AN EVALUATION OF UNDERGRADUATE FAMILY CARE PROGRAMS

Edward B. Silberstein, M.D., and C. Jane Scott, B.A.

ABSTRACT: Evaluation of the many new family care programs (FCP), and others of similar intent, however defined, is as essential as determining the value of any other curriculum change. Replies to a questionnaire from 101 U.S. and 15 Canadian medical schools indicated that 80% of the former and 93% of the latter had FCPs; 35% and 29%, respectively, were not evaluating their program by any method. No single evaluative technique was used by more than 42% of the American medical schools. A review of the literature on FCPs frequently indicated that the conclusions that could be drawn about the programs were ambiguous.

Students in the University of Cincinnati Medical Center FCPs elected family practice or pediatric internships significantly more often than did the FCP nonparticipants, but they indicated that the program had little effect on this choice, despite almost uniformly favorable testimonials. We discuss the possibility that FCPs may be educating the wrong students, that FCPs, if not reinforced in other clinical areas, may have few lasting effects on student attitudes or career choice, and that we may be asking the wrong questions, and with inadequate methods.

With the increased concern for community health problems over the last five to ten years, there has come a proliferation of programs that purport to teach family, community, or primary care. How should one decide whether these educational innovations are fulfilling their objectives or are worth the expense, or both? This paper will summarize the attempts at evaluation of such programs and will indicate some of the problems related to these evaluations; we will also present the results of the study we made on the family care program (FCP) at the University of Cincinnati Medical Center (UCMC).

The Cincinnati FCP, begun in 1969, provides a second-year medical student with an eight-month opportunity to observe and assist in the care of a family; a family consists, at the minimum, of a pregnant mother, at least one other living child, and often the father or an extended family, or both. Preceptors in obstetrics, pediatrics, internal medicine, and family medicine, as well as a social worker, review each telephone call, clinic visit, or home visit of the patient and medical student. An intensive series of introductory orientation lectures provide the second-year student with the necessary basic information to assist in the delivery of health care; we also emphasize during the program the development of the student's first doctor-patient relationship. In the Harvard family care program, after which ours was modeled, difficulties were encountered.
when participation in the program was required\(^2\); for this reason, we have offered the FCP as an elective only.

One of our major concerns from the beginning of our family care program has been the problem of justifying its value in terms of the time and the expense involved. The cognitive skills involved in patient care are taught in other courses during the second and third years of medical school. Patient contact also begins during the second year in the course on physical diagnosis. Student exposure to our program could certainly be judged to result in the attainment of rather self-fulfilling course goals: "be a model of medical practice", "recognize the effect of illness on the entire family organization", "acquire first-hand knowledge of medically useful information that is difficult to obtain from a textbook", "become familiar with the available community resources", "provide a base for research", and so on. But does it? That was what we wanted to find out.

A study of the Harvard family care program, in which one of the authors participated, found no parameters (career choice, class standing, grades, case reports, or test scores) that differentiated between student groups who had and had not been in the program.\(^2\) Although there is some evidence, not conclusive, to substantiate the fact that comprehensive care can make a difference to the patient and the costs of care,\(^3\)-\(^5\) there seems to be no clear case that teaching family care or comprehensive care influences the future doctor to deliver this type of care, or even to improve the quality of his care. Teachers of family practice and comprehensive care have warned that unresearched conclusions should not be drawn about these programs.\(^6\)-\(^10\) Others have cited both the lack of objective evaluation and the difficulty, or even the feasibility, of making such an evaluation.\(^11\)-\(^13\)

With so many family care programs springing up,\(^14\)-\(^15\) and our own state legislature now mandating them, we felt that many other medical educators must be wrestling with the same task of program evaluation, although some may feel that the a priori value of such programs precludes the need for justification. Furthermore, the self-selection of individuals into a family care program may bias all evaluative attempts. We will describe our attempts to evaluate our program and to learn what other American and Canadian medical schools are doing. A survey of the literature on this subject was also made to supplement the data.

**METHODS**

**Other FCP Evaluations**

A questionnaire was mailed to the 117 American medical schools listed in the AAMC Directory and the 16 medical schools in Canada; all schools having programs, graduate or undergraduate, that relate to family medicine or comprehensive health care were asked to return a completed form. The questionnaire covered the type of program, a description relating to its duration, and