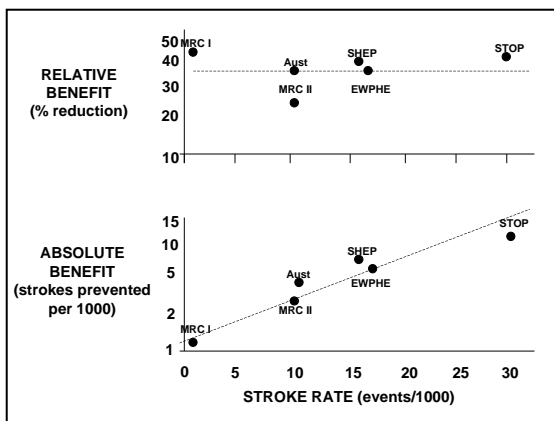


Primary Care Seminars: An Integrated Ambulatory Curriculum

An integrated curriculum that focuses on a graduated chronic disease model (screening, asymptomatic disease, symptomatic disease, symptoms as disease, etc.), evidence-based medicine, and doctor-patient relationship skills was created for the Boise VA residents in 1990.¹ A modified version was accepted by the *Educational Clearinghouse for Internal Medicine* in 1993.²

Over time, instructional methods have become more sophisticated. The main course is now delivered using case-method techniques. A difficult clinical decision from a faculty patient is described in detail (for instance a 45-year old with volatile blood pressure readings averaging 142/93). The residents are divided into two teams that initially organize their arguments 'for' or 'against' treatment or further testing. Questions that often come up during the above case include: "What 'costs' and 'benefits' may accrue for this young man who has no other risk factors?" "Does volatility suggest an underlying cause (alcohol, methamphetamines, or pheochromocytoma)?" and "What is the relationship between anxiety and hypertension?"



During the above module we avoid giving a 'state-of-the-art' lecture about current hypertension treatment (which will change), and focus instead on underlying principles for treating an asymptomatic disease. For instance, this figure (from the syllabus) shows that the relative improvement in stroke incidence for most randomized treatment trials is similar (~ 35%), but that the absolute cost/benefit for any given individual depends to a large degree on their specific risk. The seminar would also focus on how to obtain

and interpret existing evidence relative to these underlying treatment principles and the relationship skills necessary to negotiate treatment goals using this knowledge.

The curriculum also includes several experiential elements designed to create greater empathy and self-awareness including critical reflections, critical incidents, framing effects exercises, and role-playing.³

This curriculum has had impact inside and outside the Seattle program. The residency program adopted a modified version for Harborview in 1995 and for the primary care track in Seattle in 2008. The plan is to adapt it residency-wide in the near future. Faculty from Oregon Health Science University sent a team to observe our classroom techniques and also adopted the curriculum. More than 60 copies of the curriculum were requested from *Educational Clearinghouse* by programs nationwide.

¹ Smith CS, Lee DK (1991). *An ambulatory medicine curriculum with a progressive interactional focus*. Poster presentation. 6th Biennial Teaching Internal Medicine Symposium, Chicago, IL.

² Smith CS, et.al. (1993). 'Seminars in Primary Care' in *Educational Clearinghouse for Internal Medicine, 2nd Edition*. Published by APDIM and SGIM

³ Smith CS, Francovich C, Gieselman, J (2000). Description of an experiential empathy and self-awareness curriculum for medical residents. *Ann Behav Sci & Med Ed*;7(1):3-12.