Primary Care Internal Medicine Training and Women's Health

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In this study, directors of primary care residency programs were sent a questionnaire that asked for information about their program and examined their perceptions of program curricula and resident mastery of seven preselected topics in women's health. An elective ambulatory gynecology experience was offered in 52% of programs, and 35% of programs had all residents experience such a rotation. All seven selected topics were felt to be important for residents to master, but the prevalence of structured teaching experiences and resident mastery for each topic varied widely. For the majority of programs, domestic violence was not a curricular component. However, 44% of respondents spontaneously commented that they were expanding their curriculum in the area of women's health.

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There is concensus that a comprehensive women's health curriculum should include not only diseases or conditions that are unique to women, but also conditions that are more prevalent or more serious in women, have distinct causes or manifest themselves differently in women, have different outcomes or interventions in women, or have behavioral or psychosocial repercussions on the health of women.[1–7] This study was undertaken to evaluate primary care program directors' perceptions of what should be and is being taught to residents, as well as what is mastered by residents in the area of women's health.

METHODS

In June 1994, an anonymous questionnaire was mailed to the 147 program directors listed in the 1994 Society of General Internal Medicine (SGIM) Directory of Primary Care Medicine Residency Programs, a biannually published directory that provides demographic and curricular details for prospective applicants to primary care internal medicine training programs. We chose program directors listed in the SGIM directory because this group voluntarily identified their programs as providing an experience to train general internists. The survey asked respondents to "please answer all questions in reference to the primary care training track or program described in the SGIM directory." A subsequent mailing was sent to nonrespondents 2 months later. Approximately 10% of internal medicine trainees that year were training in primary care programs (C. Little, personal communication on the National Study of Internal Medicine Manpower).

Respondents were asked if their faculty included a women's health expert, if an ambulatory gynecology elective was offered in their program and how many residents take the elective each year, what percentage of graduates pursue careers in general internal medicine, and if their program offered a "structured teaching experience for all residents" in seven topics. We chose these areas because they represent knowledge or skills that are relevant to leading causes of mortality for women, widely accepted screening techniques, or conditions more common in or unique to women. The topics were cancer screening guidelines for women, changes of menopause and hormone replacement therapy, diagnosis and treatment of coronary artery disease in women, pelvic examination, technique and interpretation of Pap smears, breast examination, and domestic violence. Finally, respondents were asked to choose which of these seven areas they believed all residents should master and to estimate what percentage of their residents mastered each skill.

RESULTS

Of the 147 questionnaires mailed to primary care residency program directors, 3 were excluded because the programs surveyed did not have primary care training and 1 was excluded because the director declined to participate. This left 143 eligible respondents. Ninety-three questionnaires were returned giving a response rate of 65%. The total number of primary care residents represented by these data is 2,171. Slightly less than half (45%) of the respondents identified a women's health expert among their faculty. Thirty-five percent of programs required an ambulatory gynecology rotation for all residents, 52% of programs offered an elective ambulatory gynecology rotation, and 13% offered no rotation. In total, 68% of residents spent time on an ambulatory gynecology rotation. At least 75% of program graduates pursued primary care careers in the majority (53%) of responding programs. Forty-four percent of respondents spontaneously commented that they were actively improving their curriculum in the area of women's health.

The proportion of programs offering a "structured teaching experience for all residents" in the seven knowl-

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edge or skill areas is presented in Figure 1. Cancer screening and changes of menopause and hormone replacement therapy were offered by over 80% of the responding programs; about 60% offered teaching experiences in most of the other topics. Of note, structured teaching experiences about domestic violence were present in only 40% of the programs. Also shown are the percentages of respondents who believed all of their residents should master, and had successfully mastered, each topic. For each topic, more than 88% of respondents felt that the topic should be mastered by residents. Perceptions of resident mastery were lower than expectations for mastery with marked variations between topics. Only 20% of respondents believed that the overwhelming majority of residents had mastered the area of domestic violence, whereas perceived mastery levels for all other topics were between 50% and 70%.

DISCUSSION

Our data suggest that selected women's health issues are viewed by program directors as important topics for primary care residents to master and that many primary care programs (or tracks within internal medicine programs) are actively improving their curriculums in this area. Previous reports have suggested that internal medicine training may not prepare residents to practice ambulatory gynecology.[8–13] Internist training confers only 62% of competencies needed to deliver comprehensive care to women.[3] While one might expect more favorable results in primary care programs, in our study respondents were not confident that the overwhelming majority of residents were mastering basic skills needed for providing generalist care to women, such as breast and pelvic examinations. This may be due to the fact that although 87% of programs provided an ambulatory gynecology experience for residents, only 68% of residents represented by this survey spent time specifically devoted to ambulatory gynecology. Of all the topics, domestic violence received the least curricular emphasis. Findings have been similar in surveys of family practice[14] and obstetrics and gynecology training programs,[15] and the need for improving physician education in the area of violence to women has recently been addressed.[16]

Interpretation of our data may be limited by several factors. The undesirability of expressing the idea that a curriculum in women's health is not necessary may have influenced respondents either to not complete the survey or to skew their responses, thereby overestimating the extent of teaching of women's health topics. Furthermore, we were unable to assess the unstructured learning that occurs during a resident's 3-year experience. As formal curricula or specific elective experiences do not fully represent the skills, knowledge, and attitudes that are learned during residency training, our data may underestimate actual educational experiences. Finally, directors'

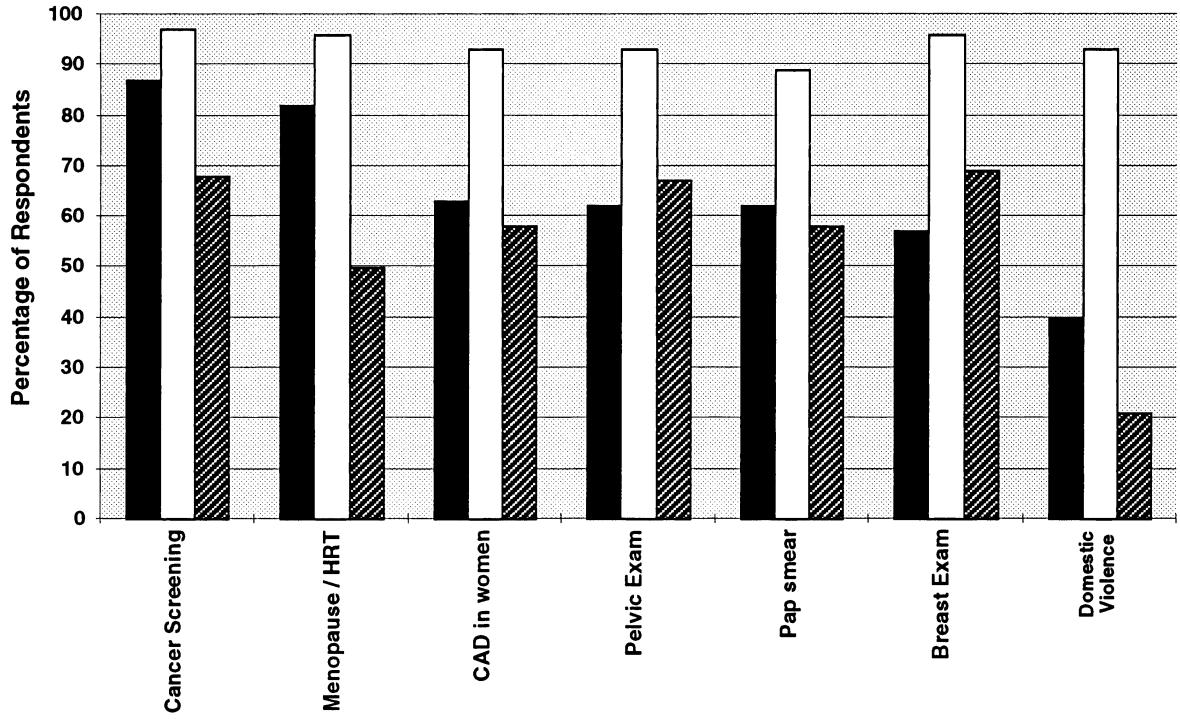

FIGURE 1. The percentage of primary care residency programs that offered a structured teaching experience in each of seven areas related to women's health is indicated by a solid bar. The percentage of program directors who believed all their residents should master each area is indicated by an open bar, and the percentage who believed the overwhelming majority (>90%) of their residents had mastered each area is indicated by a striped bar.

perceptions of "mastery" may not directly correspond to residents' perceptions or objective measures.[17]

The separation of reproductive and nonreproductive health care has led to fragmentation of health care services for women. The integration of knowledge and skills needed to provide generalist care for women into a medical training curriculum presents a challenge.[6,18] Recently published articles and resource books address a comprehensive model for teaching women's health,[3,4,6,7,19] but the details of successful implementation remain to be resolved. As the model for women's health evolves, the approaches to teaching in this area will need to be reassessed.

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