The Mount Sinai-HIP Joint Program

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AS MEDICAL KNOWLEDGE grows and as health needs of society become clarified, medical schools are confronted with the problem of curriculum change (*1, 2*). In 1966, the Third World Congress on Medical Education recommended that medical schools develop their curriculums in response to the needs of society (*3*). In 1970 the Panamerican Federation of Associations of Medical Schools, in discussing the needed changes in the current health scene, asserted the continued importance of engaging medical education in the advancement of community health (*4*). Health maintenance organizations in general, and prepaid group practice systems in particular, have been singled out in recent years as settings of major educational value for that purpose (*5*). These and many other similar calls are for major changes in medical education and in the delivery of health services. The two are inseparable, and this indivisibility is one reason why medicine is confronted with a dilemma that is so difficult to solve.

Prepaid group practice, operating on the principles of continuing and high-quality medical services delivered to a defined, enrolled population on a prepaid basis, is viewed by the Department of Community Medicine of the Mount Sinai School of Medicine as a health system that offers unique opportunities to implement some of the desired changes. Indeed, with the growing interest in prototypes of fully developed health maintenance organizations (*6*), it becomes essential that medical schools get involved in such agencies. The projected manpower needs make educational ventures a first priority. As a Carnegie Commission report emphasized, "although institutional associations have many potential problems, medi-

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cal schools and prepaid group practice health plans should join efforts in educational ventures to produce a different kind of physician" (*7*).

Beginning with these considerations, the Mount Sinai School of Medicine and the Health Insurance Plan of Greater New York (HIP) established in 1970 a joint program of education for health professionals, closely intertwined with the ongoing service and research activities of both institutions (*8*). The main practice setting for this program is the Yorkville Medical Group (YMG), one of the 27 medical groups that contract with HIP to deliver health services. The program itself, and different roles identified for medical students as learners in a prepaid group practice, have been described elsewhere (*9*). In this paper the program's staff are identified, the cooperative efforts and joint learning of staff and students are described, and the major problems encountered in implementing this experiment are discussed. In the second part of this paper, five former medical students in the program recount their learning experiences and, from their perspective, discuss some of the basic issues presented here.

Staff in the Program

The Yorkville Medical Group serves the Yorkville and East Harlem areas of Manhattan. The group provides services in two centers, one located at 84th St. and Lexington Ave., and the other at 3d Ave. and 124th St. Members of the staff of both centers and of the medical school function as teachers. In general, a member of the medical group's health team functions as a field preceptor for one or two students at a time. The most active participants in the medical group have been the medical director (an internist), two full-time family physicians, one full-time pediatrician, one part-time surgeon, and the health educator. Other staff members of the group, especially the administrator, the supervisor of social services, and the community health worker, have been actively involved as consultants.

Members of the Mount Sinai staff do not provide services to patients; two physicians on the faculty of community medicine and three residents in the department of community medicine function primarily as academic tutors or consultants to the students. Two sociologists, a social worker, a nurse, and an administrative assistant from the department also function as consultants.

The interdisciplinary staff from both institutions share and divide educational responsibilities. It would be an onerous task for members of the medical group with a heavy service load to (*a*) undertake the interviewing of students for placement, (*b*) help the students learn the theoretical structure and basic principles of prepaid group practice, (*c*) help the students understand HIP as a health system, (*d*) analyze critically the different roles of health personnel in the group practice, (*e*) make pertinent bibliographic material available, and (*f*) discuss that material. The faculty of the department of community medicine fulfills this more academic phase of the program.

The field preceptors primarily assume responsibility for the exploration of clinical or administrative issues, or both; serve as professional models in group practice (medical and paramedical); provide the opportunity for experimental learning; and conduct discussions centered around the everyday problems of the medical group. Although the entire medical group partnership has endorsed the affiliation with Mount Sinai, not all 24 physicians in the group have expressed interest in working with students. Currently, more than half of the physicians are participating at least to some degree, and three have faculty appointments in the school's department of community medicine.

The Students as Learners in the Field

Students have entered and participated in the program at different stages of their careers and in a variety of ways. An experience in prepaid group practice is an option in the required and elective community medicine programs. More than 60 students have participated in the required community medicine curriculum in the first, second, and fourth years, in a summer apprenticeship program, or in an elective program. All students who have entered the program chose to do so; none were assigned to the YMG against their expressed wishes or interests.

The first step in the individual learning experience is for each student to specify his educational objectives for the assignment. In consultation with his academic tutor, and during contact with the field staff, he defines reasonable specific knowledge and skill objectives that he expects to have achieved by the end of the available period of time.

By the end of the experience, a change in the behavior of the student should have occurred.

The student is expected to have acquired an elementary understanding of the theory of prepaid group practice and of existing examples in the United States, gained clinical knowledge and epidemiologic skills in the identification and solution of a community health problem, and had an opportunity to observe and analyze in detail the form of practice in one medical group of HIP. Most students go far beyond these achievements; they are able to compare an academic ideal with their perceptions of reality, they learn how to deal with common health problems, and they begin to appreciate the importance of accepting responsibility for the health care of a known population as opposed to the "sickness care" of individual patients.

Through participation in the definition of what he or she should learn, the student becomes an active partner in the learning-teaching process. The health educator in the group practice commented: "When we were first beginning our adolescent program [student] S.T.'s assistance was invaluable. We all learned together."

After the student has defined his objectives, the academic tutor helps him to identify a feasible role in the Yorkville Medical Group. This role can be predominantly clinical, administrative, epidemiologic, or sociological, but the student is expected to have some clinical involvement in primary care. The strongest interest of most medical students is clinical. Their interest in organizational issues is expressed as a desire to understand the context in which they will carry on their clinical work. During the experience, the student spends most of his time in the field, meeting his academic tutor at least once a week for interpretation, analysis, explanation and, if necessary, modification of the objectives or assigned role. The specifics of student roles and their evaluation are described in detail in another publication (*8*).

The Student as Partner for Change

If the desired change in medical education is related to change in medical care, the participation of medical students in this double process of institutional change is of paramount importance. Many Mount Sinai students have had impact on the educational process and on the health system itself. The student body, as a group, has triggered the introduction of a variety of important innovations within the Yorkville Medical Group, particularly at the East Harlem Center. The health accountant at the center, reporting her observations on student learning, said, "I saw many weak spots in our program, and the students saw even more. Many of these weaknesses I felt needed changing, but the students were able to subtly induce the doctors and the administrator to bring about change."

Early in our field trials, the community medicine faculty realized that it would be difficult to initiate any joint activity within the medical group without the students. The town-gown split was too wide in our community. In addition, prepaid group practice in general and HIP in New York City have been stigmatized by academia for more than 25 years. Nonetheless, medical education was recognized as a neutral subject, and the group was eager to have students. Research and service programs followed the entry of students into the group. With the common concern of a new kind of medical education, the academicians and the practitioners began to cooperate and to trust each other. Bringing together town and gown was the most important function of the students as agents of change. The health accountant also reported, "The doctors went along with the changes because they were students and it was part of their program." Students are able to demand consultation with any member of the departmental faculty, and they can then bring this information to the medical group. With developing trust, the Mount Sinai faculty are now asked directly to be consultants to the group.

The faculty also are aware of being changed by the students. An academician has a problem in knowing the reality of a community. The practitioner knows, but has little time to teach. The student functions as a bridge to bring knowledge back to the medical school, which then influences the student's education. At least one of the authors has come to appreciate the fundamental importance of primary care through this program.

Students have been instrumental in introducing the group to the Weed problem-oriented record (*10*), to the Williamson technique of continuing education and quality assessment (*11*), as well as to current research data in such areas as drug addiction and nutritional disorders of adolescents. One physician in the group commented that "the presence of students has stimulated the entire staff, causing them to try to put their best foot forward. They have been responsible for establishing interdisciplinary case conferences from which our entire staff has benefited. They serve

as a stimulus to my continuing education. They have also given me cause to wonder and ponder the newer trends and changes in medical education, and their intimate effect on the practice of medicine." The students' accounts in the second part of this paper illuminate these effects on their preceptors.

Implementation—Problems and Rewards

In a program where responsibilities are shared by two different organizations (a university and a health system), with very different ultimate goals (education and service), and therefore with health professionals performing very different roles, there are problems in developing and maintaining interinstitutional relationships. The usual town-gown distance inevitably leads to distrust and lack of understanding and appreciation of each other's roles.

For example, when the department of community medicine of Mount Sinai made its first approaches to the Yorkville Medical Group, there was an avowed fear on the part of the group's staff that the school's goal might be to learn everything about that particular prepaid group practice in order to set up a competing system. This feeling is no longer a serious problem. The distance between HIP as an enrolling health plan agency and the medical profession has historically been even greater. Prepaid group practice has been attacked over the years by organized medicine and stigmatized by academia. Attempts had been made by HIP to gain medical school involvement (*12*) with poor results. Indeed, it is undoubtedly true that medical schools have had a part in weakening the image and potentials of HIP, especially through what medical faculty have taught their students.

The existing distance might very well have been unbridgeable without the students. Students were accepted where faculty was not. As the students continued to come to the centers and faculty from the medical school and physicians from the group began to meet around a common educational task, trust began to develop. Eventually, some members of the group began to realize that members of the

Students, staff, and a community medicine resident during a lunch break

An academic tutor and a field preceptor exchange ideas outside the East Harlem center of the Yorkville Medical Group of HIP

department of community medicine had skills and knowledge that could be useful to the group. At the same time, the faculty were learning to respect the educational capabilities of the primary care physicians and other members of the health team. This problem is far from solved; no more than five of the physicians, the administrator, and the health educator in the medical group have been involved with students to any great degree.

The primary problem from the practitioners' point of view has been the extra time needed for teaching. The field preceptors assume major responsibility for the total care of a large number of families within the group. A family physician who functions as an excellent field preceptor commented: "My heavy patient load and lack of time is one of my major difficulties. This has often meant that I did not have the time to spend explaining how I reached certain conclusions or why I did certain things. At present, I am not sure how this can be solved." The cost of time spent to educate students requires careful analysis and a source of funding separate from service funds.

The authors believe that students in their first 2 years of medical school can assume meaningful roles in serving as consumer advocates, in collecting epidemiologic information, in helping to improve a statistical system, and in other similar functions. Such tasks, however, do not relieve the

physician's load, and his involvement with the student, if not well organized, can be demanding. By his fourth year, with some clinical knowledge, the student can care for his own small panel of patients under the tutelage of the physician and, with a well-defined role, he can be of help to the physician.

One strength of the program is early involvement. The motivation of first- and second-year students to see patients and learn simple skills about clinical primary care is very great. The authors encourage early responsibility in the physician's office and are reluctant to limit work with the physicians to the student's fourth year. It has been found that physical diagnosis can be taught very effectively in the physician's office. A partial solution to this burden on the medical group physicians is the system of shared responsibility between the field preceptor and the academic tutor previously described. The sharing of educational responsibilities has been helpful to the tutors and preceptors in understanding each other's roles. Since primary care has not been taught in medical schools until recently, the faculty have had to learn about primary care, evaluate their strengths, interpret their weaknesses, and appreciate the importance of organizational issues. The members of the medical group have had to learn basic elements of epidemiology, administration, social science, and education.

By and large, students have had amazingly few problems working in this field setting. Self-selection must have a great deal to do with this. It is probably true that a student trained in a rigidly structured clerkship program who is suddenly required to work in such a field situation would not do as well.

No major problems have arisen with patients. A question often asked, "How can private patients be part of education programs?" is a legitimate concern in this program. Prepaid group practice is still a form of private practice; the only major difference is the method of payment.

One family physician in the medical group highlighted this problem. Dr. E. stated: "To not have the patient feel this is another clinic and to present the student so that he is accepted and that the patient feels at ease [is a problem]." Physicians make it a practice to ask the patient if he minds having one student in the room. Almost none do.

Students at all levels often have more time than the physicians to spend on the patients' problems, and patients have responded well to this attention. Some students have become involved with families and visited their homes or have gone with family members to local agencies and even to court. In general, the student can function quite well in dealing with those who have chronic diseases, for whom the quality of the relationship and of the patient's health education is very important. Indeed, the authors believe that having students at the centers can be a definite plus as far as the patients are concerned.

Dr. E. also asserted, "I have tried to overcome this by assigning certain patients to the students for care and followup. For this reason, I prefer to have students assigned for an extended period of time rather than a few weeks." If the student's presence is explained properly to the patient, the patient sees him as another member of the health team. While he learns, he becomes a legitimate partner in the provision of medical care and often an important agent to achieve desired changes in patient behavior.