Alton Ochsner Medical Foundation's Combined Family Practice and Internal Medicine Residency Program

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The impact of managed care in the 1990s and the need for more broadly trained primary care physicians led the American Board of Internal Medicine and the American Board of Family Practice to explore ways to collaboratively train primary care physicians. One proposed solution was a combined residency incorporating the training curriculums of both boards in an integrated fashion. In 1995, the Alton Ochsner Medical Foundation Combined Family Practice and Internal Medicine Residency Program was one of the first to be approved by the two boards. The first residents began training in July 1996. Due to overlap in curriculums, completion for both boards is possible in 48 months as opposed to the 72 months a consecutive approach would require. The first graduates completed the program in July 2000.

The combined residents rotate on both the Family Practice inpatient service and the General Internal Medicine wards and participate in continuity care clinics and precepting in both core programs. Facilities for the program involve only existing clinics and administrative personnel. Residents serve as primary care physicians for a mixed ethnic, middle-class patient population at Ochsner's New Orleans East satellite clinic, provide longitudinal obstetric and pediatric care at an inner city clinic, and complete a rural primary care rotation. Inservice examination scores have been consistently high with several combined residents scoring at the top United States level on both examinations. The program has matched with our highest ranked students over each year of the program despite a marked decline in US graduates entering primary care fields. Graduates of the combined program are ideal staff for either medical schools or residency programs of either core program.

While this residency is in its early stages, both boards have mandated an indepth evaluation to determine the quality and outcomes of training. The results of a recent survey of current Ochsner residents assessing their perceptions of the combined program were encouraging. We plan to track our graduates and compare them with recent graduates of the two core programs in order to document long-term impact.

Murphree PD, Brandon W. Alton Ochsner Medical Foundation's combined family practice and internal medicine residency program. The Ochsner Journal 2000; 2:228-232.

During the 1990s, the impact of managed care and the emphasis on the need for more broadly trained primary care physicians led the American Board of Internal Medicine and the American Board of Family Practice to explore ways to collaboratively train primary care physicians (1-3). Several board members strove to create a training process that contained the comprehensiveness of family practice while maintaining a disease-specific, subspeciality-based Internal Medicine focus. The goal was to most cost-effectively train the best prepared primary care physicians. A combined residency incorporating the training curriculums of both boards in an integrated fashion was one option (2).

The Alton Ochsner Medical Foundation and the Eastern Virginia Medical School were the first two programs to be approved to help meet these goals in 1995 (4). A 48-month curriculum was developed to meet the specific objectives of this unique training program. The first residents were taken in the March 1996 match and began training in July 1996.

The goals of the combined program are to:

1. Provide residents with enhanced generalist training
2. Provide additional training in a variety of communities (rural, inner-city, etc.)
3. Improve training resource efficiency
4. Increase the attractiveness of primary care
5. Improve communication between Internal Medicine and Family Practice
6. Increase the number of effective faculty role models for medical students and residents.

The curriculum of the Alton Ochsner Medical Foundation's 4-year integrated program is outlined in Appendix 1.

Administration

Monthly meetings with core faculty and the chief residents provide an opportunity for comanagement of the residency. Combined residents are given a faculty advisor in Internal Medicine for quarterly reviews of Internal Medicine academic performance and undergo quarterly reviews in Family Medicine with the Family Medicine program director. An annual faculty retreat is held to review the entire program along with the core Family Medicine program.

Curriculum

The curriculum, submitted to both boards and approved in 1994, was developed to meet the 36-month requirements of both boards. Due to overlap in curriculums, completion for both boards is possible in 48 months as opposed to the 72 months a consecutive approach would require. It was essential during the development of the program that no "short cuts" were taken, but that combined training fulfilled the requirements of both core programs.

Generalist Training

The first goal of the combined program was to enhance generalist training. The combined resident rotates on both the Family Practice inpatient service and the General Internal Medicine wards. This allows for precepting on inpatient issues by both family and internal medicine physicians. The combined residents also have continuity care clinics and precepting in both Internal Medicine and Family Practice. The total ambulatory experience is approximately 50% of the residency, as opposed to the ~30% ambulatory requirement of the Internal Medicine program.

Care was taken to avoid disrupting ward responsibilities with this increased ambulatory curriculum. The number of clinics are adjusted based on the intensity of the rotation (i.e. medicine wards vs.consult rotations). Continuity clinics are provided in the family practice residency model clinic for all 4 years. Originally, residents also had Internal Medicine continue in the third and fourth years, but the requirement was recently changed to start in the second year of training. Now the residents spend a day every other week in the Internal Medicine clinic (just as the categorical Internal Medicine residents) alternated with a day-long clinic every other week in the Family Practice model clinic. This gives the residents at least 1 day per week in either Internal Medicine or Family Practice clinic. Residents meet the 24-month continuity care requirement defined by both boards of Internal Medicine and Family Practice.

Care To Differing Communities

Caring for differing communities is a strong aspect of the Ochsner combined program. Ochsner residents serve as primary care physicians for a mixed ethnic, middle-class patient population at the Ochsner's New Orleans East satellite clinic, which is ~95% managed care. Residents also provide longitudinal obstetric and pediatric care at the inner city St. Thomas Clinic providing indigent care.

A rural Family Practice rotation is also included. Residents perform a 1-month rotation through Chabert Medical Center, approximately 30-40 miles from the main Ochsner campus, providing care for an uninsured (and largely Cajun) population. This includes rotations in Internal Medicine, ICU, OB/GYN, and newborn nursery, and provides a community experience as opposed to the tertiary referral experience obtained at the main Ochsner campus.

Efficiency of Training Resources

Program efficiency is improved in several ways. Facilities involve only existing clinics and administrative personnel. The continuity clinics are provided in the existing Family Practice Residency model clinic and one of the Internal Medicine clinics used by the Internal Medicine Residency. In addition, Family Medicine participation in Internal Medicine morning report includes twice-monthly cases presented by the Family Medicine hospital service. Geriatrics lectures are also provided for both Internal Medicine and Family Practice residents once-monthly. Noon conferences and Internal Medicine Grand Rounds are open to all house staff.

Attractiveness of Primary Care

Medical students have found the combined residency attractive, as denoted by a significant number of high-quality students applying and accepting appointments to the residency. Of the original five matching residents appointed to the residency, all completed the residency in June 2000. The program has matched with our highest ranked students over each year of the program despite a marked decline in US graduates entering primary care fields.

Interdepartmental Communication

Monthly curriculum meetings between the core departments enhance communication on a departmental level. Resident-level interaction on the Internal Medicine ward and consult rotations have also enhanced communication between the departments of Internal and Family Medicine. Combined residents are constantly interacting with residents of both core programs and have fostered more interactions between these residency groups. Both programs' faculty and residents have noted that the combined program has served to improve the core programs from which it derives.

More Role Models

Once several combined residents have completed the residency, they become ideal staff for either medical schools or residency programs of either core program. Their added training is invaluable both in the clinic and on inpatient ward services for either Family or Internal Medicine. We plans to use our graduates as faculty for the combined program in the future. To date, two Ochsner graduates have become staff of the Ochsner Clinic.

Evaluation

There is currently not a separate Residency Review Committee to evaluate combined programs, which can only be carried out when both core programs are accredited. While this residency is in its early stages, both boards have mandated an indepth evaluation to determine the quality and outcomes of training. Although many of the day to day details of the program have been satisfactorily resolved at this point, the program has now changed its focus to a more long-term assessment.

Monthly evaluations of the residents on their rotations are generally highly satisfactory. Inservice examination scores have been consistently high with several combined residents scoring at the top US level on both examinations. Combined residents also have biannual meetings with the program directors to discuss evaluations and problems with the residency.

Resident Survey

A recent survey of all current residents assessing their perceptions of the combined program was encouraging. All 16 residents, 66% male and 33% female, completed the survey. Ninety-one percent (91%) said they would choose the combined residency again—this is especially encouraging since all four levels (years) of training are represented. When specifically asked to rank their level of satisfaction, 9% were "extremely satisfied," 64% were "mostly satisfied," and 27% responded with "average satisfaction." When asked why they chose the residency, "broader training" and "dual boarding" were the top two reasons. The residents identify general Internal Medicine and ambulatory clinics as their residency's strongest area. Forty-five percent (45%) reported a lack of general inpatient Pediatrics as the residency's weakest area.

When interviewing for residencies, 55% interviewed primarily for Family Practice and 27% interviewed primarily for Internal Medicine with the remaining 18% of residents interviewing for both residencies. Both groups indicated that the *least* influential factors leading to the choice of the combined program was "could not decide between Family Practice and Internal Medicine" and "unsure of future job requirements." The potential future benefits of the combined residency training were ranked as follows: 45% "more knowledge," 27% "more opportunity for jobs," 18% "aid in becoming a hospitalist," and 18% "other." Most residents found the combined program through literature and "other" means.

Information was obtained regarding planned practice patterns, but no specific trends could be concluded at this early date. We plan to track our graduates and compare them with recent graduates of the two core programs in order to document long-term impact.

Challenges

In this time of diminishing resources for graduate medical education, it remains a challenge to justify new and unique programs. The success of combined programs depends on the strength of the two core programs. At a time when fewer US medical students are choosing primary care, recruitment remains difficult. Extra effort in communication is necessary to maintain integration, and it will be critical to get the word out to potential applicants about this innovative program.

Conclusion

The Alton Ochsner Medical Foundation's Combined Internal Medicine and Family Practice Residency is now well established and accepted by both core programs and is fulfilling the goals set forth by both boards. The residency has attracted many students to interview and match for the program and continues to do so.

By balancing inpatient and ambulatory education in many different patient encounter settings, the combined residency is enhancing the medical education of the residents. The combined residents are generally accepted by both Internal Medicine and Family Medicine staff and residents, which enhances communication between these departments. Most importantly, the residents appear to be satisfied with their training.

Nonetheless, these programs remain controversial and their necessity is questioned by many leading physicians within both core programs. It will be important to demonstrate an added benefit for this type of training in a more long-term fashion. We plan to track graduates of the combined and core programs to more accurately evaluate the impact of the combined program.

References

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Appendix 1

Alton Ochsner Medical Foundation Combined Family Practice and Internal Medicine Curriculum.

PGY1 - 12 months

General Internal Medicine (inpatient) - 2 months
Critical Care Medicine - 1 month
Family Medicine Inpatient - 1 month
Cardiology - 1 month
Emergency Medicine -1 month
Pediatrics - 1 month ambulatory, 1 month inpatient
Obstetrics - 2 months
General Surgery - 1 month
Ambulatory Medicine - 1 month
Continuity care clinic in family practice clinic 1 half-day per week.

PGY2 - 12 months

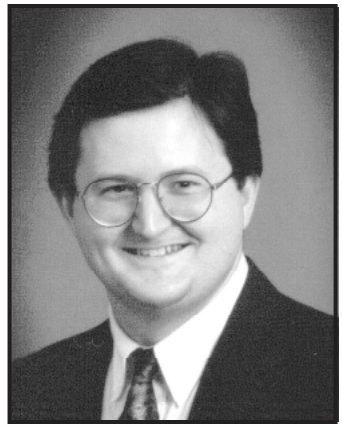
General Internal Medicine (inpatient) - 1 month
Family Medicine Inpatient - 1 month
Critical Care Medicine - 1 month
Cardiology - 1 month
Neurology, Pulmonary, Nephrology consults - 1 month/ea.
Pediatrics - 1 month Newborn Nursery
Gynecology - 1 month (primarily clinic)
Orthopedics - 1 month (clinics)
Colon-Rectal Surgery - 1 month (clinics)
Elective - 1 month
Continuity care clinic in family practice clinic 1 day every other week, alternating with internal medicine clinic 1 day every other week , with additional family medicine clinics on consult and elective months.

PGY3 - 12 months

General Internal Medicine (inpatient) - 1 month
Family Medicine Inpatient - 1 month
Infectious Disease, Gastroenterology, Endocrinology, Dermatology - 1 month/ea.
Ophthalmology / Urology - 1 month
Sports Medicine / Occupational Medicine - 1 month
Pediatrics (clinic) - 1 month
Rural Family Practice - 1 month
Elective - 2 months
Same as PGY2

PGY4 - 12 months

General Internal Medicine (inpatient) - 2 months
Family Medicine Inpatient - 1 month
Cardiology (clinic) -1 month
Critical Care Medicine - 1 month
Pediatrics (clinic) - 1 month
Rheumatology (clinic) - 1 month
Psychiatry - 1 month
Allergy / ENT - 1 month
Elective - 2 months
Managed Care - 1 month
Continuity care clinics in Family Practice 3-5 half-days per week



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