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Training the Urban Health Care Provider: One Department's First Steps

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As our country faces a national crisis in health care, few have outlined plans to improve the shortage of primary care physicians. This is especially critical in urban areas where sociocultural impacts on health are large. The Department of Family Practice and Community Medicine at the University of Texas School of Medicine in Houston has begun development of a division of Urban Family Medicine to address the special training needs of the urban family practitioner. Subdivisions that have been formed focus on undergraduate curriculum, graduate educational strategies, service, and research and policy to further develop the training model. (Henry Ford Hosp Med J 1992;40:26-8)

Over 37 million Americans are currently living without health insurance (1) while total costs of health care delivery are increasing faster than the cost of living index (2). These factors have prompted the nation's health experts to be involved in a crucial debate about the direction that health care reform must take. Resolution of this health care crisis is particularly critical for those Americans comprising our urban indigent and vulnerable populations. Like their rural counterparts, the urban underserved have found access to affordable primary care services difficult in most of our major metropolitan areas. Some of the difficulty can be traced to the movement of the middle class into the suburbs and the resultant economic climate of the inner cities. Primary care physicians during that era often chose to move with the middle class in an effort to maintain living standards. Inner-city hospitals became increasingly indigent care institutions as their primary care physician referral base dwindled. Medicaid reimbursements during the 1980s did not keep up with inflation, resulting in decreasing enrollment by physicians which further exacerbated the access crisis. Teaching institutions also came under increasing pressure to develop revenues from practice activities which resulted in more restrictive policies affecting indigent care. The effect on access to care for the urban underserved was dramatic. Between 1965 and 1980, as the American medical community experienced a large shift toward specialization, the number of general practice physicians in major urban areas declined by over 10,000 (3).

Recent discussions about reforming our nation's health care system have largely centered around health care systems' organization and financial reimbursement. However, a current and future deficiency in primary care provider manpower trained to target the urban environment has largely been overlooked in the discussion. For example, while a 1991 issue of *JAMA* was devoted to health care reform, only one of more than 12 different proposals to address the current crisis gave any emphasis to the need for primary care providers as part of the solution (4). Without primary care physicians adequately trained not only to deliver excellent clinical care but also to practice principles of community-oriented primary care (COPC) and cross-cultural medicine, the urban underserved are unlikely to benefit dramatically from health care reforms currently being discussed.

If fiscal reform does take place, one might ask if the much heralded oversupply of physicians (5,6) will not cause the now "covered" urban underserved to have ample access to a primary care provider. The answer, in my opinion, is an emphatic no. From the mid 1960s to the mid 1980s, the United States had a net loss of primary care physicians. We have seen a steady decline during the past decade both in enrollment in primary care residencies and in medical student interest in primary care. Between 1987 and 1990, the total number of graduating students choosing family practice residencies declined by 100; internal medicine was the choice of 274 fewer graduates; and pediatrics had a net loss of 27 student graduates (7,8). In 1991, less than 10% of senior medical students chose family practice as a career (7). This decrease in student interest, coupled with the overall underrepresentation of African-Americans and Hispanics in medicine (9), means that patients currently underserved by urban primary care are likely to remain so despite financial reform.

The curricular structure and location of graduate training programs in family medicine also give little hope that we will meet our urban primary care manpower needs. Many training programs were started in suburban or more rural areas of the country and, as expected, their graduates practice in similar settings. In the successful residency program most closely linked with our department, not one graduate in the past ten years entered a

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practice serving Houston's urban underserved. Despite some feeling that a good primary care provider can flourish in any environment, be it urban, rural or suburban, the unique issues of the urban underserved require special skills that only a few training programs now provide.

Urban Family Medicine

With these factors in mind, in the past year our Department of Family Practice and Community Medicine has begun the development of a Division of Urban Family Medicine to specifically address educational and research issues unique to training the urban primary care provider. Located in the nation's fifth largest city, the University of Texas School of Medicine has developed in the midst of the Texas Medical Center. This medical metropolis employs more than 55,000 persons in its 40 affiliated institutions. The school and our department have provided most of the clinical teaching in private hospitals in the Texas Medical Center or around the greater Houston area in the past two decades. Although much care could be termed "nonreimbursed," the department had minimal clinical activities with the urban underserved of Houston. That care was largely provided by three major entities: the Harris County Hospital District (HCHD), the Harris County Health Department, and the City of Houston Department of Health. The city and county health departments provide preventive care, including low-risk prenatal clinics, sexually transmitted disease services, and well-child services, whereas the HCHD provides the curative care, including high-risk prenatal care and chronic disease maintenance. Since its inception in 1965, the HCHD has been affiliated with Baylor College of Medicine. Specifically, Baylor provided housestaff and faculty supervision at the two HCHD hospitals and faculty at the network of community health clinics that provided primary care services.

During the late 1980s, the HCHD elected to build two new full-service hospitals to replace the aging existing facilities. The HCHD requested the University of Texas School of Medicine to consider entering into an arrangement at one of the hospitals (LBJ Hospital) similar to that which had existed for Baylor College of Medicine. As this arrangement included providing physician staffing at the community health clinics in the catchment area of LBJ Hospital, the Department of Family Practice was approached to provide that staffing. The department had simultaneously begun plans to develop a residency program in part based in the medical center and a curriculum for a mandated third-year medical student rotation in Family Medicine. We saw these three separate charges as an opportunity to coordinate the teaching, service, and research that would occur in the urban environment by expanding our clinical, undergraduate, and graduate teaching activities into the community health clinics and LBJ Hospital. Coordination of these separate activities was necessary in an effort to keep a continuity of purpose throughout the teaching and research activities.

As a result, the department formed the Division of Urban Family Medicine to bring together our urban activities and to develop a model of service, research, and education that would produce more physicians who choose to have all or part of their practice be with the urban underserved. The division's mission is:

> "To improve the health of the urban underserved through clinical services within Harris County; perform research in primary care; assume advocacy for the community's underserved; integrate the concepts that are unique to Urban Family Medicine into the department's education programs; and to examine, develop and promulgate policies that impact the wellness of urban dwellers."

The basic thesis of the division is that a coordination of teaching and research by mentors with a vision for indigent care can result in an experience for students and residents that enhances their interest in practicing in the inner city. We look to the Montefiore inner-city family practice residency in New York as an example of what can occur if a training program focuses on issues of the urban underserved.

In an effort to assist in the financial development of the division, the department applied for and was awarded a federal establishment grant beginning in the fall of 1991. These monies will aid the division in retaining urban family medicine experts from around the county as we develop the curriculum and divisional research activities. Since September 1990, the division has been working toward the goals stated in our mission without formal funding. The division has been administratively organized into four subdivisions: undergraduate, graduate, service, and research and policy.

Undergraduate

The undergraduate subdivision will be responsible for the development and implementation of curriculum pertinent to urban family medicine. These include COPC, cross-cultural medicine, health care delivery systems, sociocultural impacts on health, and health care advocacy. These topics will be integrated with our existing third- and fourth-year clerkships, with blue book electives that link urban family medicine with the MD/MPH program and with educational programs of our sister institutions in the Texas Medical Center. Students are being placed for clinical experiences with our faculty at the health centers where they work with mentors who will try to demonstrate the practical applications of urban family medicine concepts. We also intend to develop policy and advocacy electives for interested students who would be placed either locally or at state or national sites where policy development and advocacy for the poor occur. We are not quite a full year into the student clinical experiences but the feedback has been gratifying, enhancing our desire to complete the curriculum.

Graduate

The graduate subdivision will have curricular activities similar to those in our developing residency. Additionally, we will be attempting to establish resident continuity clinics at one or more of the community health centers. During the three-year residency program, we hope to have each resident participate in the development of a COPC project that will benefit their pa-

tients. We have plans to establish a fellowship in Urban Family Medicine in conjunction with the School of Public Health that would focus on an MPH as well as COPC research. We will be involved with the residency faculty in recruitment of potential residents who have an interest in the urban underserved. Early 1992 will see the start of our resident activities on a formal level.

Service

The service subdivision has been the most difficult to establish. We started with a premise that primary care providers trained to flourish in the urban environment are rare. This theory has proved true as we have experienced difficulty in locating and recruiting skilled faculty. Our faculty in this subdivision see over 60,000 patients annually in the four health centers and bring a family practice mind-set to the centers that is slowly changing the way patients are cared for within the clinics. Our goal is to have a full complement of faculty mentoring our students and residents which will in turn become a recruitment tool for our residency and later for our faculty.

Research and policy

The department was given the task of coordinating all research that occurs within the clinics, whether from the medical school or other institutions. This position allows us to shape the type of studies done to fit with our mission statement. In the past months literally dozens of projects have been discussed and developed, and the first few have begun data collection. Early in the course of developing the division, members of the department discussed the ultimate nature of our research activities. Inasmuch as we are able, we will try to encourage projects that will produce data for use in advocacy activities which are necessary to effect policy changes for our patients. The issue of research with an eye toward advocacy may raise some ethical questions in a medical school. From experience, I am aware of the amount of local and statewide advocacy in which physicians who care for the underserved are often involved. Often, data regarding important questions impacting funding of indigent care services are minimal, hindering the efforts of the physician in speaking for his patients. Good primary care physicians who have some knowledge of COPC are aware that speaking out for the indigent with only the power of anecdotes is often ineffectual. Policymakers want factual data drawn from the population under question. As we begin foundational data collection of our service population, divisional members will continue to be aware that data generated may be our only tool to increase funding for health care services provided to our patients.

Within this subdivision, activities of the faculty that promote urban family medicine in the public arena will occur. In the past several months faculty have been asked to be interviewed by local media. Others have been selected as content experts for various local, state, and national committees discussing health care for the underserved.

The Future

The first months have been exciting and difficult. With suboptimal financial support from the HCHD and the school, we have pieced together the framework of a division. We have become integrated into the HCHD decision-making process to the benefit of our patients, and we have been receiving high marks from students and residents alike for our efforts. However, we have had reduced public funding for services in the HCHD, delays in development of an inpatient service, and difficulty recruiting faculty.

With federal funding, the next three years should be productive. As our groups of students become residents, and later, hopefully, as some of our residents become Fellows and faculty, we believe we can have an impact on the primary care access for the urban underserved in Houston.

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