Student Perspectives on Learning in a Prepaid Group Practice

STUART H. BENTKOVER, RICHARD BERNSTEIN, MD, ALLAN GREENBERG, PHILIPPA NEWFIELD, MD, and STEVEN THACKER, MD

THE FIVE INDIVIDUAL learning experiences which follow illustrate some opportunities for learning which are unique to ambulatory and in-hospital care in a prepaid group practice (ppgp).

S.T.

S.T.'s exposure to ppgp first centered on organizational issues. During an elective in his first year of medical school, he was a participant-observer in the planning of a comprehensive health care clinic which brought a union, a hospital, and a medical school together with an existing health plan. There was little "doing" in this elective; observing and reading predominated, along with constant feedback to and from a tutor.

During his second year S.T. completed an elective in the adolescent program of the East Harlem Center. The adolescent program is concerned with the health needs of the adolescent members of families enrolled in the ppgp. Both the adolescent program and the medical group's educational program were in their formative stages at the time S.T. took this elective. Nevertheless, with the cooperation of his academic tutors, field preceptor, and the staff of the adolescent program, S.T. was able to formulate objectives and develop a student role. The adolescent clinic was scheduled from 3 to 6 pm every Wednesday, and interdisciplinary conferences began 30 minutes before each clinic. Every Thursday, medical school faculty and HIP staff met to discuss the educational and service aspects of the program.

S.T. also joined social work students and the family health worker to make home visits, and involvement with patients led him into a drug rehabilitation center and civil court as a patient advocate. Furthermore, he helped adapt a history form to the particular clinic setting and resources, and he designed the organizational framework for program evaluation. Coupled with his input on specific issues, this evaluation was crucial in the subsequent extension of the adolescent program.

A critical aspect of this elective was S.T.'s role as a partner to promote change. S.T. confronted an unfamiliar situation without a defined role. With the freedom to develop his ideas, he was able to mold the student role from that of an ob-

Mr. Bentkover and Mr. Greenberg are fourth-year medical students at Mount Sinai School of Medicine, New York City. Dr. Bernstein is a resident in social internal medicine at Montefiore Hospital, Bronx, N.Y. Dr. Newfield was a fourth-year medical student at New York University School of Medicine, New York City. Dr. Thacker is an intern in family practice, Duke University, Durham, N.C. Tearsheet requests to Samuel J. Bosch, MD, Department of Community Medicine, Mount Sinai School of Medicine, Fifth Ave. and 100th St., New York, N.Y. 10029.

A full-time family physician discusses a health problem with a medical student and a community medicine resident

server to one of physician's apprentice, taking histories on his own and doing physical examinations under the supervision of the physician. His efforts were rewarded by the respect of the group physicians and his input was instrumental in the further acceptance of students by the HIP staff.

In all these electives, therefore, S.T. developed clinical and organizational skills while acquiring knowledge in clinical medicine and health care delivery. He also clearly demonstrated the active role a student can perform as an agent of change in a health care system.

S.B.

During the summer following his first year of medical school, S.B. worked with another medical student and a social work student identifying the problems of drug abuse in the adolescent population enrolled at the East Harlem Center of the medical group. The students helped design a questionnaire to identify potential or current drug users, and it is now used in the intake procedure for all new participants in the adolescent program. S.B. also led informal discussion groups with the adolescents, and student-organized outings led to the establishment of a full-time recreational program at the clinic. The center's staff regards this program as an alternative to the boredom and frustration which often lead ghetto adolescents to drug abuse. S.B. also worked with an urban-planning student, evaluating patient charts and determining the exact size of the adolescent segment of the subscriber population eligible for the new adolescent program. Their recommendations led to program expansion and record modification.

During the following summer, S.B. worked with a full-time pediatrician in the group as his field preceptor. He was given the responsibility of interviewing parents and examining acutely ill children and adolescents as they came to the office. The pediatrician verified his findings, explained them to the parent, and prescribed appropriate therapy. At the end of each session, S.B. and the pediatri-

cian discussed the medical and social implications of the cases.

The pediatrician felt that students had a definite effect on his attitude. He believed that interaction with the students constantly encouraged him to review current pediatric literature. However, the exposure also frustrated him because he wished that he had more time to spend teaching and learning. The pediatrician is now actively engaged with other students.

Thus while learning clinical pediatrics, S.B. helped stimulate the continuing education of his field preceptor. Also, his research demonstrated the value of good-quality medical records in the delivery of comprehensive care as well as the research and health planning implications of a defined population.

R.B.

During an elective in his first year of medical school, R.B. studied the history, economics, and organization of ppgp. The following summer he worked with another student and a faculty preceptor on an epidemiologic study in which they documented differing use rates of medical services for non-Medicaid and Medicaid HIP subscribers. HIP later implemented an aggressive outreach program to inform Medicaid subscribers how to use the health plan better.

During an elective course in his second year, R.B. spent one afternoon a week seeing patients with the medical director of the Yorkville Medical Group in his internal medicine practice. R.B. also accompanied the director to meetings at the central offices of the health plan and discussed administrative problems with him. For R.B., the medical director was a role model that differed significantly from those available in the teaching hospital. One afternoon a week was spent in an interdisciplinary group discussion with nurses, the administrative assistant, social workers, the health educator, and faculty members from Mount Sinai. These sessions provided an interesting perspective on the problems of a ppgp.

During his third-year community medicine

Mount Sinai medical students, staff from the Yorkville Medical Group of HIP, and medical school staff during a case conference

clerkship, R.B. spent part of his time in planning a project to integrate the YMG with a community hospital in East Harlem. As a fourth-year student, R.B. worked with another student in the adolescent program. With the cooperation of two practitioners and a health accountant, the students converted the medical records to Weed's problem-oriented format (*10*). In addition, they became involved with the application of Williamson's technique (*11*) for assessment of outcome and quality care to several problems frequently encountered in the adolescent program.

For R.B., ppgp provided a rich environment for learning about clinical medicine, epidemiology, team functioning, health care organization, financing, planning, and quality care assessment. Furthermore, he made contributions in subscriber education and medical records.

P.N.

P.N. worked two summers in a temporary job at the central office of HIP, researching Puerto Rican health practices and attitudes and learning about the organization of HIP. During her third year in medical school she participated in the continuing education program of the staff in the adolescent program of the East Harlem Center and worked with R.B. in the conversion of the program's records to the Weed system.

Upon completion of her surgical clerkship, P.N. worked with a surgeon in the medical group. In an effort to understand his role as a member of the ppgp, she accompanied the surgeon throughout the day. She participated in morning rounds, operating room procedures, office hours, clinics sessions, and conferences.

P.N.'s experience demonstrated to her the continuity of prehospital, inhospital, and posthospital surgical care in this ppgp and provided the opportunity for her active participation in the delivery of this care. The value of her clinical experience in surgery was in "learning by doing." The surgeon's willingness to delegate responsibility to a student was predicated upon adequate and honest student-physician interaction. Furthermore, assignment of responsibility to the student freed the physician to attend to other problems and partially compensated for the time he devoted to teaching.

Working in different levels of a ppgp, P.N. learned the central organizational functions of that system of health care delivery, as well as the particular role of a surgeon within the system. She developed means to improve physician understanding of the patient population and methods for quality care assessment.

A.G.

In the summer after his second year of medical school, A.G. worked in the East Harlem Center as a physician's apprentice. Early in the summer, his role was limited to observing his field preceptor's practice. However, A.G. felt that group practice should offer students clinical responsibilities comparable with those offered in a teaching hospital. He and his academic tutor suggested this to the family physician. Initially hesitant to delegate some of his patient care responsibilities, the physician soon accepted this concept.

This acceptance laid the groundwork for the development of a graduated program of learning which enabled A.G. to assume increasing clinical responsibility commensurate with his ability. He interviewed and examined patients and, upon the completion of each examination, the family physician corroborated A.G.'s findings and discussed the patient's management and prognosis.

A.G. was also given the responsibility to organize weekly case conferences in the adolescent program. These sessions were designed to improve the understanding and management of common medical and social problems. He prepared each conference protocol and presented the case to the multidisciplinary staff of the center and consultants from Mount Sinai.

A.G., therefore, learned clinical medicine in an ambulatory setting by working with a primary care physician in a multidisciplinary group; he obtained a broader understanding of the patient in his environment through group problem-solving sessions. Finally, he helped a practitioner in a ppgp re-evaluate his goals for student education in the medical group.

Discussion

A prepaid group practice is an appropriate and rich setting for medical education. As indicated previously, there are ample opportunities for acquiring traditional clinical skills in data collection and diagnosis. What has been of special importance to the students in this experiment is the opportunity to learn these skills in a primary care setting. Students follow a limited number of patients with their field preceptors over an extended period; the long-term management of patients with somatic, emotional, financial, housing, and other problems is a particular challenge.

In a ppgp a multispecialty-multidisciplinary team faces a challenge, and good team care demands an interaction which can provide a traumatic, yet often critical, learning experience for the student. Beyond simple observation of an existing team, a medical student in a ppgp can learn conjointly with students in other health care fields. In this setting the student confronts the dilemma of role definition as an integral part of learning.

Students encounter in a ppgp a group of physicians who are legally, morally, and financially responsible for the well-being of a defined population of subscribers. Students can become involved in preventive services like sex and drug education for high-risk teenagers, annual physical examinations, and breast cancer screening. This intimate engagement in the health maintenance of a defined population serves as a valuable contrast to the mainly curative activities in teaching hospital wards and emergency rooms.

Electives in basic science and clinical research structured around faculty research are offered in the teaching hospital; clinical research at YMG is oriented around the needs of patients. Many have written on the potential of such research (*5*) in a ppgp. In this setting, actual health problems provide the data for learning basic epidemiologic skills through useful research. The YMG has provided the basis of projects for those with research interests in patient care, health services organization, and epidemiology. Furthermore, there have been opportunities to learn about pragmatic problems of administration, financing, and health care organization within the framework of ppgp.

Participation in a ppgp has led students to define a spectrum of roles. Unlike a teaching hospital, ppgp lacks the historical precedent of student involvement. After experimenting with various roles, students have molded a place for themselves as observers, consumer advocates, clinical and administrative apprentices, researchers, health accountants, and health care planners (*9*).

Contributions to faculty development, health care delivery by existing organizations, and interinstitutional relationships resulted from this program. Students learned useful skills while gaining knowledge and evolving attitudes in a setting which offers a valuable supplement to a hospital-based medical education. Progress is possible because of faculty and practitioner recognition and undergraduate testing of new student roles as partners in an educational enterprise.

REFERENCES

(*1*) Lee, P.: Medical schools and the changing times; reorganization of the medical curriculum. J Med Educ 36, pt. 2: 45–128 (1961).

(*2*) Sanazaro, P.: Innovations in medical education. Social and scientific determinants. Arch Neurol 17: 484–493 (1967).

(*3*) Patiño, J.: Education for the health professions to meet countries' needs. Address at the Third World Conference on Medical Education, New Delhi, India, Nov. 24, 1966.

(*4*) Santas, A.: Address at the 3d Panamerican Conference of Medical Education, Panamerican Federation of Associations of Medical Schools, Buenos Aires, Nov. 4–6, 1970.

(*5*) Vayda, E.: The potential of prepaid group practice in community medicine teaching programs. Milbank Mem Fund Q 2: 129–141 (1970).

(*6*) Myers, B. A.: Health maintenance organizations: issues for neighborhood health centers. Presented at the Workshop for Directors, Staff, and Board of Neighborhood Health Centers, sponsored by the Group Health Association of America and National Association of Neighborhood Health Centers, Washington, D.C., Apr. 13, 1971.

(*7*) Carnegie Commission on Higher Education: Higher education and the nation's health: policies for medical and dental education. McGraw-Hill, Inc., New York, 1970.

(*8*) Bosch, S. J., and Banta, H. D.: Medical education in prepaid group practice. JAMA 212: 2101–2103, June 22, 1970.

(*9*) Bosch, S. J., Bass, H., Gold, H., and Banta, H. D.: Medical student roles in prepaid group practice: early findings of an educational program. J Med Educ 48, pt. 2: 144–153 (1973).

(*10*) Weed, L. L.: Medical records that guide and teach. New Engl J Med 278: 593–599, Mar. 14, 1968; 652–657, Mar. 21, 1968.

(*11*) Williamson, J. W.: Evaluating quality of patient care, a strategy relating outcome and process assessment. JAMA 218: 565–569, Oct. 25, 1971.

(*12*) Barr, D.: Comprehensive care through insurance plans. J Med Educ 36: 185–192 (1961).