early stages of the development of residency programs, this was largely a matter determined by the director and various curriculums were devised, based upon the practice, experience and inclination of the individuals involved. This did result in a great variety of curriculums but in the last 2-3 years these have become much more similar, although certainly not identical.

Residents are interested in treating patients who have active unmet needs. They are particularly interested in conditions where they know something about the disease and its treatment. They tend to be most interested in treating patients who respond to therapy, preferably quickly, and conversely dislike treating patients with problems about which they know little or for which there is an indefinite therapy regimen with variable response or response only over a long period of time. But regardless of that, their learning comes from clinical experience which is set up as a learning situation because the family physician is basically a problem solver.



The steps in this learning process are: 1) recognize the problem — or problems, as is usually the case; 2) find the root of the problem i e treat the infection and not the fever; 3) devise a plan for the immediate needs and also for long term needs; 4) get patient's acceptance of this plan of treatment.

In our program we, like others, are faced with the problem of giving the resident enough freedom to operate on his own and at the same time ensuring adequate back-up and supervision. He must have the responsibility for the patient but there must be a review of that responsibility. He must have an opportunity to show initiative and individuality but enough supervision so that no serious mistakes will be made. He must be free to make decisions on his own with the patient's welfare as his main criteria but he must have help available when he feels that he needs it. The resident who is overly aggressive must learn to second-think himself and the resident who is overly cautious must learn confidence in his own decisions. It is one of the most difficult areas in the residency program to keep in balance. We must supervise what they do but yet they need to be completely on their own at times. We accomplish the latter by allowing them to moonlight in emergency rooms after setting up guidelines governing this moonlighting activity. This occurs in the second and third year after licensing and when they are working on their own, they do achieve this autonomy and almost total responsibility. When operating under these guidelines, this experience has proved a great advantage to the residents and to the program.

The faculty guides the residents but does not dominate them.

To achieve a balance between supervision and autonomy and to allow growth of the residents, it is necessary to create an atmosphere in which the residents do not feel threatened by their fellow residents, by the faculty, by the medical staff or by the administration. They will seek help appropriately. We feel that we are all learners, both residents and faculty. The faculty guides the residents but does not dominate them. Our mutual and close interest in the patients' problems and welfare enable us to work together for the patients' benefit.

There is no way that we can expose the residents to each little detail and technique of patient care through any structured or didactic program. We must leave the majority of the learning process to the residents. We must have assistance available at all times so that questions and problems as they arise can be dealt with immediately. When a question arises in a resident's mind, it needs to be answered when it is pertinent. Otherwise, he will forget it, put it off or prepare a treatment plan based upon an assumption which may be true but may be false. If a resident gets too busy and too rushed the learning process may suffer. The faculty exists to help the residents to learn, to learn by example. Learning is expected of everyone. Learning is encouraged. Learning is mutual and learning is supported.

Communication also means dealing with patients' anxieties.

I believe that we have engendered a *pride in excellence* but we encourage a touch of humility, the rarest of human virtues. We encourage excellence primarily for the benefit of the patients, and secondarily, for the benefit of the doctor's inner satisfaction. Residents have a genuine respect, accepctance, tolerance, and liking for all members of the program and I believe that a lot of this has resulted from a strong resident input into the selection process for each of our resident candidates. Their pride in the residency itself has important benefits in the support they give each other, by the modifying of behavioral eccentricities and by proper encouragement towards the achievement of excellence.

Over the years we have tried many tactics and stratagems and have come up with a few principles which we follow. In the early days of the program, we had a saying that the only tradition we had was that of change, and that was fairly well accepted by the residents because we had so much room for improvement. At the present time the residents are quite well satisfied with what we are doing on the whole, and change meets with more resistance. Here are the stratagems and tactics we used:

Always stress the positive. In any situation there is always something which is good and of which you can take advantage. Conversely, play down the negative and eliminate that if at all possible.

Use areas of strength. There will always be certain areas in any program which are stronger than others and which will give a greater learning opportunity for the time spent. Use this strength even if you get it slightly out of proportion to other aspects of the program. Benefits derived from a good experience in any area will flow back to provide strength in other areas. This is one reason why programs in the United States will never be identical.

Shore up weakness. Each program will have certain areas in which the opportunities for learning for one reason or another are beyond their control and are less strong than they would like. Still it is possible to add a little here and there in that particular experience until the total experience is satisfactory. It may be necessary to spend more time in this particular area of learning that you would like to, but a satisfactory result can be achieved.

Advantage over university programs. We have an advantage which most university programs will never achieve. The faculty has no ambitions beyond this particular program, no one is striving for promotion, and no one is looking towards another position. This has allowed our faculty to concentrate exclusively on the education of residents within this program as their sole goal. Each faculty member is highly interested in the product and in the process. The same is true for the residents. Their goal is completion of the program and private practice. One year we had an award for the best first year resident which created so much dissension that we have not made the award since, and the closeness of the residents has increased.

Input by the residents is extremely important. Their suggestions and criticism must be heard, must be evaluated and should be put into effect if they are in keeping with the goals and objectives of the program. I am usually quite willing to try any suggestions they make unless we have tried it previously and found it unsatisfactory. Don't make the same mistake twice.

Always use a non-threatening approach with the residents. Be analytical rather than critical, be supportive rather than destructive, be a friend and colleague to the residents.

Look for other opportunities for learning. There are always opportunities available. They may not be standard approaches, but they can be made into learning experiences.

Any learning experience can be made better. Don't be satisfied with what you are doing today. Analyze it for a better opportunity.

Create a mutual dependency with those people with whom you work. If you can supply a service for them that is beneficial, they will be much more apt to help you. Our support from the medical service is incredible. The service we give them is that they never have to come out at night to admit patients from the emergency room. When this situation can be achieved, co-operation and interchange will be highly and mutually beneficial.

Address problems with tact and understanding of the problems of both sides. Your side is always easy to see, the other is not always that simple. When you attempt to understand their problems, they are much more apt to understand yours.

Include residents in all planning and decision making. As noted before, residents tend to be fairly rigid in regard to change, so much advance talking about a prospective change is extremely important. As residents become accustomed to the idea that a change will be forthcoming, resistance to that change decreases. It may literally take months to effect a major change. An excellent technique is to present the residents with the problem. If we have done our work correctly and they have become good problem solvers, they will be able to come up with an answer and usually, when presented with all the factors, come up with very good solutions. While residents do tend to look at things from the relatively short time span of their time in the program, when the problems are presented properly and the solutions explained, they are willing to emulate their predecessors and do some things which may benefit the future residents more than themselves. I regard this as a good measure of their maturity, trust and mutual respect.

Our second major goal, that ***the family doctor have a family life,*** has always been considered in planning and administering our program. Most of our residents are married and many have their first child while in the program. Residency is a period of transition from being a medical student to becoming a practicing family physician.

Medical school in the United States tends to be highly structured, quite rigid, and with very little input from the medical students in establishing the curriculum, the courses, the administration of same. Recent studies have shown that this is highly stressful and even abusive at times and medical students feel that this experience is degrading. Certainly individuality and personality have been suppressed in that environment.

Therefore, when the medical student, now doctor, enters this residency program many changes take place. Some are uncomfortable without a strict structure and others emulate a freshman in college. Most, however, are duly appreciative and merely get down to work. It does give them a chance to begin to express their individuality, their innovation and their natural personality. It is far better for them to work out how they feel about patients, patient situations, supervisors, etc. in this setting than to wait for practice. We keep them busy with enough responsibility so that they do not have much loose time on their hands but they do have time to spend with their families at night and most weekends.

To allow growth in residents, they should not feel threatened.

In our setting the resident is treated as a family physician, both in the Family Practice Center and in the hospital. In the hospital he practices similarly to other members of the medical staff, assuming all the responsibilities of a medical staff, and in the care of the patient he is THE PHYSICIAN to each of his patients. He is responsible for their total care in the office, in the hospital and for follow-up or in the nursing home.

Each of the residents is a member of the County Medical Society and enjoys all the privileges thereof at a very nominal fee.

Although our residents work hard when scheduled, and they are scheduled approximately as often as a practicing physician, we do not schedule activities at night except for our call and the same goes for the weekend. Tired physicians do not make good decisions, tired physicians do not learn well and tired physicians do not make good husbands or fathers. I do not want a tired physician treating me.

The residents themselves maintain a fairly active social program with many encounters between individuals and groups and there are periodic parties for the entire program. In addition, there are sports participations and the residents field teams in volleyball, basketball, softball, and often share activities such as boating and sailing.

'Follow-up' must be learned by observation.

In residents that get too busy and too rushed the learning process may suffer.

Our third major goal is to *help the residents learn to learn* for the future. Our most important contribution to this is that the resident learns that learning is expected, learning is important, learning is fun, and learning can never stop. We think we have created an atmosphere in which learning meets these criteria.

We use many techniques to encourage learning. The most important, of learning by example has already been noted and, in truth, we have a superb group of physicians engaged in this program who provide excellent role models.

Secondly, we encourage residents to learn from their patients. This will always be a source of valuable material as long as the family physician is practicing medicine. It is necessary that the resident put each situation in its proper perspective and not be overly influenced by any one experience. The faculty can help greatly here, especially when an experience has been rather traumatic.

In our program we use considerably more consultations than people in practice will do. We use this, again, as a learning situation in which the residents can talk with a specialist about a patient and about a problem in detail. Our consultants are extremely good in making this a valuable learning experience for the residents. The rapport between residents and consultants is excellent and should set the proper tone for consultations in practice.

Textbooks will always remain the main standby of the family physician. In recent years textbooks have been updated at relatively short intervals to make them useful in this capacity. Journals designed specifically for the family physicians, such as the "American Family Physician" which reviews core content of family practice every six years can be very helpful in maintaining and increasing knowledge in areas which aren't encountered too frequently.

Residency is a period of transition from being a medical student to becoming a practicing family physician.

Other learning methods we have available for the residents are medical tapes, audio or audiovisual, medical meetings for each of the second and third year residents to get them into the habit of attending these educational experiences, home-study courses on particular subjects which the residents may pursue, and the Connecticut/Ohio Core Content Review yearly.

As members of the American Academy of Family Physicians, we are required to have 150 hours of continuing medical education every three years and we must be recertified by our Board every six years, so there is certainly encouragement to continue our education in practice.

> ***The family doctor should have a family life.***

Have we accomplished our goals? Yes, I believe that we have. The residents work hard at largely meaningful activities. They are essentially satisfied and happy with what they are doing; they are absolutely responsible. Those we see in practice are good family physicians and they tell me that they are well prepared for practice. Scores on Board exams tell us that they have learned much of what they should have. Fifty-one (51) of our fifty-three (53) graduates have taken the Board, and all have passed. Only four were ranked below the 50th percentile. Our last class, an exceptionally good one, had four of the eight ranking in the 94th percentile or higher.

We have entered 85 residents into the program, have graduated 53 and 9 have dropped from the program before graduating. Of those residents who are not in family practice, 9 of the 12 opted for a practice in which their responsibility was time-limited i e emergency, medicine or dermatology. I think it was wise that they recognised their own limitations in this respect.

In regard to the second objective, this is a little more difficult to evaluate. Of the 85 who entered the program 3 have been divorced while in the program and 4 subsequently (3 have remarried). 6 of the 85 have not been married to date. Compared to 7 divorces we have had 11 marriages and 3 re-marriages. They have acquired 33 children during residency. I think that we have at least given them a good example of how they can manage their practice while still having an opportunity for family life, rest and recreation.

> ***Learning comes from clinical experience; learning by example, and learning from their patients.***

A full evaluation of the third goal will have to come at a later date as it will take approximately 10 years after graduation before we can really evaluate whether our residents have kept up with their self-guided educational activities.

With regard to our special goal here at Tallahassee, 19 of the first 29 stayed in town for practice and our current goal is to provide family physicians for the small towns in our referral area. Only 5 of our first 29 graduates went to small towns but 15 of our last 24 are practicing in small towns and I believe this ratio will increase rather than decrease.

Personally, I am very pleased with what we have accomplished. I believe that we have a better training program than most people realize and that we are well on our way to provide enough dedicated, well-educated family physicians so that each patient can have his own family doctor. If this can be achieved, many of the ills besetting medicine will be diminished. This was my purpose in leaving practice for an educational role.