Program Notes

Residency Training in PHS Hospitals

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MODERN PATTERNS of medical education in this country had their inception in the celebrated Flexner Report prepared for the Carnegie Foundation for the Advancement of Teaching in 1910. This epochal report by Dr. Abraham Flexner resulted in the closing of less competent medical schools, including those operated solely for profit.

Since then, medical schools have been brought largely under the control of universities, clinical laboratories have been incorporated into the medical schools, and curriculums have been firmly established. Research laboratories in the basic medical sciences began their growth into the empires of the late twenties and thirties. From these, true graduate education programs in the basic medical sciences sprang up to produce teachers of outstanding competence, and from these teachers there emerged a flow of new medical knowledge which has since become a veritable outpouring.

The situation of 50 years ago is now reversed. Then, wide application was given to limited medical knowledge; today, there is limited application of extensive learning.

Within the past 10 years, most medical schools in this country have been forced to abandon the teaching of more and more of the details of medical knowledge. Medical students must now rely to a greater extent than ever before upon internship and residency to supply these details.

Formerly, hospitals were responsible primarily for clinical training and experience in the internships and residencies they provided. They now must teach the details of basic and clinical sciences to make up for undergraduate deficits. The teaching of these details and the integration of the basic medical sciences (anatomy, pathology, biochemistry, physiology, pharmacology, and microbiology) into a working human biology which is correlated with clinical syndromes are too often neglected in the routine of patient care.

The residency training programs of the Public Health Service were set up in the first few years after the Second World War, except the residency in psychiatry established in 1938 at the Lexington, Ky., hospital. Expansion of Public Health Service residency training began in answer to the need for specialty training for returning military medical personnel. Residency programs are now an established part of our hospital system; they are the Service's principal source of trained clinicians; they serve as the channels through which new medical knowledge, diagnostic and curative, is brought to the bedside, the laboratory, and the operating room. The programs provide incentive for study, inquiry, and research; they provide the intellectual stimulation essential to the maintenance of high clinical standards. The principal concern of a hospital is, of course, patient care, but in this day of discovery, the routines of patient care are strongly tied to education and research.

Only a professional teacher can readily translate the language of research laboratories, full of the terms of higher mathematics, inorganic chemistry, biology, and physics, into language understandable to the ordinary medical student or physician. New medical knowledge as it appears in much professional literature is incomprehensible to the undergraduate, graduate,

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or practicing physician. Thus teaching hospitals must depend more and more upon staffs of medical schools to translate this knowledge and select the more valuable contributions from the great mass of published material.

It is therefore inevitable that Public Health Service hospitals should be drawn more closely to the medical schools. Just what form the arrangements should take is difficult to say at this point. Certainly, there will have to be some "give and take" on both sides. The degree of "give" by the medical schools will bear some relationship, of course, to the contributions to their programs made by our hospitals. The balance will probably be in our favor—professional teachers are notoriously generous. We need to look seriously, however, to our ability to contribute something of worth to the objectives of the medical schools. In this regard, we may look upon our patients as a valuable study source. We may also need to lengthen the periods of assignment of our senior staff members in order to assure greater continuity and stability in our participation.

Exactly what part research will take in our residency training programs is difficult to predict, but we well recognize that research as a teaching tool has become established in this country. Francis E. Gray, chairman of the board of trustees of Massachusetts General Hospital, has said that the period of 1935 to 1955 "saw the trinity of the care of the sick, teaching, and research unite for the good of mankind as never before in the history of the hospital." We are all agreed, I believe, that opportunities for research should be available. On the other hand, we would probably be loathe to require research work of anyone. We would hope rather that our hospitals would be so charged with an atmosphere of inquiry as to nurture the highest possible accomplishments on the part of our residents.

Poison Control Centers

The number of poison control centers affiliated with the National Clearinghouse for Poison Control Centers rose to a new high of 460 as of July 1, 1961. There are now centers in all the States except Vermont and Montana, and in the District of Columbia, Panama Canal Zone, Virgin Islands, and Guam.

The National Clearinghouse, directed by the Public Health Service's Division of Accident Prevention, provides local centers with information on ingredients and antidotes for new products. More than 200 major manufacturers of drugs and household products supply the data. The centers make this information available to physicians by telephone, day or night. Parents who call the centers are given first-aid instructions and are advised to call their doctor.

The Hazardous Substances Labeling Act, enacted by Congress in 1960 and administered by the Food and Drug Administration, requires that labels on household chemical products include the identity of hazardous ingredients, antidotes for toxic substances, and warnings and precautions needed for safe use. The law is now fully enforceable for highly toxic and flammable substances. Labeling requirements for other hazardous articles become effective on February 1, 1962.

While the labels should facilitate the work of the poison control centers by providing safety information, medical consultant services will still be needed, Henry L. Verhulst, director of the National Clearinghouse for Poison Control Centers, points out. Consumers may disregard label information or leave hazardous substances within reach of small children, he said. Each year an estimated 600,000 children swallow household aids left within their reach and about 500 die.