Community-Oriented Training in Family Medicine

Integration in an urban residency program

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SUMMARY

Family medicine educators are challenged by the need to introduce community experiences into residency training programs. This paper describes one inner-city program's preliminary efforts to join with community-oriented health service agencies in the development of meaningful educational experiences and discusses problems and possible solutions.

RÉSUMÉ

Dans les programmes de formation en médecine familiale, les éducateurs doivent relever le défi d'introduire dans le curriculum des expériences communautaires. Cet article décrit les efforts préliminaires d'un programme d'un centre-ville pour participer avec les organismes communautaires de santé au développement d'expériences éducatives significatives, et discute des problèmes et des solutions possibles.

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THE WELLESLEY HOSPITAL IS A teaching hospital in east central Toronto. The surrounding area has a variety of neighborhoods ranging from Rosedale, the most affluent in Canada, and Cabbagetown, a gentrified former slum, to large public housing projects, including St James Town and Regent Park.

In 1989 the hospital, in conjunction with the University of Toronto, determined that its future as a teaching facility lay in developing an "Academic Community Health" focus. What is meant by this is a community-oriented service pattern with closer ties to its immediate surrounding community in which both undergraduates and postgraduates are taught.

This paper describes a process followed to make family practice residents more involved in the surrounding community, discusses what was learned in that process, and makes some recommendations for others who might wish to move in a similar direction, whether it be in a core urban setting or in a different type of community.

While there has always been poverty in cities, recent years have seen an enormous increase in the numbers of disadvantaged individuals living in the core of major urban centers in Canada. High unemployment rates, chronic illness and disability, alcoholism and substance abuse, the management of chronic mentally ill patients in the community instead of institutions, immigration policies, breaking up of family units, and migration to major centers from poorer parts of Canada motivated by the hope of finding work have all contributed to this phenomenon. Food banks are feeding thousands of individuals and families every month. Homeless people and street kids requiring shelter in our cities are highly publicized.

Several recent studies in Ontario of the health care system[1,2] have emphasized the need to recognize the intimate relationship between health and other personal circumstances, such as income, housing, and education. Family physicians have always recognized the importance of viewing patients' health care in the context of their family, job, education, and other personal circumstances. We have advocated the importance of knowing patients over a long period, the physician-patient relationship as a therapeutic tool, and of understanding the total circumstances of our patients (not only by asking the right questions in the office, but by visiting patients in their homes). We have taught these behaviors and issues in residency programs and have produced

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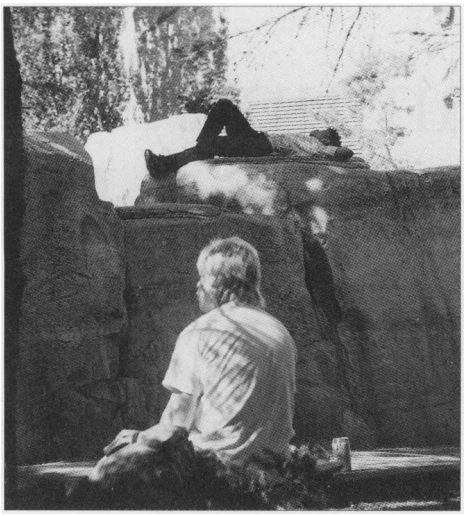

INVOLVING RESIDENTS IN COMMUNITY HEALTH CARE: *Health must be viewed in the context of the patients personal circumstances.*

physicians with heightened awareness that will ultimately benefit their patients.

The concept of orientation to the community is an expansion of this biopsychosocial approach to medical care. It advocates a wider perspective on the activities of physicians, changing the focus on the patient and his or her immediate experiences to a focus on the community environment and its influences on the patient. The concept also involves a team approach with closer links between physicians and other helping professionals and agencies within the community.

The College of Family Physicians of Canada has addressed this issue in its *Report on the Task Force on Curriculum. Section of Teachers of Family Medicine.*[3] The Task Force concluded that family medicine is a community-based discipline. The report stated, "Day to day practice is significantly influenced by community factors over which the physician has less than complete control." Further, "the family physician uses knowledge of the probabilities of morbidity in the community, which morbidity differs from that of hospital based practice." To make their practices truly community based, family physicians must be prepared to learn about their community and work with others within the community for the betterment of their patients.

Beginning a dialogue with the community

How should one approach the community in order to determine its needs?

In the case of The Wellesley Hospital, many voices offered ways to enhance and strengthen the relationship between the hospital and the community. Opinions were diverse, however, and no one was willing to say that they spoke for the community. At open community meetings organized by the hospital, it became clear that local community members felt alienated from the hospital, even though they acknowledged that good care was available. There was a feeling that certain groups were not welcomed as they should be and that there were attitudinal problems among first-line providers throughout the hospital.

While various staff members in the hospital administration set out to improve community relationships, the Department of Family Medicine independently established contacts with the leaders in various types of social service agencies. This was done through a series of one-to-one encounters, always concluding by requesting referrals to other related agencies. Eventually, we were able to establish a network of sympathetic agencies with directors who knew personally of our wish to become more involved in the community and to have our residents understand what was happening in their programs.

With this informal network of friendly community services, we were able to look at ways of structuring experiences in the community for residents.

Objectives of community-based experiences

Any discussion of an educational experience must first focus on its objectives. In this case, our first objective was to expose our trainees to the nature of inner-city populations and their needs and the relationship of those health care needs to other issues, such as housing, education, income level, and lifestyle. We hoped to foster an understanding of the great need for medical care of individuals in population subgroups, such as the homeless, street kids, the chronic mentally ill, and other individuals who for various reasons find it difficult to gain access to our clinics.

We also wanted to introduce our residents to health care professionals and others working in community settings and to expose the residents to their philosophies of

care and their ideas for solutions to these enormous social problems.

The Street Health experience

Street Health, an organization that provides primary hands-on nursing care, works on a weekly basis with homeless people at drop-in centers and shelters in east central Toronto. Begun in 1986 as a volunteer group staffed entirely by nurses, Street Health is now funded by the Ontario Ministry of Health. The Street Health Board of Directors is composed of 12 members, six of whom must have experienced homelessness. The organization subscribes to the following philosophical statements.

Street Health follows a holistic approach to health. We do not view health as merely a lack of disease. The concept of health includes living conditions, work, employment, education, fair salaries, food, etc. Once we recognize that most illnesses are a clear expression of environment, it becomes evident that health involves more than just a medical problem. . . . Two philosophies emerge from this belief: 1) The community must take responsibility for health issues as a central aspect of its daily work. It must organize autonomously to meet the community health needs with links to the formal health system; and 2) Advocacy is an important element. If we don't link the urgent survival needs to adequate income, housing, food, etc, Street Health will be only a bandage, a part of the community's problem. We must see Street Health as a structure through which people are empowered to effect social change.

The nurses involved with Street Health were willing to join with us in creating a community-focused teaching experience, on a trial basis, for our first-year residents.

At the beginning of the 1990-1991 academic year, we arranged for first-year residents, on their family medicine block time, to go to one Street Health nursing clinic per week, which was held in the evening at a church several blocks from the hospital. Each resident went for four sessions. The clinic was held in a large open room, with nurses seeing clients one at a time. Complaints included everything from sore feet, skin problems, lice, and lower leg inflammations to cold injuries and the need for clothing and emotional support. Another staffed area dealt with other problems, such as lost birth certificates and the need to register for OHIP. Residents sat with nurses as they interviewed clients and provided care.

Evaluation

All of the residents reported enthusiasm for the experience. Many were amazed. One said, "It's like going to Vietnam." Another commented, "It makes your job in the Family Practice Unit easier when you can understand where these patients come from and where they go back to." The residents immediately indicated an interest in expanding their exposure to the community by asking for tours of other facilities. This request was accommodated by Street Health staff, who walked with them to different sites each week. Seaton House, an 800-bed men's hostel, the largest in North America, was toured; the residents also went on a "street walk," during which they talked to prostitutes, passed out condoms, and visited other drop-in centers for street people.

Residents were asked at the end of their first month of family medicine block time whether they wished to go for eight more sessions during subsequent blocks. Some stated they felt awkward and peripheral. They did not see a clear role for themselves in the provision of care at the clinic. Occasionally, residents did not visit the clinic when they were expected. Some made comments that they felt it was hard for a physician to fit into a setting where nurses provided the care. One complained that he felt that inadequate care was being given to these patients, since they were not being referred appropriately, and he couldn't see that the nurses actually did anything.

Despite their early enthusiasm, most of the residents asked not to be reassigned for a further 8 weeks of this experience, stating that they had nothing more to learn there. Considering their initial very positive reactions, this development was surprising and indicated to us that a more careful assessment of the problems arising in this experience and identification of the challenges that remain to be overcome are necessary.

Discussion

We are at an early stage in developing community experiences for residents. Obviously, some problems remain to be addressed.

We have attempted to synthesize the requirements of a successful community experience for family practice residents, from the Street Health and other examples.

The first requirement for success is a commitment to teaching within the institution or agency undertaking the project. Street Health is one agency that willingly accepted our residents. The Street Health nurses planned and coordinated a learning program that allowed first-hand experience with the problems of homeless individuals.

Many of the other very dedicated service providers in the urban setting have great difficulty seeing themselves in a teaching role. Some harbor resentment toward institutions, such as university and teaching hospitals, which they see as neglecting their clients; they therefore do not feel disposed to participate in teaching programs. Views such as this are frequently quite clearly stated and serve as a definite warning to a residency program director that trainees are unwelcome in that setting.

Residents must understand clearly the goals and objectives of these experiences. They also must learn to accept as teachers representatives from other health care professions. For some residents, these are particularly challenging concepts, immersed as the residents are in the experiences and value systems of tertiary care medical centers.

Residents want a way to be involved in their experiences and not be "just tourists." Our trainees are accustomed to solving problems, learning theory, and learning by doing. They do not readily accept a spectator's role for very long.

Ongoing feedback, in both directions, is important as new programs develop. Good communication between hospital and community is essential so that problems in the learning experience can be identified and rectified promptly.

Understanding of the relationship between health and other social issues is crucial to the success of such programs. This understanding is sometimes difficult to reach on both sides. While family physicians may have grown accustomed to the notion that health care needs are inextricably entwined with housing, poverty, and education, this perception is not necessarily understood by those working in the social assistance field. When discussing health care needs in a social agency, it is surprising, but not altogether uncommon, to hear such comments as, "We are not in the health business, we are in the shelter business."

As with most resident learning experiences, physician role models are extremely important. Unfortunately, there are very few in our area. The nurses from Street Health have developed some understanding of what constitutes a profile of a community- sensitive physician. In a word, it is willingness: willingness to listen to and co-operate with other professionals who are familiar and effective with not just patients, but with various government agencies; willingness to do psychiatric assessments; willingness to provide drugs for pain and "nerves"; and willingness to order expensive testing (eg, computed tomography) when requested. No doubt, physician readers will quickly see problems with the latter two practices.

Finally, teachers and the organization where teaching is occurring must be acknowledged, in whatever form possible. Acknowledgment can take the form of positive feedback from trainees and staff, status-only university appointments, or inclusion in departmental social functions. The possibility of financial rewards is non-existent; in any event, they are generally unnecessary.

Conclusion

Providing community-oriented training experiences for family practice residents requires knowledge of local service organizations and of their missions and the development of increased understanding between academic institutions and grassroots helping agencies. One example of an early attempt at such a co-operative teaching venture has been described. Many challenges remain if we are to successfully create learning experiences that will develop a philosophy of community orientation in our graduating family physicians. ■

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