In Memorium

Family Medicine Visionary F. Marian Bishop, PhD, MSPH, Made a Difference in Countless Lives

On March 15, 2003, a stalwart visionary in the field of family medicine died. Marian Bishop, PhD, MSPH, was amazing throughout her life, working diligently, faithfully, and persistently toward her long-term goals of seeing family medicine become a rightfully dominant player in medicine. The combination of training in sociology, anthropology, and public health provided the broad background that she parlayed into a long career intertwining medical and social factors in health and educational administration.

She was often called "the mother of academic family medicine," a title earned because of all of the organizations she led in their developmental stages and her strong push to develop leaders in family medicine. She was the first female and the first PhD president of STFM, the first PhD president of the Association of Teachers of Preventive Medicine, the first woman chair of a department at the University of Utah School of Medicine, the first representative of academic family medicine in the Association of American Medical Colleges' (AAMC) Council of Academic Societies (CAS), the first representative of family medicine to be elected to the CAS Administrative Board; her list of honors goes on for two pages. She was a department chair for 20 years, divided between two different institutions. She was a faculty member in Schools of Dentistry, Health and Allied Health, and Medicine. Her reach was felt throughout medical education. She worked on many federal government advisory committees, influencing public health and health personnel policies, work of which she was quite proud. At almost every annual STFM meeting, she was presenting something about federal issues to inform the membership.

Surviving a long-term medical illness is often referred to as a "battle." This did not characterize Marian's zest and desire to make a difference, no matter what befell her personally. Her public acknowledgment of her breast cancer and her continuance in public roles exemplified her strong will. In the last few years of her life, she was anything but waning. She tackled every task, going to meetings with oxygen tank in tow and speaking when it was difficult, such as giving a rousing and memorable speech on leadership at the Piscano Scholar's Leadership Conference last fall or working with her esteemed Bishop Fellowship Program several days before her death.

F. Marian Bishop, PhD, MSPH
1927–2003

How can one express the treasure she was? There was so much to learn from her. She had a disarming way of telling someone that she disagreed with their position (it was at least partly her smile). She knew how to get things done. Just as she gave money, she could ask for money. She called it as she saw it, and we can only wish to be so insightful, so quickly. A few aphorisms may also describe other pertinent characteristics: "Persistence pays." "Maintain a strong ethical stance." "Do not be a wallflower." Each of these major abilities are needed by leaders.

But, there is another ability that I found simultaneously simple and profound. "Promote others, while also promoting yourself." She wanted to develop leaders. While she may call it mentoring, I call it promotional mentoring. Promotional mentoring was such a driving force in her life, through both action and word, that her deeds will be remembered and felt for many years. "I am submitting your name

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for . . . (major position)." "Of course, you can." "We need more family medicine leaders in academic medicine." Her letters of reference were a marvel, well crafted, and eloquent.

She lived up to her ideals by contributing her personal efforts and money. There are annual awards given at both STFM and the University of Utah in her name. She created the major 1-year program to develop high-level academic leaders in family medicine—the Bishop Fellowship Program of the STFM Foundation—through her tremendous generosity. She was careful with her money, so she could have more money to give to others, to "make a difference." And, make a difference she did.

Her husband, Dr Robert Froelich, was a significant influence on her career and a wonderfully supportive life partner. They cowrote a book on medical interviewing for medical students. His travels influenced her early career through remarkable adventures and new institutions. Their relationship and their ability to manage two separate careers are an inspiration for others. The closeness of the family, including children and grandchildren, felt special. For her family's tribute and more details on her life, go to www.fmbishop.us.

Dr Marian Bishop will be missed, tremendously. Her contributions are something to which each of us should aspire. A friend, a promotional mentor, a true leader.

Marjorie A. Bowman, MD, MPA
STFM President 1991–1992

Letters to the Editor

Victoria Neale, PhD, MPH
Editor, Letters to the Editor Section

Editor's Note: Send letters to the editor to **vneale@med.wayne.edu** or to my attention at *Family Medicine* Letters to the Editor Section, Wayne State University, Department of Family Medicine, 101 East Alexandrine, Detroit, MI 48201. 313-577-7680. Fax: 313-577-3070. Electronic submissions (e-mail or on disk) are preferred. We publish Letters to the Editor under three categories: "In Response" (letters in response to recently published articles), "New Research" (letters reporting original research), or "Comment" (comments from readers).

In Response

Building Research Culture

To the Editor:
I read with interest the commentary titled "Cultural (R)evolution: Developing A Research Culture in Family Medicine."[1] As a presentation of change within systems, or namely the family medicine culture, the authors have presented, explained, and explored the possibilities for developing a research culture within family medicine.

Though I welcome this system change approach for its effectiveness, change of this type is typically slow in reshaping a discipline. While instituting this system change, perhaps an expansion of our conceptualization of the family medicine research culture might serve research in family medicine well. Collaboration, or team building, would serve to provide for a research culture in family medicine. Research in family medicine would be conducted by collaborative teams, not solo clinicians or groups of clinicians. As a broad model, these teams would consist of family physicians, biostatisticians, econometricians, epidemiologists, psychometricians, developmental specialists, nurses, systems managers, and so forth, where appropriate. Each collaborator would contribute his/her expertise to the research agenda. Through these research collaborative teams, clinical or practice-based research questions could be posed, researched, evaluated, and answered, resulting in a culture of family medicine research that would, in turn, advance the discipline.

Janine E. Janosky, PhD
University of Pittsburgh

REFERENCE

1. Katemdahl DA, Parchman M, Larme AC. Cultural (r)evolution: developing a research culture in family medicine. Fam Med 2002; 34(8):616-8.

Authors' Response:
We appreciate the thoughtful comments of Dr Janosky's letter. We agree with the value of developing multidisciplinary collaborative teams as a way of promoting research and developing local culture in universities. These teams are developing at several universities and should be encouraged. Practice-based research networks (PBRNs) are another way of promoting family practice research among community-based physicians.

However, most family medicine faculty teach in community residency programs without access to researchers in other disciplines. Family physicians in faculty positions represent a small minority of all family physicians, and only a small percentage of practices are involved in PBRNs. Hence, we need to pursue additional, broader approaches to changing the culture of the discipline of family medicine.

Yes, cultural change will be a slow process, but we must start now. We cannot wait for the replacement strategy of research-oriented resident graduates replacing non-research-oriented retiring practitioners. Our discipline cannot afford it.

David Katerndahl, MD
Michael Parchman, MD
Anne Larme, PhD
University of Texas Health Science Center at San Antonio

Comment

Credit Where Credit Is Due

To the Editor:
The theme of this year's Association of American Medical Colleges national meeting was "Improving the Nation's Health." Interwoven into the program were a series of well-attended presentations intent

on providing suggestions as to how this could be done. The creation of an institute for proactive care was proposed, with its primary focus the identification of factors to eliminate preventable disease, along with a plea to improve quality of care, reduce medical errors, and improve communication with patients and their family members by using information technology and other resources. Concern was also expressed that we are facing an impending shortage of specialists.[1-3] The role of family medicine's contributions to the discourse on this topic was conspicuously absent in any of these presentations.

With the exception of sessions devoted to and administered by academic family physicians, one of the few references to family practice came from a presentation by Fitzhugh Mullan, MD, through his new book, *Big Doctoring: Primary Care—Essential and At Risk*. Drawn from extensive interviews with family physicians, general internists, and pediatricians, the value of personal and continuous medical care administered by primary care physicians and the essential nature of that kind of care was emphasized. Tucked into the program was a session titled "Hopes to Needs, Fears to Dreams: The Future of Family Medicine." During this presentation, Norman Kahn, Jr, MD, proceeded to outline the findings of the first Future of Family Medicine task force. The material presented was meticulously assembled and prescient in its scope and implications. One could draw considerable optimism for what is to follow based on this first glimpse.

My only concerns are that this compilation is still somewhat limited in its release and that thus far, the decision appears to have been made to withhold a complete revelation of the task force's findings until January 2004. In the meantime, those of us engaged in the education of future family physicians are facing another potentially bleak year in the Match and probable further erosion in both the number of residency program slots as well as a further decline in the number of programs. Although I respect and appreciate the deliberate nature with which this planning process has been constructed, I fear that this may be an inopportune time to hold this information so close to the chest. Other leaders in organized medicine appear to be planning for the future as though we don't exist and perhaps even consider us unnecessary.

In that light, I would suggest that as information becomes available from each of the task forces that appropriate summaries be released as soon as possible. If the remaining reports are as extensive and well done as the first, the value to those of us in academic family medicine as well as those in private practice could be immense. Rather than watching others continue to appropriate the foundational concepts of family practice, we could instead seize this as an opportunity to reassert ourselves in such a way as to not only receive appropriate recognition for what we stand for but as an ideal group of individuals into which the care of Americans can be trusted.

Russell G. Robertson, MD
Medical College of Wisconsin

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1. Snyderman R. Prospective medicine: the next health care transformation. Chair's address presented at the Annual Meeting of the Association of American Medical Colleges, November 10, 2002, in San Francisco.
2. Lawrence DM. Out of the wilderness: medical care in the 21st century. John A.D. Cooper Lecture presented at the Annual Meeting of the Association of American Medical Colleges, November 11, 2002, in San Francisco.
3. Inglehart J, Ginsburgh PB, Fox DM. New perspectives on physician workforce: what if Buz is right? Council of Deans/Council of Teaching Hospitals/Council of Academic Societies Joint Plenary Session presented at the Annual Meeting of the Association of American Medical Colleges, November 10, 2002, in San Francisco.

Opposed to Unopposed

Standing in front of our booth at a recent residency fair, I was astonished as students approached me and their first question was, "Are you an opposed or an unopposed program?" As a graduate of a large university-based program and now a residency director at a university program, I began to have questions. As I walked around the convention center, I noticed that a large proportion of the booths had bold letters that stated clearly "unopposed," meaning no other residency programs based at the hospital. No booths used the word "opposed" to describe their program.

What is this dichotomy? Clearly, residency programs come in more than two flavors.

The Residency Review Committee for Family Practice (RRC) accredits many different types of programs: large and small; inner city; urban, suburban, and rural; 1-2 programs; programs with fellowships and those without; university programs with strong community ties; and community programs across a spectrum. Both unopposed and so-called "opposed" programs utilize the resources of specialty children's hospitals, large teaching hospitals for subspecialty rotations, or clinical sites that provide volume experiences such as OB. Clearly, one can become a competent family physician in a variety of different settings. As educators who pride ourselves on communicating complex concepts, it is ironic how fully this oversimplification has been embraced.

As an exercise to think about the power of labels, imagine that we change the semantics from "unopposed" and "opposed" to "isolated" and "collaborative." Would anyone really want to attend an "isolated" program? The practice of medicine after residency training is a collaborative venture. Should not our training reflect this? Where better to learn to collaborate than with a variety of different trainees? The

negativity conveyed in an "isolated" label would clearly demand an outcry and be viewed as divisive.

In times of scarcity, there is a temptation to devalue others. As the mismatch between residency positions and perceived excellent applicants increases, marketing to students is likely to intensify. What saddens me is the subtle message to students that family medicine training and by extension the specialty of family practice can only truly flourish in a setting where other learners are not present. This undermines our specialty as a whole and the contribution we can make across all practice and educational settings.

Family medicine is in transition. As residency programs continue to market their unique strengths and the Future of Family Medicine Project contemplates the reworking of our specialty, my hope is that we would become more collaborative. It is through collaboration that many of the pressing health needs in this country can best be addressed. As educators, we should differentiate ourselves based on excellent clinical outcomes, specific measured competencies, and innovative educational methods that create supportive learning environments—not by a dearth of learners.

A large proportion of my graduating residents' training in an urban "opposed" program go on to practice competently in very rural areas. I think that some aspects of the collaborative learning environment in which they cut their teeth play a role in their success. Whether one trains in the inner city or a rural area, among many other resident learners or in relative isolation, once the exam room door is closed, I suspect what occurs between the patient and his/her personal physician is not so different after all.

Allen L. Hixon, MD
University of Connecticut

President's Column

The Family Farm

Elizabeth A. Garrett, MD, MSPH

In my last column as STFM president, I have decided to examine a topic I have considered for some time and one that is often referenced in conversations around our academic departments and residencies—farming. I know my rural roots are clearly exposed, but I have heard distinguished academicians, educators, and leaders mention farming since I was a medical student. What else could they be talking about when they talk about such things as protecting one's turf, silos, or fertile soil/fertile minds?

As someone who has spent much of her career in predoctoral education, I have been one of those countless folks toiling in the fields working my assigned plots and furrows beside the other workers while helping to plant ideas and skills in seedling learners. These seedlings have come from seed beds all over the country, have a diverse genetic makeup, and can be quite variable in hardiness, temperament, and eventual type of plant that will result. Even for experienced farmers, it can be impossible to identify the plant when in its seedling form.

We must be on the watch for all sorts of maladies that can threaten the precious young crop. We work to harden off the seedlings to prevent transplant shock when they first arrive. We spend a great deal of time worrying about a plant that is not doing well and always trying to find the best mix of organic nutrients, mulch, light, pinching, pest control, and even pruning when needed. We are called on to apply any new farming theory to the realities of our local soil conditions, temperature zone, and rainfall, using the experience and wisdom we have acquired along the way. We use crop rotation techniques in the third and fourth years to maximize growth and vitality.

We have been fortunate over the years that the soil in our academic fields has been fertile as has the minds of the growing learners. And, we do protect that soil. The upper stratum of earth and vegetable mold is filled with our seedlings' roots and is precious. The harvests of our academic health science centers have been prolific by many measures over the years, though the particular crops have not always been those favored by the local populace or most needed to fill deficiencies that exist. Growing conditions have begun to deteriorate, and the environment is changing in many places around the country. Finding money and ways to keep down costs have reached critical proportions at some of our academic farms.

As predoctoral workers, we are not the managers of the farm or even the folks who often see the mature plants. We work day by day, get dirt under our nails, and tend our patches of educational soil until the 4-year old plants are ready to be transplanted to specialized residency fields. It is there that much-different doses of learning and service are given in a new environment that demands strength, flexibility, and rapid growth. Specialty farming theories are also under evolution, with new requirements for periods of rest and daylight, distributors increasingly unable to deliver desired quantities of certain types of residents, and an increasing variety of those that do arrive.

In these farm landscapes, silos can be seen and serve a useful purpose, though they can also present a danger. Silos have been around since the early Romans when they were in the form of covered pits. Nowadays, most are upright cylindrical structures for making and storing silage. Silage is green feed/chopped-up fodder such as corn stalks that can be stored in silos for up to several years. During this time, heating and fermentation will occur so that when it is fed to stock during winter months, all parts of the original crop will have been able to be consumed. This allows farmers to reduce waste, increases the value of the crop, and ensures ready availability of food year round. Silos do represent dangers to the farm workers; deaths are reported every year from exposure to toxic levels of carbon dioxide and nitrogen dioxide that build up shortly after the silos are filled. Safety measures include being on the lookout for signs of toxic buildup, ventilation, and never entering the silo without

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From the Department of Family and Community Medicine, University of Missouri-Columbia.

someone else being around who can keep you in eyesight and call for help if needed.

The family medicine farm is under stress. There are dwindling government subsidies, deflated market prices compared to other specialties, crops are getting more and more expensive to plant and produce, and it is getting harder to get the younger generation to return to or stay on the family farm. Costs are skyrocketing, and some are giving up traditional parts of their farm operation, such as obstetrics. Experienced family farmers are talking together and meeting to look at the whole process from initial seed nurturing to seedling selection; efforts are also being focused on how to identify and share best cultivating and marketing practices and how to keep the family farm and the farmers as productive and healthy for as long as possible. We continue to be proud of the quality, value, and safety of our products and believe that they are good for the health of our patients and communities. We have stayed connected to the land and its complex ecology of biology-psychology-sociology.

Farming has always been a complicated process, and it is no surprise that cooperatives have been a common survival strategy over the years. Farmers have often joined forces to help neighbors in times of plenty and in times of hardship. Even neighbors as diverse as farmers and cattlemen have joined together in issues of common interest while remaining clear on their many differences. These are stressful times for the largest academic corporate farms to the smallest family farms. Cooperation is still important, as is sharing our accumulated knowledge and wisdom, making sure we meet the needs of the people and communities we serve and protecting the soil, water, and air on which we all depend. I think we still need some of those silos to help store and protect our history, retain what is distinct and unique, and make sure we are sustained through cold winters and bad weather. But, we have to be smart about them and careful. We need to air them out from time to time and ventilate our concerns, make sure toxicity is minimal, and not go it alone. It is too dangerous unless we look out for each other and are prepared to help each other out.

> Gardens, scholars say, are the first sign of commitment to a community. When people plant corn, they are saying, 'Let's stay here.' And by their connection to the land, they are connected to one another.—Anne Raver

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For the Office-based Teacher of Family Medicine

William Huang, MD
Feature Editor

Editor's Note: In this month's column, George Henning, MD, and John George, PhD, of Penn State University Department of Family Medicine, discuss evidence-based medicine instruction to medical students "in the field."

I welcome your comments about this feature, which is also published on the STFM Web site at www.stfm.org. I also encourage all predoctoral directors to make copies of this feature and distribute it to their preceptors (with the appropriate *Family Medicine* citation). Send your submissions to williamh@bcm.tmc.edu. William Huang, MD, Baylor College of Medicine, Department of Family and Community Medicine, 5510 Greenbriar, Houston, TX 77005-2638. 713-798-6271. Fax: 713-798-8472. Submissions should be no longer than 3–4 double-spaced pages. References can be used but are not required. Count each table or figure as one page of text.

Teaching Evidence-based Medicine in a Small Rural Family Practice Office

George Henning, MD; John George, PhD

As a family physician practicing in a small rural town in central Pennsylvania, I was amazed to find that I was being asked as a preceptor for third-year primary care clerkship students to help teach evidence-based medicine (EBM). My question was how could I, a busy practitioner in a small rural office, possibly contribute to the education of a third-year medical student on the application of EBM in my practice? I always thought that the ability to utilize EBM was reserved for those faculty fortunate enough to teach in large academic medical centers where time and access to electronic resources were not a problem. However, after participating in the faculty development program offered by Penn State College of Medicine and administered in my office, I was astounded to learn that I could have a great deal to offer to the education of medical students in this area.

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From the Department of Family Medicine, Penn State University.

As you all know, EBM is nothing more than the integration of the best, most up-to-date research evidence, expert clinical expertise, and the patient's own values or preferences. After learning about EBM, the question we all asked was "Haven't we been practicing EBM all along?" but upon reflection, I noticed that I was as guilty as others in that I have not always carefully assessed the evidence on which I based my clinical practice.

Thanks to the training provided by the faculty of Penn State, I can now truthfully say that as a rural preceptor I can make a significant impact on the education of third-year students by modeling for them how EBM can be used in a practice such as mine.

First, some background information on the program in which I precept. Penn State University's College of Medicine, through the Center for Primary Care, has a required third-year primary care clerkship. Since this clerkship was designed to provide students with an experience in primary care, there is a great opportunity to demonstrate across the disciplines of internal medicine, family medicine, and general pediatrics the application of principles of primary care. Students are assigned to my office for a 4-week period and work alongside me for 40 hours a week. Recently, as part of the curriculum for the clerkship, the College of Medicine asked preceptors if we would be willing to learn how we could model application of EBM in our practices. Students

at Penn State are gradually introduced to the concepts involved in EBM throughout their first and second years of medical school. With such background courses as biostatistics, in which they learn the art of critically appraising articles through an introduction to EBM in year two, the students are introduced to the basic knowledge and skills required to do EBM. Unfortunately, the students, when evaluating the courses, indicated that they often lack a feeling for the applicability of EBM to medical practice and thus were not paying sufficient attention during this instruction. Therefore, the third-year primary care clerkship curriculum was revised to incorporate EBM as a practical application for third-year students and to allow students to see how practicing physicians can use EBM on a daily basis.

Based on the training provided, I can now report that teaching EBM in a busy rural practice is not only practical but desirable. The first step in EBM is generating the clinical question. Obviously, whenever physicians see a patient, they often leave that exam room with some underlying questions in their minds that they're not sure about. The questions are often whether or not there has been a change in the approach to treating a particular disease or if there is a better test that could be ordered or a new therapy that might be tried. Regardless, we always walk away with underlying questions. The trick is to learn to write those questions down and save them for a later period. So, when students arrive in my office and begin to see patients, I ask them to intentionally make notes at the end of each patient's session on what questions were raised in their minds regarding the patients or the underlying disease process that they have just seen. At the end of the day, we gather to review what we have learned from the day, and that's when our list of questions come out, and we begin to think about how we could build some good clinical questions that would help guide us in a search for answers.

Particularly helpful in this process is to consult the Web site developed by Penn State at www.hmc.psu.edu/cpc/ebm. This Web site has as part of its content a four-step process for working through EBM. There are simple, clear instructions on each of the four steps used in applying EBM.

The first step is asking the well-built clinical question. By looking at the kind of issues that provoked questions in our minds after seeing patients, it is easy to refer to the Web site and begin to build some good clinical questions. Then it's a matter of going to the various EBM search sites that have been incorporated into this Web site and choosing one of those sites. Useful sites include POEMs, the site developed for family medicine, or Best Evidence, the electronic version of the American College of Physicians Journal Club, or the Cochrane Library, which is a collection of medical analysis on a variety of clinical issues. Picking one of these, we are able to enter our clinical question and see what kind of results we can get. Often, we will search several different sites so that we can compare the results from each site and determine which site can provide the best information for our application. Once we have narrowed the search and collected the evidence, we can then work through appraising the evidence. The Web site has provided worksheets for the students and me to use in helping us work through an appraisal of the evidence. Finally, we get to the most important part, which is a discussion about whether the findings presented in the article can be applied to the patient population in a practice such as mine given their economic, social, and financial considerations. It is in this last step that the preceptor is most helpful in bringing reality to the student in terms of the application of the findings. Yes, there may be a new drug on the market, but is it affordable and accessible to the patient given the patient's type of payor?

Helping medical students understand the realities of practice and the application of these findings is a key component that the rural preceptor can add to the student's education. Participating in this program and providing an opportunity for students to work alongside a preceptor using EBM within our practices allows students to see how simple and easy it can be for a physician to review evidence and investigate ways of doing things within a practice. This process also allows the integration of factors regarding family, economics, social histories, culture, and religious implications into the application of clinical findings.

An added benefit to me as a preceptor is that starting to model this behavior for the students has caused me to improve the care I deliver to my patients. By reexamining many of the habits I had developed over the years, I have found that there may be better and different ways that can be incorporated into my practice and, ultimately, my patients are the winners.

If you are ever given the opportunity to help teach EBM to medical students, do not feel that this is something that only an academic physician will have to do, but, in fact, you can become a positive role model for students in demonstrating how EBM can be applied successfully in a busy practice. You may find that teaching EBM principles will actually help you improve the care delivered to your patients.

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Joshua Freeman, MD
Feature Editor

Editor's Note: Send submissions to jfreeman3@kumc.edu. Articles should be between 500–1,000 words and clearly and concisely present the goal of the program, the design of the intervention and evaluation plan, the description of the program as implemented, results of evaluation, and conclusion. Each submission should be accompanied by a 100-word abstract. You can also contact me at Department of Family Medicine, KUMC, Room 1130A Delp, 3901 Rainbow Boulevard, Kansas City, KS 66160. 913-588-1944. Fax: 913-588-1910.

The University of Missouri Rural Obstetric Network: Creating Rural Obstetric Training Sites for a University-based Residency Program

John E. Delzell, Jr, MD, MSPH; Erika N. Ringdahl, MD

This paper describes a rural obstetric experience that was developed for a university-based family practice residency program and designed to increase the number of deliveries per resident, the number of graduates practicing in rural areas, and the number of graduates doing obstetrics. Rural hospitals can be a source of deliveries for residency training programs. This rural obstetric experience also offers more training months in a rural setting and more months training with family physicians.

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Statement of the Problem

There is a need for more rural family physicians, particularly those who provide maternity care. Many rural areas lack obstetrical services if their local family physician does not do obstetrics. Only 30% of family physicians practice obstetrics, and the number has declined significantly over the past 20 years.[1] There is evidence that the use of rural training sites for obstetrics during residency encourages rural and obstetrical practice after graduation.[2-5] Specifically, the more exposure and time spent in rural areas, the more likely a residency graduate is to go into rural practice.[6] While not specifically stated in the Program Requirements for Family Practice, the Residency Review Committee for Family Practice (RRC) generally expects each family practice residency graduate to have performed a minimum of 40 deliveries. Many family practice residency programs struggle to find the obstetric training opportunities to meet the minimum standards set forth by the RRC.[7,8] This problem can be acute in areas of the country where family physicians are not typically providers of maternity care, such as in the Northeast and in hospitals where there is a competing obsteterics residency.[9] This paper describes a rural obstetrics experience designed to increase the number of deliveries per resident, increase the number of graduates practicing obstetrics, and increase the number of graduates practicing in a rural area.

Background

Since 1973, the University of Missouri-Columbia Family Practice Residency Program has used multiple training sites for obstetrics to provide an appropriate experi-

From the Department of Family Medicine, Saint Francis Family Practice Residency Program, University of Tennessee (Dr Delzell); and the Department of Family and Community Medicine University of Missouri-Columbia (Dr Ringdahl).

ence for our residents. In 1995, we began to develop a network of rural obstetrics training sites in an attempt to increase deliveries for residents, increase the number of graduates practicing obstetrics, and increase the number of graduates practicing in rural sites.

Methods

We developed criteria (Table 1) to select new training sites. Two sites initially met our criteria, and interested residents participated in pilot rotations at those sites. Most preceptors were graduates of our program and had previously precepted for medical students; therefore, no formal faculty development was done prior to beginning the rotation. Federal residency training grant dollars were used to reimburse resident mileage to the rural site and to provide housing and computers in each site. Each site was given $3,000 per year to help offset the costs of on-site coordination of the rotation.

Both pilots were successful, and at the present time, our residents have the option of a 1-month rural obstetrics rotation in either Washington or Houston, Mo. Washington is a town of 12,282 that is 96 miles from Columbia. Residents work with eight family physicians and five obstetricians. Houston is a town of 2,023 that is 160 miles from Columbia. There, residents work with three family physicians. In both sites, the residents' primary responsibility is to staff the labor and delivery suite. However, if there are no obstetrics patients, residents participate in prenatal clinic visits, emergency room visits, or practice management activities with their preceptors.

Program Evaluation

At the end of each rotation, preceptors evaluate the residents, and the residents evaluate the experience and the teachers at their site. In addition, each resident documents all deliveries and procedures and submits these for entry into the residency program database. Practice locations for graduating residents are recorded. In addition, graduates are surveyed every 3 years to update their practice demographics.

Results

The Rural Obstetrics Network was implemented in 1995. Two groups of residents were compared—those graduating from 1988 to 1994 and those graduating from 1995 to 2001. There were 79 graduates between 1988 and 1994 and 81 graduates between 1995 and 2001. The percentage practicing in rural areas was 38% in both groups, but the percentage that included obstetrics in their practice increased from 30% to 41% (Table 2). Additional benefits of the program include an increased number of months training in rural sites and an increased number of months that residents learn obstetrics from family physicians.

Discussion

A rural obstetrics rotation can enhance a residency program's obstetrics training and at the same time provide a valuable experience for residents who are interested in rural practice. According to data from the American Academy of Family Physicians (AAFP) in 2001, 30% of family physicians were performing routine vaginal deliveries.[10] At the same time, 34.6% of family physicians under the age of 36 (an age that is comparable to new graduates) were practicing obstetrics.[1] By using rural obstetrics training sites, we have increased the number of graduates who have included obstetrics in their practice after graduation. It is also important to note that the use of these rural sites increased the time spent learning obstetrics from family physicians and increased the number of months of training in a rural setting. At the University of Missouri-Columbia, the Rural Obstetrics Network has improved our obstetrics training and at the same time complements our rural mission.

Table 1

Criteria Used to Select Rural Obstetrics Training Sites

- Within 200 miles of residency program base
- More than 30 deliveries per month
- Interested and effective family physician preceptors

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Table 2

Outcomes

Outcome	*Pre-rural Sites (1988–1994)*	*Rural Sites (1995–2001)*
Available months learning obstetrics from family physicians	5.5	7.5
Available rural training months	3	5
# of graduates practicing rural areas	30/79 (38%)	31/81 (38%)
# of graduates practicing obstetrics	24/79 (30%)	33/81 (41%)

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Lessons From Our Learners

William D. Grant, EdD
Feature Editor

Editor's Note: Submissions to this column may be in the form of papers, essays, poetry, or other similar forms. Editorial assistance will be provided to develop early concepts or drafts. If you have a potential submission or idea, or if you would like reactions to a document in progress, contact the series editor directly: William D. Grant, EdD, SUNY Upstate Medical University, Department of Family Medicine, 475 Irving Avenue, Suite 200, Syracuse, NY 13210. 315-464-6997. Fax: 315-464-6982. grantw@hscsyr.edu.

Requiem for a Resident

John E. Halvorson, PhD

Even before her illness, Liz was a teacher. Perhaps we didn't think of it so much then, but just the way she was, was instructive. We were aware of her fine academic record, strong endorsements, and desire to be a rural family doctor. Following a month's rotation with us as a fourth-year medical student, we were beginning to know her personally and gladly found that our compatibility resulted in a match for our residency program. From the start, her presence was stimulating: for her energy, for being so pleasant to be around, and for her intellectual brilliance. She obtained in-training exam scores as an intern well above what most third-year residents achieve.

What Liz taught us was how to live, in the face of death, whenever it may come. From the first blood test, suggested by a fellow resident when Liz was so pale, through several courses of chemotherapy and a bone marrow transplant, Liz sought the best advice and was willing to try every reasonable possibility for cure. She did battle, courageously and tenaciously. She endured hair loss several times, joking about how fortunate it was that she had such a beautifully shaped head. She had eggs harvested and stored for later use to have the children she desired.

While Liz battled and planned optimistically, she also lived actively in the present, knowing that there may be no future. She talked with and e-mailed friends. Friends? We were her family, and she was ours, perhaps more so than her traditional family. She supported us as much as we supported her. She and Jeff, the soulmate with whom she planned the rest of her life, planted and tended their garden, took walks, and were in her beloved mountains and desert as often as possible. In the residency, we held a place for her return whenever that might be.

Somehow, losing someone so young (29) and capable seems more tragic. Also, coming from our midst made the lesson of life's uncertainties and our vulnerability all the more poignant. For many of our residents, the loss of someone close was a new experience. These young medical warriors were gearing up to do battle with disease, aging, and death as the enemy—but not part of our camp. The closeness of Liz made this life experience profoundly personal, the reality of intrusive disease and ultimately death no longer a medical matter that could be held at professional distance.

Prompted by seeing the marginal edge to which she clung to life and the uncertainty of her future, many in our program appreciated with renewed awareness how fleeting and fragile life is and looked inward to discover or reaffirm what is important in their own lives.

Other feelings were stirred too. Neither life nor death are simple. Several close friends were angry at Liz. In following her heart, she had sometimes disappointed, even hurt, others. She was not perfect. Some found that it is difficult to support someone who is suffering when one

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From St Mary's Hospital Family Practice Residency Program, Grand Junction, Colo.

has mixed feelings about that person, eg, anger or disapproval. Guilt can emerge as if one should not have those feelings. A dying person does not become perfect, mixed feelings are not always resolved, and unfinished business may remain undone. It was a burden for some to know how to respond to Liz and her condition when they had not been that close before. What do you say, what is expected, how do you appear to others in your response? There can be a concern about proper etiquette and protocol; one does not want to appear uncaring. Yet, one may not feel moved to care so deeply in the circumstance of not knowing the person well. Perhaps it is not wanting the added burden of another's troubles or not being personally ready to tackle one of life's big questions. Liz's condition was thereby a teacher, raising unavoidable issues that required attention.

Now, life goes on for the rest of us. One resident recently commented, perhaps somewhat apologetically, how the residents find themselves thinking less often of Liz. A life is over, and the living get along without the one who died. Just as we feared. Or perhaps as it should be. Where is the meaning of a life? A death? What can we learn from it?

What Liz helped me relearn is that life is fleeting, uncertain, and wonderful. Live it when you can. I hope this is the lesson our young physicians have learned from Liz too.

The following, Liz's favorite poem, was included in all her e-mails during her last year:

YES
It could happen anytime,
tornado, earthquake, Armageddon.
It could happen.
Or sunshine, love, salvation.
It could you know.
That's why we wake and look out.
No guarantees in this life.
But some bonuses,
like morning,
like right now,
like noon,
like evening.

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Literature and the Arts in Medical Education

Johanna Shapiro, PhD
Feature Editor

Editor's Note: In this column, teachers who are currently using literary and artistic materials as part of their curricula will briefly summarize specific works, delineate their purposes and goals in using these media, describe their audience and teaching strategies, discuss their methods of evaluation, and speculate about the impact of these teaching tools on learners (and teachers).

Submissions should be three to five double-spaced pages with a minimum of references. Send your submissions to me at University of California, Irvine, Department of Family Medicine, 101 City Drive South, Building 200, Room 512, Route 81, Orange, CA 92868-3298. 949-824-3748. Fax: 714-456-7984. jfshapir@uci.edu.

Service Above Self

Lieutenant Colonel Brian Unwin, MD

In 1995, I purchased a reproduction print of a 1942 Army Medical Department war poster titled "Service Above Self" when I became program director of the Family Practice Residency Program at Eisenhower Army Medical Center, Fort Gordon, Ga. The print depicts a combat medic offering water to a wounded comrade on an active battlefield. Above the medic, the words "Service Above Self" are inscribed. At the time, I simply liked the message and the artistry involved and the relevance of the print to my profession as a military family physician. Part of the success of America's military is the fact that our soldiers count on the presence of a trained and ready medical force to care for them in battle—what we call a "combat multiplier."

My use of this print as an interview device has taught me much about residency applicants and continues to enlighten and guide my thoughts as I continue my service. I started using it that summer during a particularly unremarkable interview with yet another applicant for whom I felt I really hadn't developed an understanding. In that moment of frustration, I asked the applicant to "interpret" the print that was positioned above my head. What followed was a very pregnant pause; the body language registered a "what's the answer he's looking for?" discomfort. He then stated what I felt was a superficial interpretation of our responsibilities as physicians to care for our patients. In that moment, I had found a gold mine of real applicant information and decided to use the print for subsequent applicant interviews.

In 7 years of interviewing family practice residents and listening to their reflections about "Service Above Self," I have discovered that there are, in general, three types of responses. The first response type is of the "duty, honor, country" variety. The second is purely descriptive and literal, focusing on the words and actions displayed in the painting. The final response variety is of a "personalization" of the actions and words. Although no single student response fits cleanly into only one category, these themes consistently appeared during all resident interviews. Beginning in 2001, the Family Practice Residency Program at Darnall Army Community Hospital conducted a faculty group interview process of student applicants. The picture interpretation was included in many of the interviews that were conducted, and the pattern of responses still seemed evident.

"Duty, honor, country" response themes are in some ways expected in light of our student applicant pool that comes from individuals with military obligations from the Uniformed Services University of the Health Sciences, West Point, the Reserve Officer Training Corps, and the Health Professions Scholarship Programs. Responses with this theme are often characteristic of individuals who could be envisioned as career military medical officers.

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From the Department of Family and Community Medicine, Darnall Army Community Hospital, Fort Hood, Tex.

These individuals might typically draw on their prior military experiences and training to relate that this print depicted the essence of what they were "called upon" to do. For many, the picture symbolized the entire reason for their joining the military medical profession. The self-sacrifice implied by the background war scene and explicit wording were felt to be core to the job of becoming a military medical professional.

The "describers" could be characterized as individuals who conducted their interpretation in much the same way as they might analyze a chest X ray: they noted the calm in the soldier-medic's face, the offering of simple comfort through the provision of water, the evident professionalism of the medic caring for the wounded soldier. The words "Service Above Self" served as an overall impression of the work.

My personal reflections on this category of responses are that these students approached the interpretation in a clinical manner, seemingly searching for the clues to the right answer. These individuals were often caught off guard by the nature of the interview question. For some, their physical and verbal behaviors suggested a struggle in creating an unscripted, coherent response.

The "personalizers" are by far the most memorable. The first response from one applicant was, "It scares the hell out of me." The discussion that followed was a frank, open conversation about the challenges of providing care to patients, the challenges of military service, and the real threat of giving up one's life to save another.

Another memorable exchange occurred during a group interview that included an applicant with extensive past military experience. After viewing the picture and receiving the question, a profound silence followed, and the faculty participating in the interview felt the intense emotion building in this particular applicant. Finally, through tears, the applicant shared his grief over lost friends and the roles they played in his life and he in theirs.

The effect of art on different audiences was evident when the painting was presented as a topic for discussion to the spouses of new military family practice residents. The intended purpose of this discussion was to orient spouses to the importance of military family support groups and the unique demands placed on our soldiers. The goal of the discussion was to explore feelings, beliefs, and coping mechanisms for dealing with the job stressors of being a military physician. My wife, a veteran of my Somalia deployment during Operation Restore Hope, was the group leader.

We were unprepared for the depth of fear, anger, and worry for their spouses that the painting unmasked in these men and women. All worried for the physical safety of their spouse if deployed to a hostile environment. All displayed angst for the mentality of "service above self" and how the residency would potentially disrupt family life. All prayed for "uneventful" military service.

Several of these spouses are currently waiting for their soldier-physicians to return from their service in Afghanistan and a potential war with Iraq. My wife and I hope that discussion 6 years ago prepared them in a small way for the separation, fear, and reunion that stems from the deployment of their "medics" to America's war on terrorism.

Our residency faculty do not believe that there is one "right" answer to the challenge posed by the "Service Above Self" painting. Rather, it is its ability to convey humanistic qualities that we value most. The group interview environment stimulates a sharing and collective interpretation of responses that would otherwise not be available if the interview were conducted in a one-on-one fashion. Our faculty view the group interview process as one that allows for more-open discussion and interpretation of applicant attributes and responses. In addition, it allows each faculty member to develop a greater understanding of the values and belief patterns of colleagues.

The painting also affords an opportunity for individual faculty to share personal insights and program objectives with the potential resident. In personal discussion with applicants, I often share my own interpretation of the painting that

(This print was originally commissioned by the US Army.)

has developed through my clinical practice and position as an educator of young physicians. In particular, I express my fervent hope that I demonstrate the same degree of compassionate, professional caring for my patients as that exhibited in the painting. I disclose my hope that I will never again be called on to go to war for my country, yet my willingness to do so if called again. I offer my interpretation that the patient cared for in the painting could also represent my family and friends whom I love and support. I offer that the patient could be me and that I must care for myself. Finally, as a leader in the department, I need to care for the residency program with the same dedication as the medic in the painting cares for the patient.

"Service above self" can occur on the battlefield of a war. More often, it is conducted in the privacy of the clinic exam room or the middle of a long on-call night admitting people with diseases and injuries that are often brought about by self-inflicted wounds. The explosions, devastation, bombs, and bullets may be real at times but more often are found in the challenges of juggling the demands of our profession, family, and personal needs.

Art is important because it is expression without words. The interpretation of art allows for limitless expression of beliefs and attitudes that may be similar or different from our own. The emotions uncovered by interpretation can allow for true communication and insight into an individual's soul.[1]

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