

Letters to the Editor

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Editor, Letters to the Editor Section

Editor's Note: Send letters to the editor to jscherger@ucsd.edu. 858-232-8858. 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

Urban Underserved Training Praised

To the Editor:

We appreciated reading "The Central City Site: An Urban Underserved Family Medicine Training Track"¹ and applaud the University of Wisconsin Department of Family Medicine for its efforts to train physicians to meet the needs of inner-city areas like Milwaukee. Knowing there are others out there committed to the same values and purpose as we are is always heartening.

We do, however, find inflated the claim that our colleagues are "pioneers of this type of program." We believe that our peers, and sometimes competitors for applicants, at places like Cleveland Metropolitan Hospital, Chicago's Cook County Hospital, Miami's Jackson Memorial Hospital, Philadelphia's Thomas Jefferson University, San Antonio's University of Texas, and the University of California, San Francisco, among many others, would feel similarly. The 39-year-old mission, curriculum, and outcomes of the Residency Program in Social Medicine (RPSM) of Montefiore Medical Center of the Albert Einstein College of Medicine were most recently described in the April 2008 issue of *Academic Medicine*.²

Other descriptive articles about the RPSM were published as a chapter³ in a 1987 textbook, *Urban Family Medicine*, edited by Richard Birrer, then of the Department of Family Practice of the SUNY-Downstate Medical Center in Brooklyn, and again in 1986⁴ and 1988.⁵

The RPSM is different from the University of Wisconsin program in that it is not a separate track within a family medicine residency, but the University of Massachusetts-Worcester and University of Rochester among others have long had urban tracks. Like the authors of "The Central City Site" article, we too "hope that our experiences will encourage and inspire others to use, and possibly improve, our model." Such motivated others should know there are several models of training residents for urban underserved communities out there, and some have been tried and true for decades.

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Authors' Reply:

Drs Gorski et al remind us that there are many organizations and institutions committed to training primary care physicians to work in underserved populations, some of which have been doing so for decades. The longevity of these programs and the significant outcomes seen are a testament to the quality of training provided and the good work being done.

Our program is, to the best of our knowledge, unique in being in a mid-size urban center rather than a major metropolitan region, and not being affiliated with an FQHC, but rather with a private health care organization. The smaller urban centers referenced, including Worcester, Mass, and Rochester, NY, from our research, still include urban training at an FQHC, which can be a very different setting from a privately funded nonprofit health center clinic. These qualities make

our training quite distinctive compared to many of the other institutions mentioned and perhaps opens the door to learners not seeking a larger urban center and to similar private institutions contemplating the provision of such training.

There continues to be a shortage of primary care physicians for underserved populations in this country, and there is certainly room for many different types of training in this niche—from large urban centers to urban training tracks, to FQHCs and, of course, in private health care centers. We can all be pioneers in this area and can learn from each other how to maintain our mission and goals to provide quality primary care and improve the health of our urban populations. Thank you for your interest.

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New Research

Measuring Behavioral Science Curricula in Family Medicine Residency

To the Editor:

Effective residency training in behavioral science is strongly endorsed by principal groups in family medicine. Nevertheless, residency programs put variable emphasis on behavioral science training and train residents using a variety of methods. A commonly used measure of resident and curricular performance is the American Board of Family Medicine (ABFM) In-training Exam (ITE). This study aimed to determine what features in behavioral science curricula relate to higher mean scores and score improvement on the psychogenic subsection of the ABFM-ITE.

Methods

The investigator e-mailed surveys to all family medicine program directors in the United States inquiring about programs' behavioral science curricula. He also requested permission to use program mean psychogenic subsection ITE scores for the study. The survey included 26 topics divided into five categories: program demographics, behavioral science instructors, teaching sites, teaching methods, and the degree of program emphasis on nine stated ACGME-required curricular elements. The curricular features were largely drawn from prior studies evaluating behavioral science curricula from family medicine residency programs in the United States. Curriculum performance was judged by program average third-year resident scores as well as improvement in average scores over 3 years of training.

Results

A total of 142 (31%) of all surveys were completed. Seventy-five programs (16%) also allowed permission to analyze their subsection scores. There was no difference in psychogenic subsection scores between the 75 programs analyzed and the mean subsection scores for all US family medicine residency programs. Nor was there a difference between the curricular features of the 75 programs studied and the 142 programs that completed surveys.

Curricular items that positively related to scores included: compulsory reading ($P=.01$ for mean third-year scores and $P=.02$ for Class of 2007 score improvement), instruction by either a behavioral scientist or physician but not both together ($P=.004$ for Class of 2006 score improvement), and behavioral science training in a non-psychiatric hospital ($P=.013$ for Class of 2006 score improvement). Reported curricular emphasis on three of nine topics required by the ACGME demonstrated negative correlations

with performance and improvement on the subsection: emotional aspects of non-psychiatric disorders ($P=.04$ for Class of 2007 score improvement), counseling and psychotherapy ($P=.01$ for mean third-year scores and $P=.04$ for Class of 2007 score improvement), and death and dying ($P=.01$ for Class of 2007 score improvement).

Conclusions

The observation that psychogenic subsection scores of the ITE relate very little to common teaching approaches—and even demonstrate a negative correlation with curricular emphasis on ACGME-required topics—brings the properties of the subsection into question. Specifically, it undermines the commonly held presumption that the subsection has content validity for measuring resident knowledge in the behavioral sciences. The psychogenic subsection seems to measure little of what is taught in family medicine residencies.

One limitation in the study is the small sample size and a potential for bias: only 16% of all family medicine residency programs both included surveys and gave permission to analyze subsection scores. Still, the programs analyzed seem to be an accurate representation of the general program population; the mean ABFM scores of the sample were the same as the general mean, and the curricular features of the sample were not statistically distinct from the larger body of programs that completed surveys.

This study supports prior recommendations to avoid using the ABFM ITE subsections to evaluate individual resident knowledge. It adds to that recommendation by suggesting against using subsection scores as rationale for grading or modifying behavioral science curriculum.

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