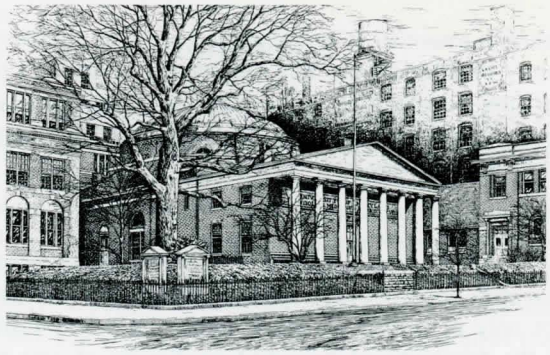
no. 1, Sept. '76

AESCLEPIAN

School of Medicine
University of Maryland



RESIDENCY PROGRAMS:
Basic Resources Needed for Training Programs

Dr. Edward Ciriacy, Chairman of the Department of Family Practice and Community Health at the University of Minnesota, spoke to the University of Maryland Family Practice Club concerning some important elements of Family Practice training programs. His remarks were aimed at helping medical students to evaluate the strengths and weaknesses of various residency programs. Although he specifically addressed himself to Family Practice residencies, the portion of his talk commenting on the basic resources needed for training programs applied to graduate education in all the medical specialties. The Aesclepian *is printing that section of Dr. Ciriacy's speech so that students will know what information they should gather when writing and visiting different residency programs.*

Quoting Dr. Ciriacy –

" . . . . . I would like to give you some of my thoughts as to what the important elements of a family practice training program might be. First, I will comment on the basic resources needed. These include facilities, faculty, patients, and residents. Then, I will look at some of the organizational requirements necessary to place these resources into an educational program for the training of family physicians.

Of the facilities required for family practice training, the first and one of the most important that comes to mind is the base hospital. What kind of hospital is it? Is it a university hospital? A community hospital? A county hospital? How large is it? If you are interested in size, then the percentage of bed occupancy is important. Many of us feel that the autopsy rate is an indirect indicator of medical staff activity and the willingness of the staff to undergo scientific scrutiny. How many house staff physicians are available? What specialties are represented, and how many residency positions are filled? Are they filled by United States medical graduates, or foreign medical graduates? What services are included in the medical staff organization? Is there a broad spectrum of basic specialties represented on the medical staff? If affiliated hospitals are involved in the training program, what type are they? How are they used within the educational program? What are some of the characteristics, as outlined above, of these instituions?

One of the unique and very important facilities related to family practice training is the model family practice center. This, of course, is an ambulatory center and because of the emphasis placed on ambulatory care, it is a major classroom for residents within any family practice training program. It should, indeed, be a model of private physician practice; it should demonstrate all of the elements of an efficient, high quality center for the provision of ambulatory care. How large is this unit? Is its design functional? Where is it located in relationship to other support services necessary for ambulatory care? What kind of equipment is in the facility? What kind of support systems are present within the model center itself? Is it currently operational? What kind of a record system is kept? What types of support staff are available at the center, and what is their quality?

Another facility which must be available for a quality family practice training program is a library. This must be a modern, well funded operation which can provide the necessary breadth in current books and journals that provide the necessary support for a good educational program.

Finally, within the area of resource facilities, the geographic relationship of the various elements must be considered: Are they placed in a reasonable degree of proximity sufficient to allow residents to maintain continuity of care for their patients? Are the mechanics of transportation such that they will not interfere with the educational program? Do they allow for the efficient integration of all the facilities in the program?

The second major resource that I would like to discuss is the faculty. We are interested in the number of faculty and the amount of time they can commit to the educational program. What specialties do they present? Are all the major specialties, including family practice, well represented? Does the faculty specialty distribution include people who are skilled and knowledgeable in behavioral science? In community health? What is the quality of the faculty? What is their level of commitment? What is their level of expertise? Do the physician members of the faculty have continuing patient care responsibilities? Faculty members can lose their expertise if they do not have the opportunity to continue practicing their professions. How available are faculty, not only in the hospital but also in the model family practice center and in the physician's private office? For our training programs in family practice, the ambulatory

setting is essential. It is represented not only by the model family practice center, but also by the physician's office. For the subspecialty areas, such as opthalmology and otolaryngology, the private office may offer the best educational experience.

The next large category of resources that I would discuss with you are the patients. In general, we need patients not only as individuals, but as family units. We must look at the feasibility of providing continuity of care to our patient population. Many patients may be available, but the ability to develop a program with any degree of continuity is limited. We must be able to develop continuity between the resident and the patient, and between the model family practice center and the hospital. We must also look at the feasibility of providing comprehensive care, not only at an ambulatory level, but also in the hospital. Can we follow our patients from the ambulatory center into the hospital and out of the hospital back to the ambulatory care center? It is important to have within our patient population a socio-economic mix of all ages, as well as all diseases and problems. There must be an adequate number of patients in the hospital and at the center.

The final category of major resources necessary for the development of family practice training programs is residents. What are the credential of the present residents? These residents will be the colleagues that a new resident will be in direct contact with for a period of three years. What are their concepts and goals? What is their motivation? Are there an adequate number to provide the necessary support, encouragement and *esprit de corps* that enhances any group effort? What is the level of resident retention? Do residents drop out after one year? After two years? And if so, why? Finally, what is the outcome of the training program in terms of its residents? Where do they go into practice? What kinds of hospital privileges are they able to obtain? How many of them become Board certified?

Another resident group which is important is residents in other specialties. What specialties? How many? What are the credentials of these people? Are they foreign medical graduates, or are they United States medical graduates? What is the relationship of the family practice residents to residents on other services? Do family practice residents have the opportunity to accept significant and first level responsibility for patient care? Are they supported by other residents or competing with them?

One of the most important aspects of a program's organization is the presence of supervised and graduated resident responsibility within the context of the educational program. This is often difficult to assess. It should be recognized that educational programs can be gradated and well supervised, and yet provide little in the way of education. Without the back-up and integration of the academic classes, the educational value of such a program may be severly limited.

Other parameters to consider are: what is the quality of the patient care? How are the records kept, and what do they look like? Are the records available for use at patient care audits and chart review? What are the evaluation mechanisms used in the program? Is there provision for evaluation of residents? Of faculty? Of the program? And of patient care? It is only through using an effective evaluation program that the necessary data becomes available as a basic for future decisions . . . . . ."

So much for the basic resources necessary for the development of a program of training in family practice. There are some important parameters to examine in the way in which these resources are put together to provide an educational program. Some important elements are in the administration of the program. First of all, who is the program director? This is an extremely important aspect in view of the importance of modeling in the learning process. What is the program director's past clinical experience? Educational experience? Also important is the relationship of the program to the sponsoring institution. Does the program enjoy a level of autonomy sufficient to guarantee its educational integrity? Are there clearly delineated responsibilities and authority? What is the program director's position within the institutional hierarchy? Does the program director hold a specific position with a university? Is the program director represented on the Executive Committee of the community hospital?

What are the relationships between the program's administrators and those of other clinical specialties? Are they supportive? Are the administrators respected by the major clinical specialties with whom they must work? Is there an adequate number of administrative and service staff personnel within the administration of the program? What is their quality? Finally, is there some mechanism for resident input to the programs? This does not imply that the residents make the educational decisions, but it does suggest that resident viewpoints and perspective differ from faculty perspectives, and are important to consider in making decisions relative to the evolution and development of our educational programs.

Other parameters that must be considered are: Where does the financial support come from? What is the amount of the support? What is the stability of the support? What are the expectations for funding the program via patient care generated dollars? Generally speaking, those dollars should not represent more than 30-50% of the total direct dollar support for the program, and they probably should rest somewhere closer to the 30% than the 50% mark. Does the program have specific objectives? Are they stated? And if so, does it appear that in the implementation of the program they are being met?

A very important aspect of the program is curriculum. Is it described through specific educational objectives? What are commitments to the major clinical disciplines? To the specialties? To the behavioral sciences, and to

community medicine? Is there an attempt to provide educational experiences in areas which are frequently not addressed in other residency programs, such as practice management, financial management, biostatistics, immunology, and genetics? What is the conference schedule? Is it adequate in breadth? Do conferences occur as frequently as necessary? Do the residents participate? What kinds of research are being done in the program? Is there any research? If present, is it traditional bench-type research, or is it related primarily to health care delivery and the medical educational process?

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WELL, WELL . . . YOU'RE BACK CHARLIE BROWN OR A MESSAGE FROM DEBBIE MONK

Welcome, all - back, or for the first time, whichever is appropriate. Those of you who had a whole summer to enjoy – savor every moment while you still remember; those of you who didn't should remember that you're two months ahead of those who did. This new-to-the-Aesclepian coeditor always tries to be optimistic.

Sitting here in M&M rounds a good many thoughts are passing through—some even communicable. One is, "Why do we all come here?" Each of us has our own reasons, which are sometimes lost in the mire of medical school, or whatever school, but occasionally an event will occur which brings these reasons once again to light, perhaps a bit stronger, some times not. But, I think it's important to keep our goals in mind, and to try to keep "things" in perspective as we travel the proverbial road of life. That same road may have at least two branches, as do many thoughts. Which brings me to my comment for the day (how's *that* for loose association!!).

It's my belief that the *Aesclepian* has several purposes and much to offer; with enough help from its reader it can be a bolster to our occasionally faltering steps, perhaps, but it can more importantly be a point of central communication. In order to be this focal point of light and enlightenment we'll need from all of you any thoughts, creative or factual, calendars of events, summaries of events, photographs or tips of things you'd like to know about—anything at all that you'd like to share with the rest of the world. That is, the important part of the world.

Besides, if you *do* send us something, you'll have two advantages: you'll have done your good deed for the day, and you'll be on our "Special Gift From Heaven" list (SGFHL). (Delivery to be at some future date).

We of the *Aesclepian* will do our best, but some help is always appreciated, even if it seems to you to be

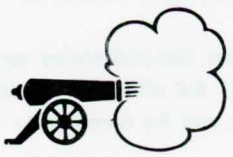
Once again, welcome to the new year, everybody, and good luck. (Get plenty of sleep, 'cause you'll need it next year!) May you happily dive into this Great Coffeepot of schooling.

EDITORIAL

As the returning co-editor of the *Aesclepian*, I want to welcome everyone to the University of Maryland at Baltimore for the 1976-77 school year. I extend a special welcome to the freshmen who are beginning their professional education this fall. I also want to welcome Debbie Monk, MSIII, to the *Aesclepian* staff. Debbie has agreed to be co-editor of the paper this year, and then will continue as the senior editor next year. This junior-senior co-editorship gives the *Aesclepian* a continuity of style and format from one year to the next.

The *Aesclepian*, as the official publication of the Student Council of the University of Maryland School of Medicine, will print notices, announcements, written opinions and creative works by any student or faculty member. Material cannot be published unless it is signed, but requests for anonymity will be honored. As in the past two years, I hope that most of the material will come from the readers. The *Aesclepian* was developed into its present form by Harry Knipp to help improve campus communications. We strongly urge participation by all members of the medical community. Without contributions from the students, housestaff, and faculty, the newspaper becomes only a mouthpiece for the editors. Debbie and I have no need or desire for such an outlet. We sincerely hope that the *Aesclepian* will be of service to everyone who reads it.

Diehl M. Snyder, MSIV



STUDENT STIPEND AVAILABLE IN ALCOHOLISM/DRUG ABUSE RESEARCH

A $1,000 stipend is available to a qualifying medical student for a research project in the study of alcoholism and/or drug abuse. Funded by a grant from the National Institute of Alcohol Abuse and Alcoholism, this project is part of the Interdisciplinary Alcohol and Drug Abuse Education Program at UMAB. Six stipends are available, for one student from each of the professional schools on campus.

Applications and project proposals must be submitted by October 1, 1976. Proposals will be reviewed by the Interdisciplinary Committee for Alcoholism and Drug Abuse Education; and one will be selected from the medical school. Projects must be completed by April 15, 1977.

For additional information and applications, contact Dr. Frank L. Iber at 5780, Dr. Willem G. A. Bosma at 6570, or Mr. James O'Donnell at 6795.

SPECIAL EVENING COURSES
Sponsored by the Office of Student Affairs

CONTEMPORARY WORLD THEATER . . . . . *Dr. Murray Kappelman*

September 20, 27, October 4, 11, 18, 25 . . . . . 6–8 p.m.

Modern playwrights and plays including Kennedy's Children, Zoo Story, Pinter's newest play, England's David Storey, David Rabe, and Ed Bullins and black theater.

Maximum: 15 participants

MUSIC APPRECIATION . . . . . *Dr. Linda Chen*

October 9, 17, 23 . . . . . 1–4 p.m.

A review of the important trends in music from the classicists to modern music with examples to compare and contrast taught in the relaxed comfort of Dr. Chen's apartment.

Maximum: 10 participants

DEATH AND DYING . . . . . *Reverend Carl Greenawald and Guest Speakers*

October 26, November 2, 9, 16, 23, 30 . . . . . 6–8 p.m.

A thorough and comprehensive seminar course in the complex subject of the effects of death and dying on the doctor, the patient, and the community.

Maximum: 30 participants

THE GIFT OF THE BLACK EXPERIENCE IN THE NEW HORIZONS OF MEDICINE . . . . . *Dr. Tyson Tildon*

October 4, 14, 18, 28, November 1, 11 . . . . . 7–9 p.m.

Evidence suggests that there are at least two distinct kinds of medical practices—white medicine and black medicine. This series of discussions will explore the proposal that medical education should include an understanding of these two distinct kinds of medical practices.

Maximum: 20 participants

BEGINNING YOGA . . . . . *Robert Schwartz*

October 27, November 3, 10, 17, 24, December 1 . . . . . 6–8 p.m.

Learn the relaxation and meditation possibilities of Yoga.

Maximum: 15 participants

PHOTOGRAPHIC TECHNIQUES . . . . . *John Stork*

September 23, 30, October 7, 14, 21, 28 . . . . . 7–9 p.m.

Improve your photographs using the technical aspects of photography. Depth of the coverage will range from simple to complex and include one session featuring a movie in which successful professional photographers discuss their techniques for outdoor portraiture, weddings, etc.

Maximum: 15 participants

FIRST COME, FIRST SERVED

APPLY IMMEDIATELY

OFFICE OF STUDENT AFFAIRS
Room 547, Howard Hall
528-7477

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RETREAT FOR WOMEN IN MEDICINE

Since medicine has recently accepted increasing numbers of women, the Office of Student Affairs has felt the need to openly discuss some of the issues that women are bringing to us: acceptance as a professional, anticipating particular stressful situations, self-concept, lonliness, and the trials and rewards of balancing a career and a family. An all-day retreat will be offered for women medical students on Saturday, October 16, 1976. This will provide an opportunity for airing of views and discussions with women in various phases of their careers and their lives. If interested, contact the Office of Student Affairs at 528-7476, or 7477.

Sharon Satterfield, M.D.
Bernice Sigman, M.D.

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CLINICAL QUIZ ANSWERS:

1. a-h; 2. none; 3. a-f; 4. cul-de-sac mass; 5. a, c, d; 6. secondary; 7. cul-de-sac; 8. an infected attempted abortion; 9. when was her previous menstrual period?; 10. a-c.

A PIECE OF MY MIND

Here's to the first of what we hope will be many such corners of the Aesclepian, *wherein may be brought forth such beasts as pet peeves, roaring headaches, or minor gripes, or even just any ideas you might have concerning "the system". If there's something you'd like to tell the world, but never before had the chance, just write it up and send it in. You never know—someone might just agree with you!*

Perhaps I should state at the outset that I am not your average medical student's wife. I am somewhat older; I have two kids—Jason, age 7 and Drew, age 4; and I don't work. Let me put that another way: I am not gainfully employed (I've already said I have 2 kids). Nevertheless, I do have many common experiences with other student wives or husbands.

The thing that troubles me the most about med school will probably come as no surprise to anyone. It's the lack of time we have for each other and to spend as a family. I'm afraid I have never been able to zero in on this, "it's not the quantity but rather the quality of time together that counts." Unhappily, into every life a little mundane must fall. When Steve gets home at a quarter to eleven, and he has to be up again at 5 AM, and I haven't seen him in two days, it's hard to tell how much "quality" there is in the recitation of the days' events. I really have to tell him that the dog walks funny because she got stung by a bee or that Drew scraped his leg pretty badly, but I think it'll be okay. I have to talk about these things when I can because I don't know when I'll get the chance again. Actually, I think I could take the late hours better if I knew in advance how late they would be. But, it's vary hard, for me, to wait all day for the phone call that says, "I'm on my way." It's hard to plan meals and to answer questions about when Daddy's coming home.

On the other hand, medicine has provided us with some fairly humerous experiences. When Steve was in his first year of school, he was trying to remove an eyelash from 5 year old Jason's eye. As sson as Steve touched his eye, Jason shouted, "Wait! Daddy, wait!" Then, more calmly, "have you had this yet?" In fact, ever since Daddy started medical school, I haven't been qualified to put on a band-aid. Drew is convinced that his Dad will be a "whole doctor" as sson as he wears both the white coat and the white pants at the same time.

Through medical school we have met some wonderful people and made some very warm friendships—the kind that last. That's invaluable and makes us rich. It also makes life a little easier.

Sandra Metz

FAMILY PRACTICE CLUB MEETING

The first 1976-77 school year meeting of the University of Maryland Family Practice Club will be held on Wednesday, October 13th, at 6:00 PM. Sandwiches and beverages will be served prior to the program beginning at 7:00 PM. Details concerning the program and meeting room will be posted around the campus. All students, faculty, and their spouses or guests are invited to attend.

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CLINICAL QUIZ

This year the *Aesclepian* plans to include a clinical quiz in each issue. The case this month is taken in part from case number 624569, pages 453-467 of *Differential Diagnosis*, abridgement of the second edition, by A. McGehee Harvey, M.D., and James Bordley III, M.D. The case histories and questions are arranged to be read and answered in sequence. Students will learn the most if they commit themselves to an answer for each question before going on to the next one. The answers the editors believe to be correct are given at the bottom of page 3.

HISTORY:

This 32 year old negro female was admitted complaining of swelling and soreness of the legs and arms for four days. Her general health had always been good. Four days prior to admission, while at work as a clothes trimmer, she had a sudden shaking chill lasting for 5 minutes. Soon afterward she developed a dull aching pain which began in the right lateral malleolus and radiated up the back of the leg to the mid-thigh. On the following day swelling appeared at the right ankle and progressed upward to the knee. The left foot also swelled slightly. Similar symptoms of pain and swelling developed in the left forearm. The patient remained feverish without further chills and one day before admission she had pain in her right arm. Her last menstrual period began two days before admission. Due to her illness she had been unable to get out of bed for three days.

QUESTION 1: Given the above history, which of the following should be included in this patient's differential diagnosis?

a. Lobar pneumonia
b. Tularemia
c. Leptospirosis
d. Influenza
e. Acute hemolytic crisis
f. Sepsis
g. SLE
h. Thrombophlebitis

PHYSICAL EXAMINATION:

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She was a well developed and well nourished young negro woman who appeared acutely ill. She was perspiring freely and midly icteric. A tense shiny edema was present over the right leg and both arms. The swollen areas were extremely tender. Small lymph nodes were palpable in each axilla. The heart was tachycardic with a Grade II/VI systolic murmur heard at the apex and along the left sternal border. The abdomen was soft without tenderness, and no organomegaly or masses were palpable. On rectal examination there was no tenderness on pressure toward the pelvis, but on orange sized mass was felt in the cul-de-sac. There was no infection of the skin present.

QUESTION 2: Given these physical findings, which diagnostic possibilities in question 1 can be eliminated?

QUESTION 3: Which of the following should now be included in the differential diagnosis?

a. Bacterial Endocarditis
b. Biliary Obstruction
c. Neoplasm
d. Arterial Trombosis
e. Gout
f. Meningitis

QUESTION 4: What is the most significant physical finding?

HOSPITAL COURSE:

The patient passed a restless night, and the following morning asked for her breakfast which she was able to eat. A few minutes later she was found dead in bed.

QUESTION 5: Excluding trauma what are the three most common causes of sudden death?

a. Acute Exsanguinating Hemorrhage
b. Laryngospasm
c. Coronary Embolus
d. Pulmonary Embolus
e. Subarachnoid Hemorrhage

DIAGNOSTIC STUDIES:

Hematocrit 45%; sedimentation rate 2. White cell count 24,640 per cubic mm with 52% juvenile polys, 41% mature polys, 5% lymphs, and 2% monocytes. Urine showed 5-10 WBC's and 40-50 RBC's per high powered field. There were no casts and urine chemistry was negative. Blood STS was negative. Abnormal blood studies showed total bilirubin 4.4 mg/dl and direct bilirubin 3 mg/dl. Blood cultures were sterile after 2 weeks. Spinal fluid was turbid; there were 900 cells, of which 94% were red cells, 4% were polys, and 2% were lymphocytic. Culture of the spinal fluid revealed a group A beta-hemolytic streptoccus.

QUESTION 6: Is the meningitis a primary or secondary infection?

QUESTION 7: What is the most likely site for this patient's primary infection?

QUESTION 8: What was that mass in her cul-de-sac?

QUESTION 9: In retrospect, what historical item should have been asked of this patient?

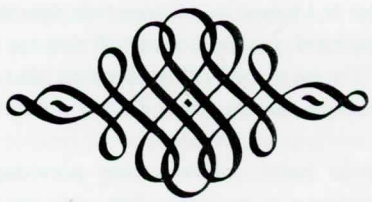
QUESTION 10: Which of the following pathologic processes could explain her sudden death?

a. Thrombophlebitis with pulmonary embolus
b. Fulminating gas bacillus infection
c. Adrenal tubular necrosis with circulatory collapse
d. Bacterial endocarditis with coronay embolus
e. Bacterial endocarditis with rupture of a mycotic aneurysm

AUTOPSY REPORT

Corpus luteum of pregnancy and pregnancy change, breasts. Infected abortion and peritonitis (beta-hemolytic streptococcus pyogenes). Tubular degeneration, adrenals. Infection granules, liver. Hyaline degeneration, cardiac muscle.

This is clearly a case of infected abortion. The lining of the uterus was necrotic and swarming with bacteria. There was a septicemia, but no implantation was noted on the heart valves.



THE AESCLEPIAN **NO. I, SEPTEMBER, 1976**

Co-editors. . . . . .Diehl Snyder, MS IV
. . . . . Deborah Monk, MS III

The *Aesclepian* solicits material from all members of the UMAB medical community. Announcements, letters, and creative material should be submitted no later than the first day of each month for publication the following week. All materials may be left at or sent to:

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