



# Special Considerations in the Preparation of Family Practice Residents Interested in Inner City Practice

American Academy of Family Physicians, Commission on Education

## Introduction

The American Academy of Family Physicians, health care planners, and patients have long promoted the concept that every patient deserves to have a personal family physician. Family physicians possess the training and expertise necessary to provide exemplary care for the vast majority of the health needs of men, women, and children in this country regardless of location. Additionally, for patients and families requiring services for which family physicians may lack expertise or available technical support, family physicians are skilled in obtaining appropriate consultation and/or referral to coordinate the patient's total health care.

Health care in the inner city is complicated by the following problems and challenges:

1. Persistent poverty
2. Depressed living and housing conditions
3. Poor health care outcomes
4. Reduced community resources
5. Diverse ethno-cultural populations
6. Limited access to health care and insurance coverage

The relative absence of preventive medicine and limited access to health care in inner city settings makes the ravages of undiagnosed or under-treated disorders such as diabetes, hypertension, heart disease and cancer particularly stressful. Poverty, violence, infant mortality, HIV/AIDS and substance abuse also contribute to the growing number of preventable deaths in urban areas. Additional challenges include language barriers, cultural differences, limited access to transportation, and safety issues which have an impact on residents' access or response to health care services.

Optimal health care for these at-risk patients requires an adequate number of physicians, especially family physicians, trained to provide

culturally effective community-responsive primary care. Although in recent years the largest increase in the number of physicians has occurred in metropolitan areas, inner city areas, particularly those with predominately underrepresented minority populations, remain greatly underserved by primary-care physician providers.

As of June 30, 1997, there were 855 health-professional shortage areas (HPSAs) in metropolitan areas. This figure accounts for 27 percent of all the 3,141 HPSAs in the United States. It is currently estimated that urban HPSAs need 3,000 primary care physicians to remove the areas from HPSA designation and provide adequate health care.

A 1993 Association of American Medical Colleges' report revealed that in the previous year, 75 percent of minority medical school graduates planned to practice in under served areas, compared with 39 percent of total graduates. Family physicians, particularly those from underrepresented minority groups, have played an important role in providing health care to the inner city residents. It is essential, however, that the number of well-trained primary care physicians choosing inner city practice be expanded.

Inner city practice offers family physicians and their families the opportunity to benefit from life in a metropolitan area, where family physicians can enjoy the challenge of providing care to a broad spectrum of patients and make a difference in the long-term health of these patients. Exposure to and training in inner city health care should not be limited to only those residents with previously defined commitment to providing inner city health care. In addition to experiences in inner city health settings, residency-training programs must include curriculum time for discussion and reflection on the residents' experiences and their consideration of selecting this environment for their practice careers.

## Specific Residency Experiences

Residents interested in inner city practice should periodically review their training and discuss their career plans with residency-program faculty, program directors, and family physicians working in inner cities. Residents should be encouraged to schedule elective and longitudinal experiences that include work in urban community health centers, homeless shelters, public health departments, and multi-cultural practices.

A curriculum designed to prepare residents for urban family practice should emphasize experience in the following:

### I. Hands-On Inner City Training

- A. A two-month rotation in inner city family medicine; if possible, the residency should employ family practice faculty and facilities developed in urban areas, such as community health centers.
- B. An ongoing, integrated curriculum that provides practice experience with inner city health issues such as limited access to primary and specialty care, and other unique environmental and socioeconomic factors that affect inner city residents.
- C. Discussion of physician, partner and family issues surrounding living and practicing in an urban area.
- D. Experiences that foster an understanding of health policy and the political and legislative factors, that impact on health services in the inner city.
  1. Understanding of obstacles to access to care for those without access including: working poor, street homeless, and undocumented populations.
- E. Experiences that foster sensitivity to cross-cultural issues and promote the practice of culturally effective care.
  1. Experiences that demonstrate effective quality health care in the inner city, including an understanding of and sensitivity to alternative healing and nontraditional healing methods; the experience should also deal with language barriers and specific skills training in learning to work with trained interpreters.
- F. Experiences that develop skills necessary for functioning in an urban setting such as providing care in patient homes and homeless shelters, outpatient alcohol and chemical dependency programs, school-based clinics and elder-care centers.

1. Incorporation of curriculum formats for reflection and processing of these experiences, including discussions with inner city residents who can serve as "teachers" for the family medicine residents.
- G. Experiences that utilize other health care professionals and develop a multidisciplinary team approach to inner city health care; this experience should also utilize other health care resources, such as public health departments, and mental health networks.
  1. Residents should be knowledgeable of the specific skills and expertise of other professionals including: public health and home health nursing, physical and occupational therapists, social services, mental health outreach workers, case management.
- H. Experiences in working with the community to include community and faith based organization leaders and boards, state and local politicians. Residents should understand the principles and purposes of performing a community assessment.
  1. Demonstrate skills necessary to complete a community needs assessment, including collection of primary and secondary data.
- I. Experiences in mentoring relationships with inner city family physicians for special rotations and projects; longitudinal exposures should be facilitated.

### II. Practice Management

- A. Professional and personal time management
- B. Health care teams, utilizing physician assistants, nurse practitioners, social workers, nutritionists, etc. (See G1 above)
- C. Knowledge of sources of funding for health care for the poor in inner cities
- D. Practice management that addresses issues unique to inner city practice, including maximizing reimbursement, medicaid managed care, state and local funding for the uninsured and federal grant programs
- E. Utilization of culturally sensitive and bilingual staff members in the practice
- F. Development of a professional support team, including attorneys, banking professional, accountants and tax specialists
- G. Challenges to the use of personal and clinical information systems, electronic resources and telecommunications networking with consultants in inner city practice

### III. Clinical Topics

- A. Selected inner city health topics to include but not be restricted to the following:
  - 1. Environmental and socioeconomic factors that affect the health and safety of patients, including post-traumatic stress syndrome
    - a. Occupational and environmental health, including visits to local factories, waste dumps, and environmental hazard
  - 2. Chemical dependency
  - 3. Adolescent risks
    - a. Pregnancy
    - b. Educational needs-assessment and knowledge of resources to address learning disabilities
    - c. Violence, homicide, accident prevention and resources
  - 4. Occupational hazards and work injuries commonly associated with urban settings
  - 5. Social service support and inner city health resources, including elder care and child care, housing and employment agencies
  - 6. Infectious diseases particularly HIV/AIDS and their effect on families and inner city communities
  - 7. Patients and families with multiple problems exacerbated by limited resources and limited access to the medical system
    - a. Chronic disease prevention and management
- B. Trauma and Emergency Care
  - 1. Recognition of and treatment protocols for common emergencies including myocardial infarction, stroke, seizures, etc.
  - 2. Laceration, blunt trauma, and minor wound treatment and repair
  - 3. Psychiatric emergencies including familiarity with available transfer and referral resources
  - 4. Drug abuse, poisoning, and exposure to toxic substances
  - 5. Trauma and illness stabilization and proper preparation for transfer to surrounding hospitals
  - 6. Recognition of and treatment protocols for child, elder or partner abuse
  - 7. Mass casualty events: role of physician, staff and clinic (e.g., environmental/natural disasters, nuclear, biological,

chemical and civil disturbance)

- C. Advanced levels of procedural and management skills should be obtained in specialties as needed to provide care when consultation is not available in the community; common areas needing advanced training include:
  - 1. Obstetrics
  - 2. Gynecology
  - 3. Musculoskeletal injury and fracture
  - 4. HIV/AIDS management

### IV. Community-Oriented Primary Care

- A. Experiences that foster collaborative leadership roles, as appropriate, for inner city family physicians in public health, community development, and political action.
- B. Training in public health education, public speaking, and social services coordination.
- C. Skills to develop and participate in culturally sensitive health promotion and disease prevention activities and collaborative projects with community, church, and elected civic leaders.
- D. Demonstrate skills to characterize an inner city community, identify existing resources and areas of health care need.

### Implementation

- 1. Curriculum should include learning objectives and evaluation tools to assess skills, knowledge attitude/behavior for residents.
- 2. An elective, or required, rotation of one or two months in an inner city family practice should be provided, no more than one-half of it in a non-clinical public health facility.
- 3. Mentoring relationships with inner city programs for special rotations projects and longitudinal practice exposures should be facilitated.
- 4. Utilization of community health facilities, county hospitals, and state or federally funded health programs should be encouraged, to facilitate optimum learning.
- 5. Evidence shows that the exposure to a racially, culturally, and ethnically, diverse professional team is essential to providing an optimal educational experience for residents.
- 6. Pilot inner city experiences should precede required or elective longitudinal experiences, to ensure quality inner city health rotations.
  - a. Curricular time for reflection must be provided.

Reflection discussions should include community representatives and professionals as well as residents and program faculty.

7. Residency programs utilizing state or federally supported hospital or community health facilities should be encouraged to support training experiences for residents in inner city health care.

## V. Resources

Urban family practice: a resource monograph. Kansas City, Mo.: Society of Teachers of Family Medicine, Task Force on Urban Family Practice, 1994

Elliot, B., Beattie, K., & Kaitfors, S. Health Needs of People Living Below Poverty Level. *Family Medicine* 2001; 33(5): 361-6.

Becker, G. Effects of being uninsured on ethnic minorities' management of chronic illness. *West J Medicine* 2001; 175: 19-23.

Birrer R., ed. *Urban family medicine*. New York: Springer-Verlag, 1987.

Nutting PA, ed. *Community-oriented primary care: from principle to practice*. Rockville, Md.: Dept. of Health and Human Services, Health Resources and Services Administration, publication no. HRS-A-PE 86-1/N, 1987.

Council on Graduate Medical Education: Tenth Report; Feb. 1998 U.S. Department of Health and Human Services, Health Resources and Services Administration.

Kmaromy, M., Grumbach, K., Drake, M. et al. The role of black and Hispanic physicians in providing health for underserved populations. *NEJM*. 334:1996:1305-10.

Shi, L., Starfield, B. The effect of primary care physician supply and income inequality on mortality among blacks and whites in US metropolitan areas. *AJPH*. 2001;91(8)1246-50.

Xu, G, Fields, S, et al. The relationship between the race/ethnicity of generalist physicians and their care for underserved populations. *AMJ Public Health* 1997; 87:817-22.

Murray-Garcia, JL, Garcia J, Schembrime, Guerra, LM. The service patterns of racially, ethnically, and linguistically diverse house staff. *Academic Medicine* 2001; 76:1232-40.

Shine KI. Health Care Quality and How to Achieve it. *Acad. Med.* 2002;77:91-99.

Health People 2010: <http://www.health.gov/healthpeople>

<http://futurehealth.ucsf.edu/cchws.html>

Institute of Medicine Report: Coverage Matters: Insurance and Health Care. The Consequences of Uninsurance. October 11, 2001. [www.iom.edu](http://www.iom.edu)

Published 03/95  
Revised 12/01