FAMILY PRACTICE PLANNING

BACKGROUND DATA

COLLEGE OF MEDICAL SCIENCES

TABLE 1

Percentage Distribution of Active Physicians in Minnesota by Type of Practice, 1910-65

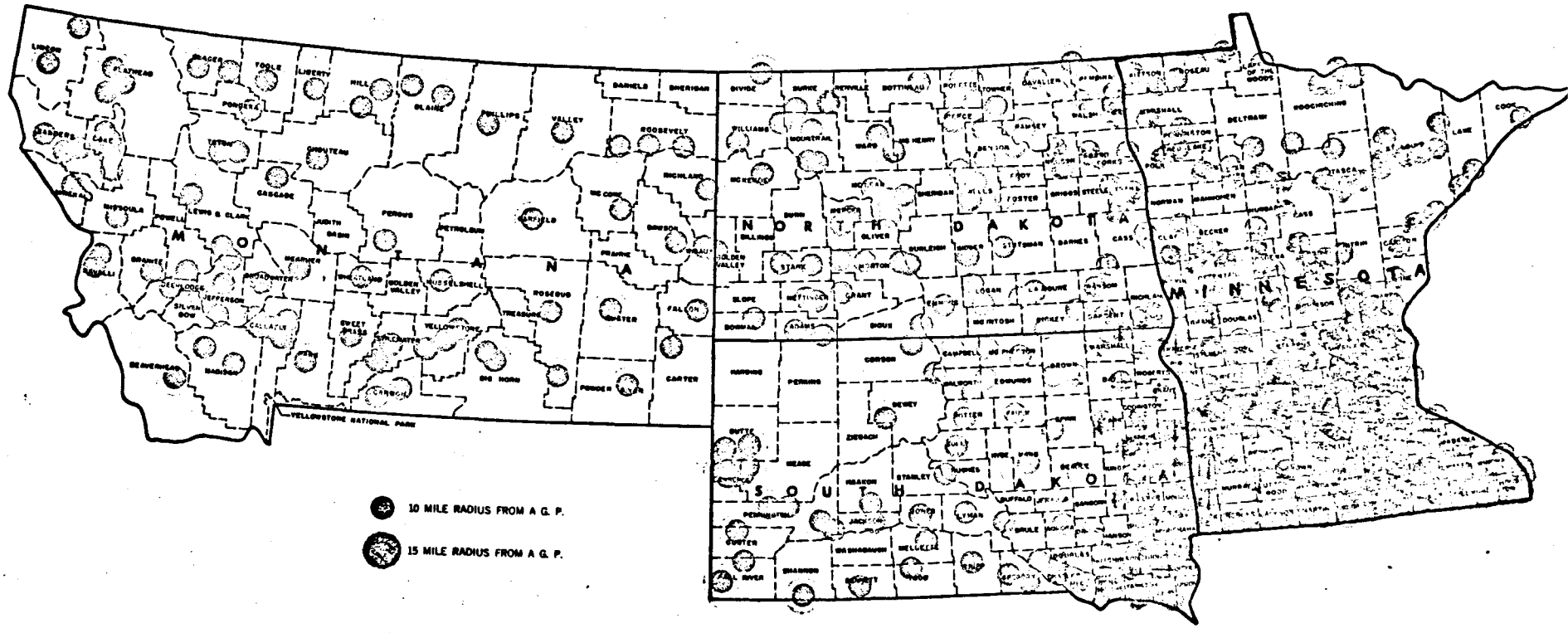
Field of Practice	1910	1920	1930	1940	1950	1960
General Practitioners	95.0	70.3	63.8	61.6	59.3	41.0
Medical Specialists	.5	3.8	8.0	7.9	10.7	18.3
Surgical Specialists	4.3	24.6	26.8	26.5	23.8	31.0
Psychiatrists and Neurologists	.2	1.3	1.4	1.1	2.2	3.6
Others	--	--	--	2.9	4.0	6.1
	100.0	100.0	100.0	100.0	100.0	100.0

Source: Health Manpower for the Upper Midwest

	1931	1940	1949	1959
United States - General Practitioners	71.7	62.4	47.4	34.7

Source: U.S. Public Health Service
Health Manpower Source Book

FIGURE 10: Map of Location of General Practitioners in the Upper Midwest, 1965.



Source: Health Man-Power for the Upper Midwest

NUMBER OF PHYSICIANS EDUCATED AT THE UNIVERSITY OF MINNESOTA PRACTICING OUTSIDE THE UPPER MIDWEST COMPARED WITH PHYSICIANS EDUCATED ELSEWHERE PRACTICING IN MINNESOTA - 1965

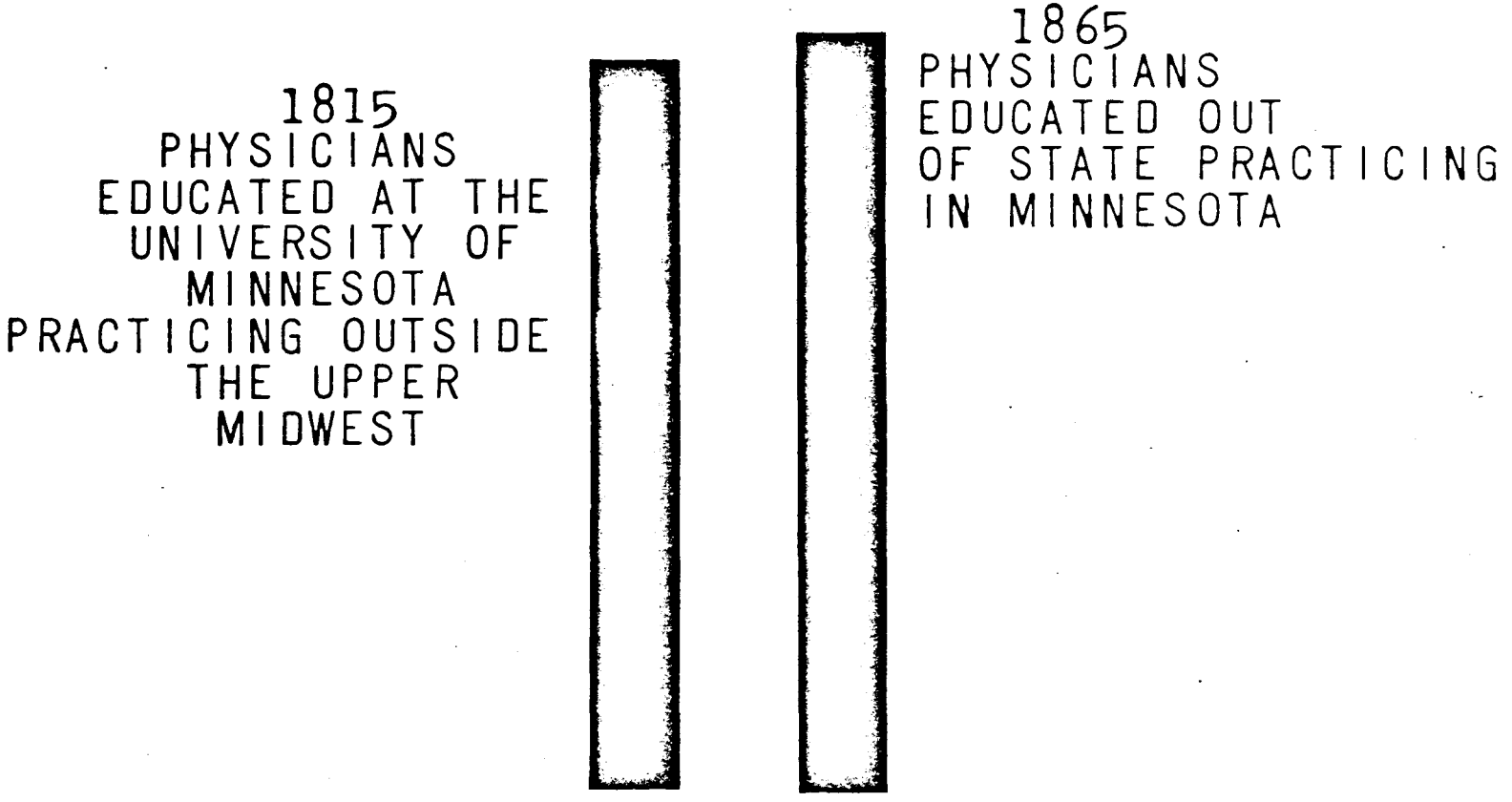


Table 3

TABLE 4

Percent of All Minnesota and Upper Midwest Physicians Educated in Minnesota, by Year

Year	Upper Midwest Percent	Minnesota Percent
1965	40	53
1960	42	56
1950	42	52
1940	41	52
1930	36	47
1920	27	39
1910	28	40

Source: Health Manpower for the Upper Midwest

TABLE 5

REQUIREMENTS TO MAINTAIN ACTIVE PHYSICIAN/POPULATION RATIO of 93: 100,000

	1965	1975
Minnesota Population	3,611,868	4,000,898
Physician increase needed		
for Population Increase		362
for Death		562
for Out Migration		683-745
Total Physicians Needed		1607-1669
Anticipated Supply of Minnesota Medical School Graduates		700
In Migration		700
		1400
Physician Deficit to be Supplied		207-269

Source: Health Manpower for the Upper Midwest

TABLE 6

Physicians Per Population for the U.S. and Minnesota by Urban-Rural Status of County, 1962

	Number of Physicians Per 100,000 Population	
	United States	Minnesota
Total	142.9	145.3
Greater Metropolitan	195.4	167.9
Lesser Metropolitan	145.3	111.9
Adjacent to Metropolitan	85.6	70.4
Isolated Semi-Rural	94.2	167.1
Isolated Rural	53.0	55.7

Source: Health Manpower for the Upper Midwest

NUMBER OF PHYSICIANS GRADUATED FROM THE UNIVERSITY OF MINNESOTA
1957 - 1967

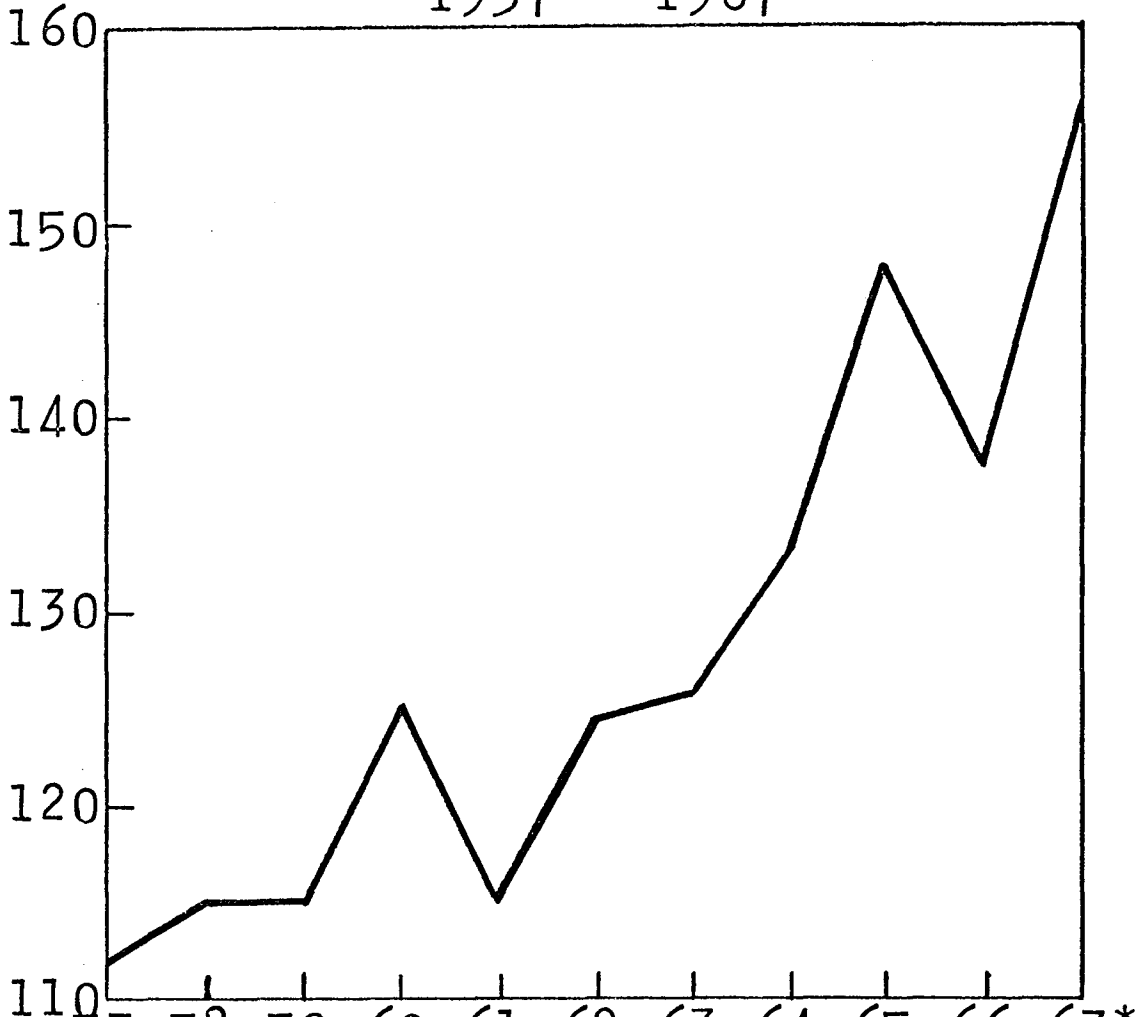


Table 7

TABLE 8

Number and Percent of Physicians in One-Physician Towns by Place of Education, 1965

Practice Location	Minnesota		Other States	
	No.	%	No.	%
MINNESOTA	68	57.6	42	35.6

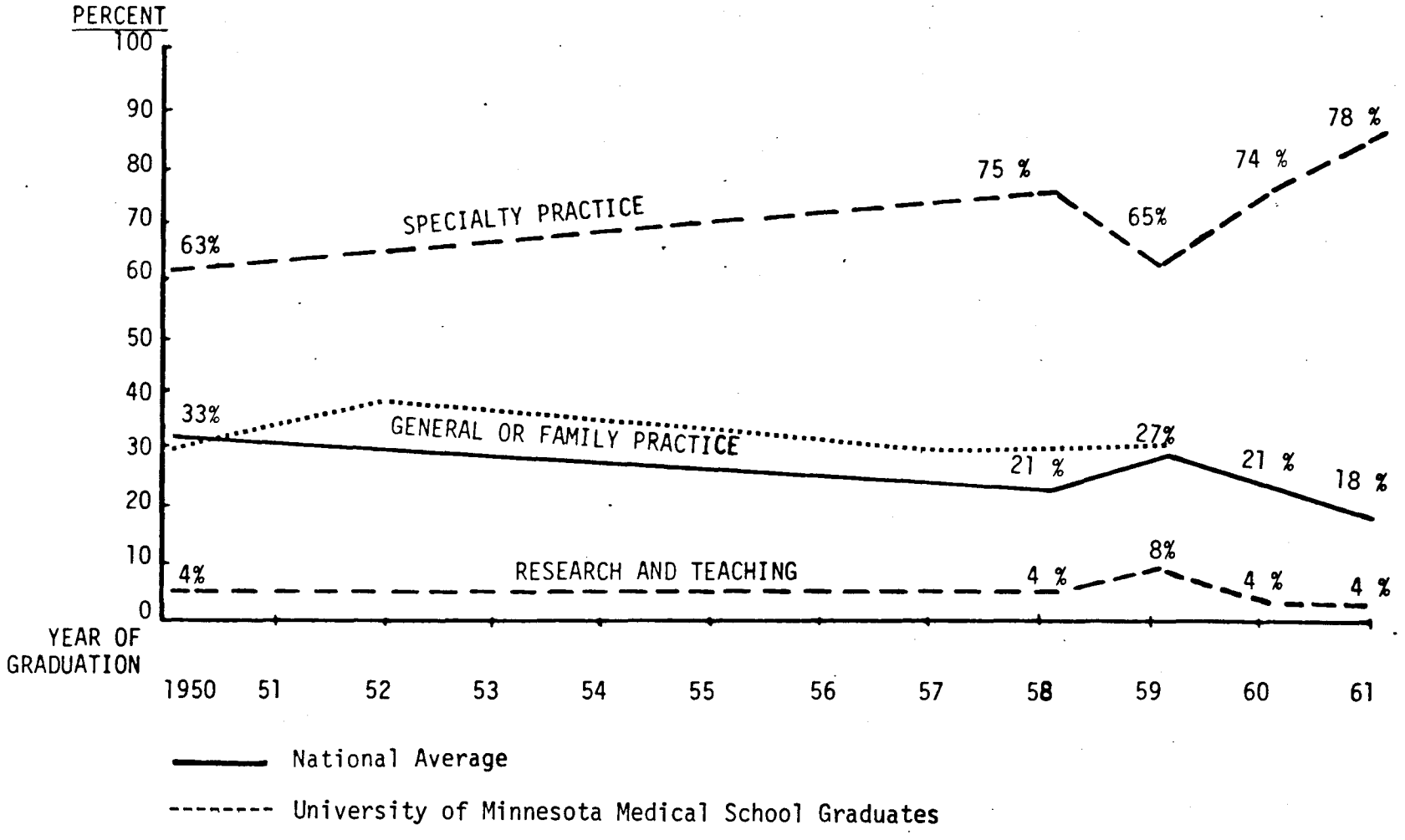
Source: Health Manpower for the Upper Midwest

TABLE 9

"While the University of Minnesota has supplied an increasing proportion of all of Minnesota's doctors, its contribution to general practice has been more striking. The proportion of the state's general practitioners who are Minnesota graduates has risen steadily from about 25% in 1910 to 65% in 1960, and even slightly higher in 1965."

Source: Health Manpower for the Upper Midwest, page 44.

PROPORTION OF MEDICAL GRADUATING CLASSES IN SELECTED YEARS MAKING SPECIFIC TYPES OF CAREER CHOICES IN MEDICINE



ORIGIN OF UNIVERSITY OF MINNESOTA MEDICAL STUDENTS
CLASS ENTERING 1965

Total population of Minnesota - 3,555,000
Total Medical Students from Minnesota - 127

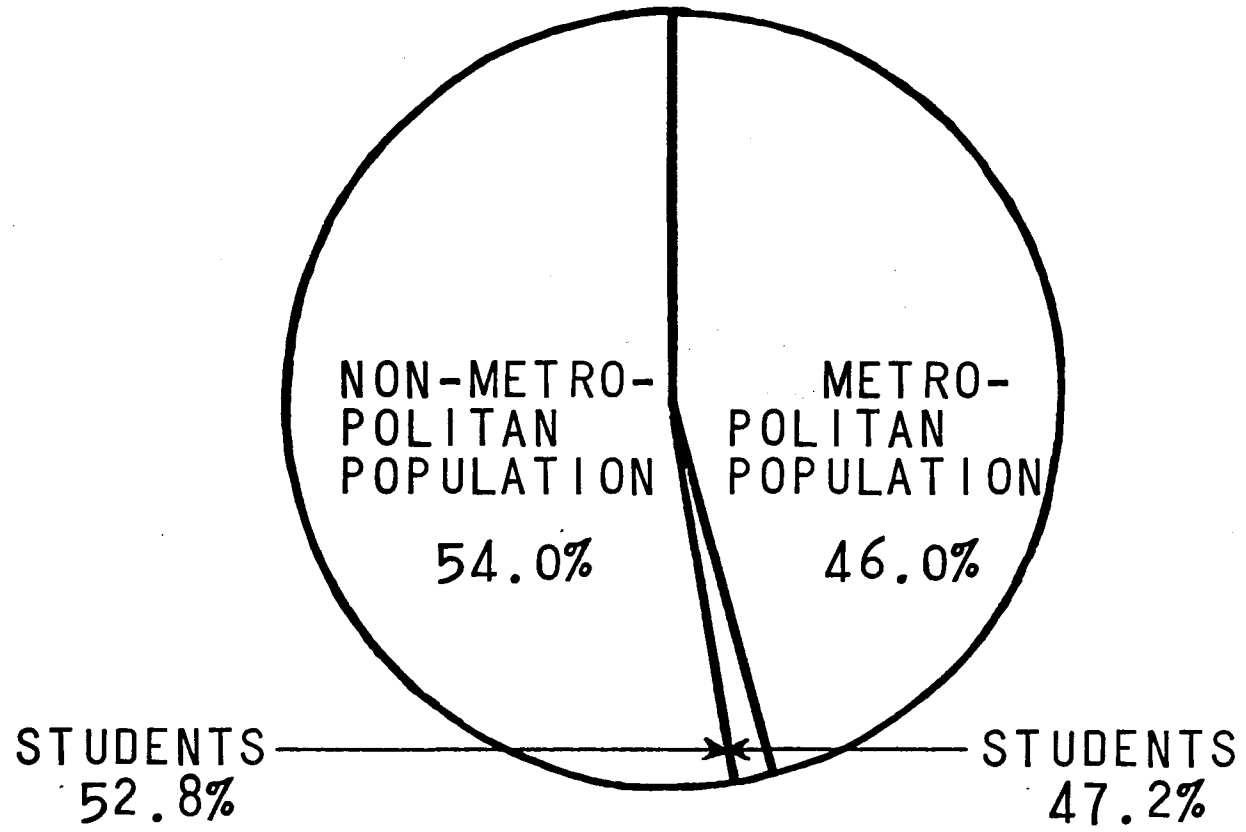
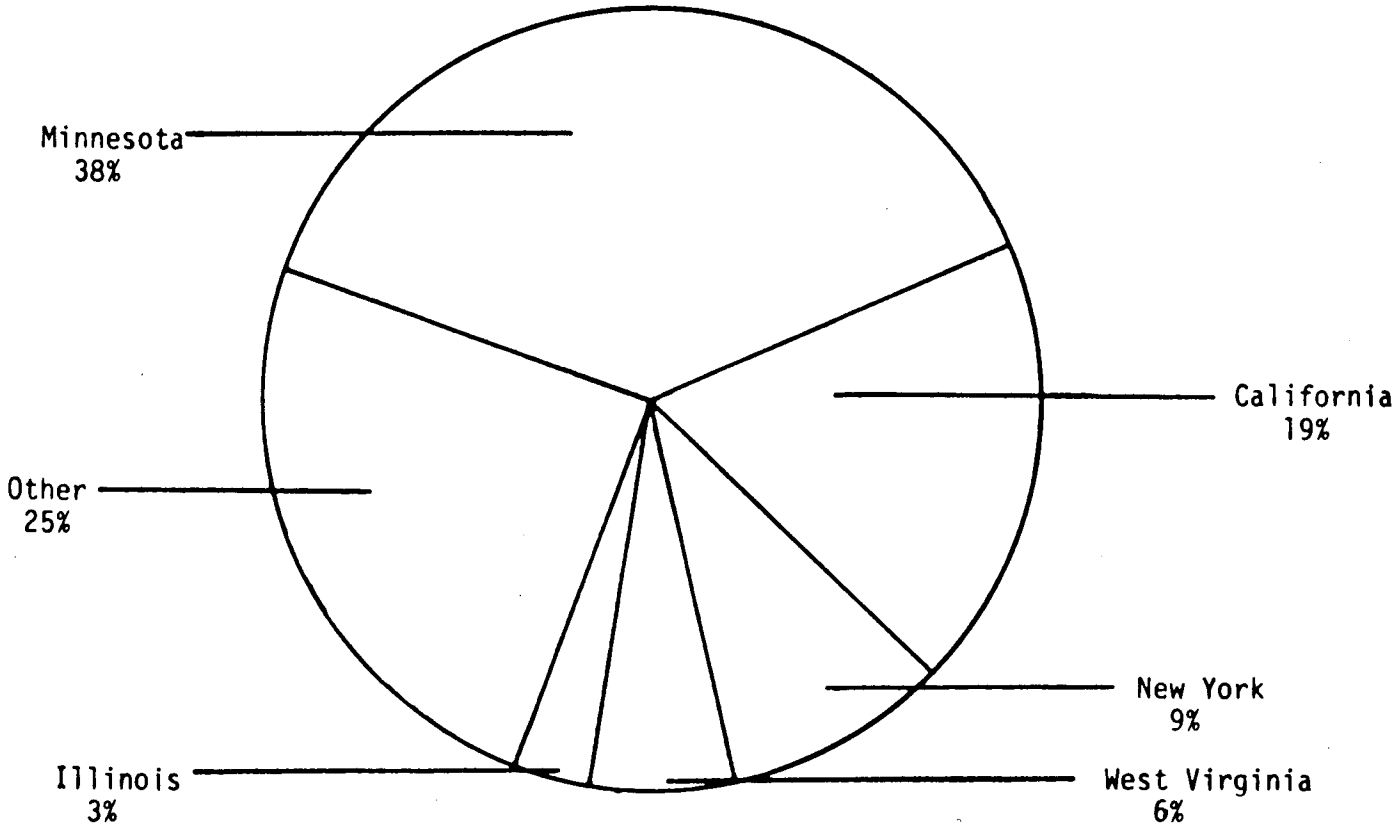


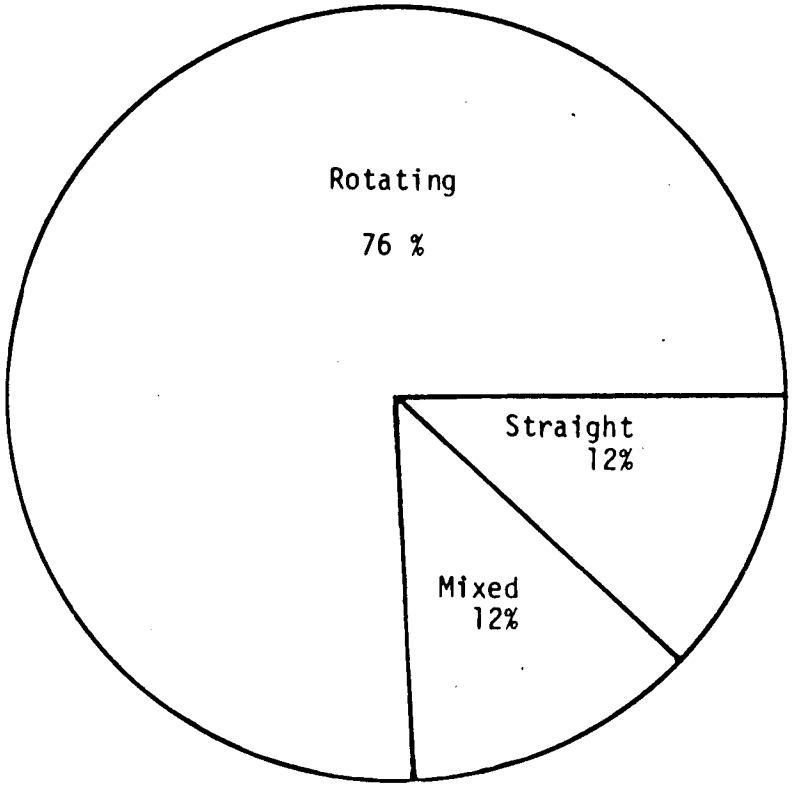
Table 11

INTERNSHIPS BY GEOGRAPHIC LOCATION

As Selected by 1965 University of Minnesota Medical Student Graduates*



INTERNSHIPS BY TYPE - 1965



* 146 Graduates

TABLE 13

FACTORS LEADING TO SPECIALIZATION OF PHYSICIANS

1. A basic human tendency to specialize.
2. The knowledge explosion in medicine.
3. The advent of the certifying boards in the various "specialties" in the 1930's.
4. The experiences of physicians who served in the Armed Forces.
5. Development of new standards for community hospitals.
6. Acclaim prestige, and rewards greatest for those who have made notable accomplishments in highly specialized areas.
7. Changing population and socio-economic patterns.

OBJECTIVES OF THE PROPOSED STUDY OF FAMILY PRACTICE

1967-69 Legislative Request - Special State
(Page 50 - Gray Book)

1. Recruitment of a study director from among the ranks of Minnesota's practicing family.

2. Increased awareness of the faculty through the activities of the study director, of the problems of the practicing physician, especially those of the family physician.

3. Increased awareness of a key representative of the practicing medical community, the study director, of the problems of medical education.

4. A careful study of the experience of other states with incentive programs, i.e., scholarships to medical students in return for stipulated periods of practice in small communities.

5. A careful study of the experience of other schools with preceptorship programs and/or departments of general or family practice with respect to career choices of graduates.

6. Determination, in concert with national activities of a similar nature, of the appropriate curricular content for modern-day family practice and implementation of such a program.

REPORT OF THE SUBCOMMITTEE ON FAMILY PRACTICE AND COMMUNITY HEALTH

University of Minnesota Medical School

October, 1967

I. Establishment of Need for a Family Physician

During recent years a significant number of major reports have been published dealing with various aspects of this problem. Some of these are listed in the attached bibliography.[1-8] They deal with the problem from various viewpoints. The most frequent viewpoints presented are as follows:

1. That there is an increased need for all types of physicians because of an increased demand for medical services by the public. The usual factors thought to be responsible for this increased demand are listed below:[5-7]
   a. The population growth.
   b. Larger numbers of older people with their increased utilization of the health care apparatus.
   c. The physician has more to offer each patient in terms of increased range of therapeutic devices and increased numbers of preventive measures to explore.
   d. Widening of concerns in public health areas.
   e. Increased affluence of the public with resultant ability to pay for the medical services they may need.
   f. Increased awareness of the public of recent advances in medicine with the resultant desire to have these advances made available.
   g. Increased tendency toward specialization with reduction in numbers of patients seen per physician.

h. Increased urbanization and easier access to rural areas.

2. That there is an increased need for a new type of physician to be trained (family physician) who, by virtue of this unique training experience, will be better able to utilize his own skills for direct patient care and for health maintenance in his patients (preventive medicine), and will also be able to better utilize the entire medical manpower pool including personnel in the associated health professions. Development of a training program for this new type of physician should be directed toward increasing the effectiveness of each physician rather than solely toward graduating larger classes.[2-5, 7-9]

Rashi Fein summarized this second approach very well in an address to the Congress on Medical Education of the American Medical Association.[9] He reviewed the overall problem of physician shortage and demand for medical services from the above viewpoints and concluded that the present apparent disparity between demand for physician's services and availability of physician's services could be improved if the effectiveness of the individual physician could be improved. He was uncertain if an increase in size of the graduating class over the next eight years could even keep up with increasing demand in the absence of a program to increase individual effectiveness.

During the early deliberations of the committee, it quickly became apparent that these different types of needs were easily confused and that such confusion hampered the progress of the

discussions. It must be clearly defined that if we are addressing ourselves simply to the problem of apparent overall physician shortage, the solution is simply to train more doctors of all types. On the other hand, if the need is for training a different kind of physician whose function will be to make recent advances in health care more widely available to the patient, we must address ourselves to increase individual effectiveness rather than to merely increase gross numbers. It must be emphasized that simply adding more physicians to the numbers of those graduating each year is not the purpose of developing a curriculum to train a family physician. It seemed to the committee that the compelling reason for training a family physician was to attempt to better utilize all of the manpower of the health professions more efficiently by developing a body of knowledge that will make the family physician a more perceptive clinician and which will also make him more knowledgeable in the recognition and use of the various kinds of help available to him from associated health professionals. In other words, the need must be considered from the point of view of how the total job may be done most efficiently.

Although this is a very complex issue, one may understand the basic problem better by looking at it in what is perhaps an overly simplified view. For purposes of this discussion, we must examine the need of developing a training program for the family physician based on what is described by Dr. Richard Magraw as the division of

labor in medicine. This division of labor is partly what we are talking about when we are deliberating concerning the need for developing a program of family medicine and community health at the University of Minnesota. We have to examine the various health needs of the public, allocate appropriate personnel to fulfill these needs, and then decide whether there is a void present in the area of primary patient care (personal physician, primary physician, or family physician). When this is done, it becomes clear that the role of the first contact physician (family physician) cannot be filled by an incompletely trained person but rather that it must be filled by the most highly trained person that we are able to develop from our student group.[5]

In order to develop this idea further, one has to recognize that a large part of the total job done by physicians has been done by the general practitioner and is still being performed by general practitioners who are practicing today. However, it must be borne in mind that there are progressively fewer students choosing general practice as a career. It is stated that most medical school graduates prior to World War II entered directly into private practice after a year of internship, but that 80% of medical graduates today engage in special training before entering medical practice.[1] In addition to this, review of the history of various medical school classes subsequent to graduation reveals that many general practitioners leave general practice and return to a training center for graduate training in specialty areas of medicine. This attrition seems to

continue for as long as 8-10 years following graduation. The inevitable result of this will be that the public will put an increasing demand on specialists of medicine to fill the role that used to be filled by the general practitioner. This creates the paradoxical situation that physicians who are becoming increasingly specialized will be called upon by the public to fill a broader and broader role for some of their patients in the absence of specific training for this role. At the same time, general practitioners (as we currently define them) who remain in practice are going to have to limit their broad role more and more in the future in order to continue to perform effectively because they are not being trained appropriately for the job they are called upon to do.

The family specialist of the future should be a more effective physician by virtue of his training. He may see fewer patients than today's general practitioner per unit of time, but he will make more meaningful decisions in his office with fewer repeat office visits. Fulfillment by the family practitioner of a prevent health role should be one of the important vehicles which will reduce pressure on medical manpower. Also, it is possible that by recognizing and satisfying the patient's problem, the tendency for patients to seek out on their own the type of physician they think they need for their problem will be minimized. This should also reduce the overall pressure on medical manpower. For example, a patient with a tension headache could conceivably see an ophthalmologist, an

otolaryngologist, and a neurologist to resolve the problem of visual disturbance, sinus problems, or to rule out a brain tumor. A well-trained family physician available to this patient should be able to establish the diagnosis and clarify the problem for the patient in most instances thereby enabling the other three consultants to utilize their capabilities more fruitfully. Even if consultation were necessary, the family physician would make an appropriate referral and still use only one of the three consultants.

To conclude, the committee wishes to reemphasize the urgency of developing such a program. Because of the long period of training involved, it will take at least four years to develop a family physician even if we were to begin training him now.

II. Definition of Function of the Family Physician

The family physician of the future must function directly in the provision of total medical care and in the supervision of total health care to all age groups. He must be willing to accept this responsibility on a continuing basis over prolonged periods of time. He should be directly involved in the provision of services most of the time and in a role of supervisory responsibility all of the time (through delegation where appropriate). He should be knowledgeable regarding availability of those services he does not provide. However, relinquishment of direct responsibility for certain services should not imply relinquishment of responsibility for total patient care.

These functions will be dependent upon a high degree of expertise in (1) disease prevention and health maintenance, (2) the diagnosis and management of common diseases (this should not be equated with trivial or simple diseases), and (3) interdisciplinary coordinative activity. His availability to the patient will be essential. In turn, availability to him of all health resources (hospital, individual professionals, agencies, etc.) will be necessary for maintenance of his role. This function is dependent on certain principles:

1. Availability
    a. Availability for treatment of patients for episodic illness as it occurs.

b. Availability to assume continuing responsibility both in health maintenance and in care for more prolonged illnesses.

2. He should provide entry for the patient into the health care apparatus.

3. He must serve a coordinating function to guide the patient to other areas of help where necessary.

   a. Into the associated medical specialties.

   b. In consulting with other health professionals when necessary; this involves knowledge of functions of associated health professionals such as visiting nurses, clinical psychologists, social workers and family agencies.

4. Health maintenance. (This is closely related to his patient care function--in many instances it is indistinguishable from it--but for clarity, it will be discussed separately.)

   a. He must be knowledgeable of health maintenance in the usual ways, i.e., preventive medicine, immunization, and so forth.

   b. He should be knowledgeable regarding child and family development.

   c. He should be knowledgeable regarding the effects of stresses of environment on health.

   d. He should be available for consultation and express willingness to assume leadership in health maintenance at the community level.

Because of his unique role which gives him access to the total family, the family physician is in a key position to be most effective in primary preventive medicine. It is self-evident that successful primary prevention is one of the most effective ways of increasing the efficiency of the health care apparatus and of reducing the gap between supply of physicians and demand for services.

III. Definition of the Body of Knowledge to be Incorporated into the Training of the Family Physician

The successes of medical education are well documented and widely publicized. These include the advances in basic knowledge and in technology which stem from the educational and research programs associated with increasing specialization during and subsequent to World War II.

There are many who feel that the greatest failure of medical educators during the same period was the failure to recognize the changing needs of the public (many of which stemmed from these same advances) and the failure to adapt their educational programs to these changing needs. This is probably one of the main reasons for the rapidly progressive decline in interest of the medical student toward choosing the general practice of medicine as a career. As an example of this, let us consider the general practitioner of the past and the difference in his training as compared to the probable training of the family practitioner of the future. It must be borne in mind that the family physician about whom we are talking today will be practicing in the year 2000. Consequently, he must be trained in a different manner from the way in which we have been training physicians to the present time. Many reasons have been given to explain the decline in attractiveness of general practice to medical students of today. It is not necessary to recount all of these reasons again, but we should consider one reason that seems pertinent

and which is not emphasized very often.

As one looks back on the recent history of medicine, there seems to be agreement that general practice was at its zenith in the late 1920's and 1930's, probably until World War II. During this time the general practitioner was trained as an undergraduate medical student and as an intern and went into practice directly from his internship. The important point is that he did receive training for general practice as an undergraduate and as an intern which was comparable to that of most of his colleagues and which was adequate for the period in which he was to begin his practice.

Subsequent to World War II, interest in specialty training increased and a progressively larger number of students went into specialty training following internship instead of into practice. In addition, it is probable that the character of undergraduate medical education and of the internship gradually changed due to the subtle influence of the knowledge that more students were taking additional training after internship. Consequently, all other forms of practitioners except for the general practitioner, were trained formally in an identifiable discipline. Of all the areas of medical practice, general practice is the only area in which no satisfactory specific training for the job to be performed is available despite the fact that this job is the broadest and most difficult of all. This is probably an important factor in explaining the declining appeal to the medical student of general practice as a career. It probably also accounts for the discouragement of many general practi-

tioners after they have practiced for a few years. Therefore, in any consideration of a training program for family physicians this factor must be borne in mind and positive emphasis must be made that the trainee in this program will be provided a highly specific training program which incorporates a unique body of knowledge for the job which he will be expected to perform. This really is the basis for the statement that a new specialty is being created.

It then becomes our obligation to carefully define the body of knowledge that will be transmitted to the student in the course of his training which will give him a function distinct from that of other physicians.

In the early deliberations on this problem, the committee decided that the most reasonable approach would be to list the life cycle of the individual and the life cycle of the family, and then to look at each portion of the life cycle with the objective of defining need which might be fulfilled by the family physician. This was done. As a result of this approach, the committee defines in broad outline the body of knowledge of the family physician as follows:

1. Knowledge of the physician's role as a clinician. This includes specific definition of the doctor-patient relationship. It also includes a definition of the nature of agreements arrived at with patients. It should also include definition of the proper use of consultation with other physicians (doctor-doctor relationship) relative to definition of responsibility toward the patient.

Also incorporated into this relationship is knowledge of the scope of the areas of interest and ability of other health professionals such as clinical psychologists, sociologists, visiting nurses, as well as knowledge of the function of various social agencies (governmental and non-governmental) that may be located in certain communities. Definition of the various types of patients' roles should also be a part of this knowledge (the different types of patients' roles in a medical sense as well as in a social sense).[6]

2. Knowledge of the natural history of disease, particularly of common diseases, both relative to the disease state and also relative to the influence of disease on the patient and the patient's family (both immediate and extended), and also relative to the influence of external factors (environmental factors outside the family) on the disease process. In addition to description of the natural history of the fully developed disease process itself, considerable emphasis should also be placed on factors involved in the genesis of the disease so that preventive measures may be taken prior to the development of clinical symptoms. This is of particular importance in the pediatric area. It is felt that in this area the preventive role should be stressed maximally. It is felt that there is currently lack of knowledge of the dynamics associated with development of illnesses which begin in the period between conception and birth. The student

should be made knowledgeable of the physiology of pregnancy, the implications of change upon the mother and the child, the genetic combinations of the parents, the effects of virus infection and drug ingestion on the pregnant woman. He should also be well versed in psychosocial and cultural combinations including such factors as inter-racial and inter-faith marriages because of their effects on the developing child. He should have an understanding of normal inter-personal relationships so that he can recognize deviations from the normal and better understand family structure. Another period in the life span where some of these kinds of influences are of considerable importance from point of view of preventive medicine is the early middle-aged adult.

It must be re-emphasized that the term common diseases should not be equated with trivial diseases.

3. Knowledge of treatment of total illness in a holistic manner. This is another important area of uniqueness of the family physician if he is trained according to these concepts. Both by virtue of his training (through recognition of the multiple factors influencing the natural history of a disease) and by virtue of his unique experience with the patient's family over prolonged periods of time, he will be in an excellent position to select the most appropriate treatment from the various possibilities that usually must be considered.

This also includes understanding the importance of assuming continuing responsibility for his patients. Continuing responsibility involves the ambulatory setting, the hospital setting, and the home setting. In order for the student to do this effectively, the training program must be developed in such a manner that the trainee's environment will simulate as closely as possible his future practice environment. If this environment is to be developed, there must be built into the administrative aspect of the Division of Family Practice clear understanding relative to the availability of such areas as an effective ambulatory care unit, ready access to the hospital in the form of a separate hospital service, and the manner in which consultation is used.

4. Knowledge of epidemiology and statistics is necessary to enable the clinician to assess the significance of various factors altering the pattern of well being of the individual and of the family and to enable him to fulfill his role in preventive medicine. This knowledge will also be helpful to aid the family physician in judging quality of medical papers.

5. Knowledge of the dynamics of family development and of individual developmental crises and their influence on the well being of the patient is necessary. This should involve study of various behavioral sciences such as clinical psychology, cultural anthropology, psychology of aging, comparative religion, comparative psychology of various

socio-economic strata, psychology of chronic illnesses, and psychology of dying. It is suggested that the student begin with a broad course in contemporary American family life, including social and religious attitudes regarding conception control. Such a background would enable the future physician to talk freely and knowledgeably with his patients rather than to merely tell the patient what he learned from his own family experiences. The student should be exposed to the attitudes of pregnant women, the emotional acceptance of the unborn child, the importance of the father in giving emotional nurturance and support. Normal individual development, patterns of family life, and individual reactions to stress and disease should be presented. This area could also include a study of psychiatric illness and emotional reactions which would be a broad course rather than the teaching of specific psychiatric syndromes.

6. Intensive training in history taking, not only from point of view of outlining a specific syndrome, but from point of view of determining what brings a patient to the physician should be included.[6]
7. Knowledge of skills and contribution to be expected from other health professionals.
8. Continuing attention must be given to improved techniques for continuing education of the physician. This should include studies of different forms of practice (such as small

group practice in smaller communities) which would enable the physician to leave the community at intervals for periods of study as well as for periods of recreation.

As one views the needs of the public from the present specialty structure of medical practice, it would seem that the greatest deficiency is in the medical aspect (in the broadest sense of the term medical). It is felt that the family practitioner should be extremely knowledgeable of principles of pediatrics, psychiatry, internal medicine, surgery and behavioral sciences in order to function effectively. Relative to the surgical specialties, it is felt that he should be well grounded in surgical principles so that he can recognize indication for surgery and can perform good pre- and post-operative care when necessary. He should also be trained to handle emergency situations.

The committee feels that the basic training should be the same for all of the trainees who participate in this program. It recognizes that there will be different needs for different regions. However, it is felt that toward the end of the training, most trainees will have made a decision as to where they are likely to practice. A period of six months elective time will be left in the program so that any special training necessary to fulfill the needs of the area where the student chooses to practice may be accomplished.

IV. The Training

The committee felt that the manner in which the training program for family practice and community health is developed will be of critical importance to the success of the program. The members of the committee agreed with the frequently stated opinion that one of the important factors in attracting students to this program will be that it be given equal consideration with other programs for time in the undergraduate curriculum. It is felt that contact with the various medical disciplines influence the student in his career decision as he progresses through his medical training. Consequently, it is felt that he should have contact with the family practice and community health program at intervals throughout his undergraduate training. The committee also felt that at least one of the areas of study should be introduced during the premedical training program at Minnesota. There was agreement among the committee members that it would be important to have an active program with which the student could identify during the entire course of his training.

As the discussions progressed, it became apparent that the training program would have to be considered from two points of view. It would first have to be developed in terms of the ultimate goals of the program and then would have to be developed also from point of view of an initial transitional program during which time a staff and physical plant could be developed. The training program from point of view of ultimate goals was discussed initially.

ULTIMATE GOALS

The undergraduate medical curriculum was considered first. The course titles listed below represent an attempt to extract from the previous section on the body of knowledge certain courses which would include the material necessary to develop this body of knowledge. The course titles and their place in the curriculum are listed below:

Last Year of Pre-Med: The Contemporary American Family (Elective, but Recommended)

The committee felt that this course should be set up in cooperation with the Family Study Center. It should include patterns of family life, family developmental crises and individual developmental crises. The course material should develop as the product of ongoing discussions between the faculty of the Family Study Center and the faculty of the Family Practice and Community Health Program. It should be oriented heavily toward problems that arise in medical practice.

First Year of Medical School: Patterns of Contemporary American Culture

This should also be taught with a medical bias rather than presenting a review of the total field in depth. This course would encompass clinical psychology, comparative psychology, psychology of aging and dying, comparative religion and cultural anthropology. The content of this course also should be developed through conferences between the staff of the family practice

program and members of the behavioral science departments who will be responsible for teaching the material.

Second Year of Medical School: Epidemiology, Statistics, History Taking, Preventive Medicine, Individual Reactions to Stress

Third Year of Medical School: Study of the total illness in a holistic manner.

Definition of the physician's role, the patient's role, the doctor-patient relationship, and the doctor-doctor relationship. Further discussion of acquisition of primary data. This would include also definitions of responsibilities and capabilities of other health professionals and of various agencies. This should be presented in a seminar type course rather than in a didactic lecture course. During the first three years, the student may have limited and gradually increasing access to patients and their families, but would have no direct medical responsibility.

During the third year, a clerkship program would be implemented during which time the student would begin to learn clinical application of principles studied in earlier years. During this time he would begin to assume increasing patient responsibility. During this time attitudes and skills would be developed by observation and example. The student would begin to develop knowledge in recognizing and caring for common diseases. Disease prevention would be emphasized. This would be done in an ambulatory setting, hospital setting, and home setting . Various clinics, seminars, and conferences would be made available to the student.

The committee felt that this portion of the undergraduate training program should be the same for all medical students. The committee was of the opinion that it was still advisable to train a basic physician initially, but is uncertain at this time at what point in his training the student will begin to diverge into the area of his career selection. It is assumed that it will begin at some time during the fourth year of medical school. At this point those students interested in making a career of family practice would select the family practice track.

GRADUATE TRAINING PROGRAM

The graduate training program will begin at the conclusion of four years of medical school. The family practice track will probably begin sometime early in the fourth year of medical school. The fourth year of medical school will probably consist of clinical work and basic science work. The committee felt that the graduate training program relevant to family practice should begin in the following manner:

The New Graduate. It is felt that the new graduate will require a certain period of time to develop further his skills and insights relative to patient care problems. Therefore, it is planned to have him undertake his initial responsibility in the inpatient department in a similar manner to the present-day intern. The duration of this period cannot be determined with certainty at this time, but it will probably be somewhere between 6-12 months after

graduation. This will be determined at least in part by the time at which he begins to track into the family practice program (i.e., if the tracking system began early in the senior year, he would probably be able to begin to acquire these skills during the last half of his senior year after his basic science work and after some further clinical clerkship experience.) Thus, it may be possible that his "internship" experience would be fulfilled six months after graduation. During the last two and a half years of the program, the trainee would serve in the capacity of a resident.

Residency Training Program. The resident will assume his responsibility in the ambulatory care unit, the hospital care unit, and in the home care aspects of family practice. As he acquires patients, he will accept responsibility for these patients and continue to assume responsibility for the same patients for the duration of his tenure with the program. He will see them for out-patient care and will advise them accordingly during these inter-actions. When it becomes necessary for the patient to be hospitalized, he will continue to assume responsibility for their hospital care. He will utilize this continuing relationship to implement principles of health maintenance. His relationship with the intern will be the same as the relationship between the resident and the intern at the present time in other departments.

Permanent Staff. The permanent staff of the family practice and community health program will function in an advisory capacity with the resident relative to the assumption of responsibility for members

of families as patients. They will assume responsibility for the patient when they first meet the patient and will continue to assume responsibility for the duration of their tenure with the program. Whenever the house staff changes, the permanent staff members will continue to assume responsibility for this patient in conjunction with the new resident. The permanent staff will also have responsibility for the patient both as an outpatient and in-patient with regard to decisions made relative to ongoing patient care. The relationship between the permanent staff and the house staff will be an advisory one in the same manner as the relationship between the permanent staff and the house staff in other departments in the medical school. It is emphasized that the ultimate decisions as to management will be those of the permanent staff.

Students. During the period of clerkship the student will attach himself to the combination of permanent staff and resident and will follow the patients along with the permanent staff and resident both in an ambulatory care setting and in the hospital setting.

During the clerkship and graduate training program of the family practice and community health division, a program of seminars, conferences and rounds will be established.

AFFILIATED PROGRAMS

It is contemplated that affiliated programs will be established in conjunction with various other community hospitals in the Twin Cities and perhaps also with some group practices throughout the

state. The committee discussed the advantages of establishing a small unit in one of the communities located centrally in the state in the form of a controlled preceptorship in order that the trainee may spend a couple of months in this environment and see how rural practice can be performed comfortably. Although this was discussed only tentatively, it could be a desirable part of the program if a group could be solicited which would be interested in making available a consistent program for the trainees and whose members would be qualified by virtue of their own interest, experience, and training to be part of the staff of the Medical School. Faculty appointments should be given to these preceptors, and there would be frequent conferences between these preceptors and the medical school permanent staff.

Initially, the permanent staff of the program should consist of pediatricians, psychiatrists, internists and family practitioners. The family practitioners for the staff will be obtained gradually as trainees graduate from the program. (See below, page 28)

INTERIM OR TRANSITIONAL PROGRAM

The committee realizes that a program such as this is an ambitious undertaking and that it will have to be developed gradually. During the period of development it will be necessary to begin in a more conservative manner. The initial full-time staff would number somewhere between 8-10 persons. The initial resident group would number somewhere between 3-5 residents per year.

The students would have to be brought gradually into the program as it is developed. Initially, the students would be selected from those expressing an interest in family practice as a career. It is hoped that more and more students will be incorporated into the program with the ultimate objective of having all of the students in the class rotate through it for a brief period of time during their undergraduate clerkships.

SOURCE OF PATIENTS

A recurrent criticism of current medical education is that the student is trained for medical care in a context which is dissimilar to the context in which he will be practicing medicine subsequently. The reason given for this inappropriate training is the past custom of using indigent patients with which to teach students and house staff. Many feel that this leads to an experience in episodic dispensary care. In those institutions where all the patients are referred, it also frequently leads to single contact and disease oriented care. The committee feels that the purpose of this program would be much better served if the patients could be truly representative of a cross section of society from point of view of economic strata, cultural strata, intellectual capacity of the patients, etc. The committee also feels that this patient source should not be dependent upon referral if we are to assume continuing responsibility and if we are to attempt to teach principles of comprehensive and continuing care and principles of health

maintenance. Therefore, the committee recommends seeking out a patient population which will fulfill these criteria. A number of methods for defining such a patient population were discussed. The group that seemed to lend itself best to this program is the group of University faculty and employees and their families. It is felt that the possibility of having this group as a source of patients should be further explored. If it should not be possible to obtain this group, another consideration may be the employees and families of one of the local industries. Other defined populations will be developed in the affiliated units.

PHYSICAL FACILITIES

During the initial planning and developmental stages, physical facilities for the family practice program should be developed within the present University of Minnesota Medical Center in accord with the need for space to service whatever patient load that the initial staff requires for a teaching model. The committee agreed that space should be provided for an outpatient lab with adequate staff and facilities to perform routine studies so that the attending physician can obtain information about his patient as quickly as possible. It is also felt that space should be provided for an x-ray department for obtaining chest films and films of long bones, etc., so that these films would be available immediately to the staff for interpretation. More complex x-ray procedures such as gastro-intestinal studies, requiring contrast studies, would be performed in

the x-ray department of the Medical Center. The x-ray films taken in the ambulatory care center of the family practice program could be collected at the end of the day and sent to the x-ray department for interpretation by the roentgenologist and for film storage. Space should also be provided for outpatient lab, electrocardiography and proctoscopic examinations.

The question of hospital bed facilities was also discussed by the committee. It is felt that during the initial stage of development of the program, the hospital bed situation would be quite labile and that only a rough estimate could be made of bed requirements. However, it was estimated that initial bed requirement would probably vary between 15-30 beds. If the program develops successfully, it is anticipated that it will become a popular and useful teaching program, both for undergraduate and graduate medical education. It seems likely that the size of the program may reach or exceed the size of some of the presently existing programs in other broad specialties relative to inpatient bed requirements. The committee feels that this should be kept in mind in regard to planning for a new physical plant.

AFFILIATED UNITS. (This is the second time this heading is used; see page 23)

The committee feels that the affiliated programs will have to await development until the program based at the University of Minnesota Medical Center is functioning efficiently. However, it will be both necessary and desirable to begin development of affiliated

programs as soon as possible. It is felt that some of the emergency room experience, which will be necessary as part of the graduate training program, may be obtainable at some of the community hospitals. It is also felt that one or two formal programs may be established throughout the state, where the trainee may have an opportunity to spend a portion of his time and directly observe rural group practice in action.

ACQUISITION OF INITIAL HOUSE STAFF

It must be realized that the developmental period of this program will be comparable to the opening of a private office and the development of a medical practice where none has existed before. The initial patient load probably will be relatively light and will then increase as members of the group selected as patients come to the program for medical care and are satisfied. Consequently, it is important that the program be initiated carefully and deliberately and that every effort be expended to assure a high quality of patient care. For this reason the committee felt that the initial house staff should be recruited in the following manner. The first group of residents should be young general practitioners who express willingness to come into the program and follow the two-year residency training program. These men should be recruited from practice and should have had enough time in practice (5-10 years) to be seasoned physicians. The purpose of the residency training program will be to give them time to develop their own ideas relative to the

purposes of the program. During this time they will be undertaking the type of training described in the above paragraphs. They will be attending seminars and conferencesand rounds and will become acquainted with the staff of the program and the staff will become acquainted with them. This initial group will be recruited with the objective of staying on as part of the permanent staff upon completion of the training program. This will represent a financial sacrifice to this group and the committee feels that attempts should be made to obtain funds so that they can be subsidized at a higher salary level than the usual resident. A precedent has been set for this where residents who come into the psychiatry training program from medical practice are subsidized by the National Institute of Mental Health to the extent of $12,000 per year. This original group of residents should number 5-6 per year so that after four years there will be 15-18 of them available for staff positions should this number be needed. When the program is running smoothly and when the patient load is adequate, an intern training program may be added. The interns could be recruited from members of the graduating class. Subsequent to this initial period, residents and interns will be recruited in the usual manner.

CLINICAL ATTENDING STAFF

The presence of a clinical attending staff in a program such as this may represent something of a contradiction. If one undertakes a program to provide continuing medical care and to provide

and teach the assumption of continuing responsibility in patient care, it is hard to visualize a role for a part-time teacher insofar as direct patient care provision is concerned. In the usual setting, the clinical staff attends episodically and at fixed intervals. If he is to assume responsibility for the total care of a patient, it is difficult to see how a patient's needs could be met under these circumstances. Therefore, it is felt that one consideration of utilization of clinical attending staff could be that they be utilized in either non-patient care areas (i.e., participation in seminars and conferences) or that they be utilized in the training areas where episodic care is being provided (i.e., during the house staff's emergency room experience.)

GRADUATE TRAINING PROGRAM IN REGARD TO SPECIFIC TIME ARRANGEMENTS FOR THE TRAINEES DURING THEIR PERIOD OF TRAINING

This section of the discussion of the training program must be viewed as a very tentative section and will almost certainly be revised as the overall program of family practice and community medicine develops. It is inserted simply as an example of how a student might progress through the training program from the time he finishes his medical school experience. It must be remembered that the students who come into this program will be coming from four different backgrounds. These are:

1. Minnesota students who take their internship in the family practice program.
2. Minnesota students who take their internship elsewhere and then return to the family practice program.
3. Students from other schools who come into the program during the internship year.
4. Students from other schools who take their internship elsewhere and then come into the program.

For this reason, the specific time sequence with which a student progresses through the training program must be very labile. With this lability in mind, the following tentative program is offered:

A. Medical School (Minnesota student)

It is our understanding that during the fourth year of medical school the medical student will have made his career choice and will be discussing a program for the fourth year with an advisor from the

area of his career choice. An advisor in the family practice program may suggest the following:

1. Three months of basic science which would probably be in one of the behavioral sciences.
2. Three months on a medical clerkship.
3. Three months on a pediatric clerkship.
4. Three months on a family practice clerkship.

B. Internship year in the family practice program.

1. Six months of inpatient training.
2. Six months of total patient care both in the ambulatory care unit and the inpatient service combined.

C. As an alternative, the internship year may be taken in either a medical internship, a pediatric internship, or in some of the approved mixed internships. This would be determined by consultation between student and advisor.

D. Residency Training Program - first year

1. Assumption of complete continuing responsibility for patient care in the office, hospital and home setting, with his staff consultant.

E. Second Year

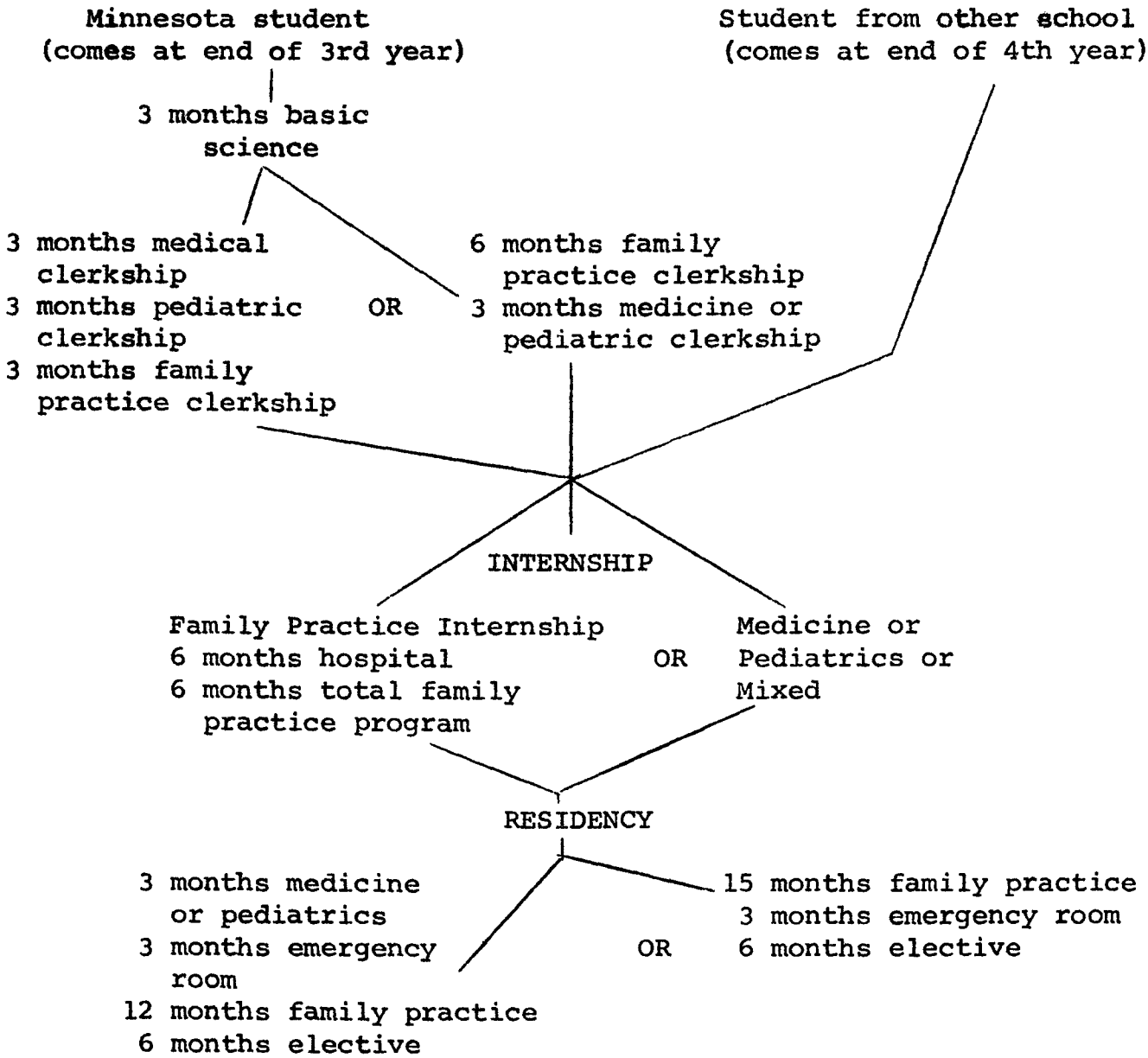
1. The first three months of the second year could be a continuation of the same experience or experience on one of the other hospital services such as medicine, pediatrics or psychiatry.

2. A second three months would be emergency room experience in one of the affiliated hospitals. A third and fourth quarter of the second year are designated as elective time and the student could choose further experience in basic science, family practice, medicine, pediatrics or OB. This would be determined by his particular interest and also would be determined to some extent by where he planned to practice.

Throughout the training period a series of conferences, grand rounds, seminars and lectures will be made available.

It must be emphasized that the above sequence can and will be altered depending on the background of experience of a particular student. In addition to the above, the committee feels that the Family Practice and Community Health Division should assume a responsibility relative to continuing education of the graduate trainee from the program.

The following diagram is another way of expressing a possible progression of a student through the family practice program, both from Minnesota and from an outside school.



(elective: family practice, medicine, pediatrics, obstetrics, basic science, psychiatry)

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PROPOSED IMPLEMENTATION OF A PROGRAM OF FAMILY PRACTICE AND COMMUNITY MEDICINE AT THE UNIVERSITY OF MINNESOTA MEDICAL SCHOOL

January 14, 1968

Proposed implementation of a Program of Family Practice and Community Medicine at the University of Minnesota Medical School

This is a projection of the probable needs of the program over the first five years. The primary goal of such a program is the training of family physicians to a high degree of expertise in all of the areas encompassed in the section of this report defining the body of knowledge. To reach this goal certain areas of development must be identified and concentrated upon particularly during the formative years of the program. Space and staff requirements must be determined in relationship to these areas of development.

A. Areas of Development

1. Overall administration of the program including
    a) facilities planning and development
    b) staffing
    c) development of methods and procedures
    d) coordination of the service aspects of the program with other Hospital services
    e) arrangement for and liaison with patient population
    f) fiscal arrangements with patient population, intermediaries, and the Hospitals
    g) representing the program to interested University and non University groups
2. Continuing educational program development both for family practice and community health including
    a) curriculum development and implementation
    b) course and student time scheduling

c) coordination between the specialty areas involved in the program

d) liaison with representatives of other community health organizations

3. Continuing improvement of service and quality of care to include

a) coordination of professional and procedural aspects of patient care

b) integration of teaching programs into care patterns

c) coordination of interservice referral and consultation

4. Continuing attention toward the development of affiliated units including

a) arrangements with existing staff of such units

b) provision of additional program related staff

c) development of physical facilities

5. Research in patient care and educational techniques including

a) development of quality and efficiency evaluation techniques

b) development of educational evaluation measurements

c) comparison of results of this program to those of similar programs

B. Staff

In order to provide personnel for performance of the above development toward the stated goals the following projections are made:

1. Developmental phase - July 1, 1968-June 30, 1969

   Four physicians, one hospital (health) administrator, two secretaries

   a) curriculum planning

   b) patient development planning

   c) physical plant planning

   d) resident staff acquisition

   Proposed interim financing for developmental phase: foundation grant to be sought

2. Program implementation - July 1, 1969 - June 30, 1970.

   This will be dominantly development of the program at the University of Minnesota Medical Center. It is felt that the following personnel are needed:

   a) Eight full time staff positions (physicians). This number of full time staff positions was selected with the consideration that each of these staff members would spend approximately half of their time attending to the development of certain portions of the program as listed under Goals and Tasks. The other half of their time during the initial period would be spent in administration, direct provision of patient care, and teaching.

   b) One hospital (health) administrator.

   c) Five first year residents selected from physicians who have had experience in general practice as defined under the section on the training program.

d) One x-ray technician, one laboratory technician, one electrocardiographic technician part time.

e) One Medical social worker, one clinical psychologist.

f) Since considerable time will be spent consulting with members of the behavioral science staffs in other departments of the University, it is felt that consulting fees for this service should be made available.

g) Three secretaries.

3. Second year - July 1, 1970 - June 30, 1971.

This will include further development at the University of Minnesota Medical Center plus the development of two affiliated units. The additional needs for the second year are as follows:

a) Two more full time staff positions (physicians) for servicing the affiliated units.

b) Five first year residents selected from general practice in the same manner as during the first year. There will then be ten residents in the program.

c) An intern staff should now be added to the program. This will consist of five interns selected from senior students.

d) Two medical social workers and two clinical psychologists full time.

4. Third year development - July 1, 1971 - June 30, 1972. This will be continuing development of the Medical Center program and the two affiliated units. At some point during the third year it is possible that beginning exploration of a distant affiliated unit to be located somewhere in the state to provide a model for rural family practice should begin. The needs for the third year are as follows:

    a) Add five family practitioners from the training program to the full time staff.

    b) Two additional secretaries will be needed.

5. Fourth year development - July 1, 1972 - June 30, 1973. This year will be a continuing development of the Medical Center program and the two affiliated units plus further exploration of a more distant affiliated unit to provide a model for rural practice. The following staff will be added:

    a) Five family practitioners from the training program.

    b) Two additional secretaries will be needed.

    c) If the service aspects of the program develops satisfactorily additional laboratory and x-ray technicians will be needed and it is felt that probably the total number necessary by this time will be three laboratory technicians, two x-ray and EKG technicians.

    d) It is probable that a visiting nurse will be needed in the program by this time also.

e) By the beginning of the fifth year, July 1, 1972, the staff will then be as follows:

1. 20 staff physicians
2. 10 residents and 5 interns
3. Three laboratory technicians, two x-ray and EKG technicians
4. Two medical social workers full time, and two clinical psychologists
5. Visiting nurse full time
6. 10 secretaries and receptionist
7. Hospital (health) administrator

6. Medical students will be added to program as soon as staff functions and patient availability permit.

B. Administrative commitments

1. Begin as a division of department of Medicine.
2. Departmental status - when the program becomes operational (tentatively, during year 1968-69).
3. Joint appointments and joint activities with overlapping clinical possibilities in pediatrics, medicine, psychiatry, obstetrics and public health at the graduate level.
4. Practicing medical community must be apprised of the need for a defined group of non-referred patients for educational purposes within a University-community setting.
5. It will be necessary for us to make firm commitments on a long term basis to certain individuals as we procure our staff during the developmental phase of this program. This is necessary before we can begin to define a patient population for the program.

FAMILY PRACTICE

UNIVERSITY OF *Minnesota*

MEDICAL SCHOOL · DEPARTMENT OF MEDICINE
DIVISION OF FAMILY PRACTICE AND COMMUNITY HEALTH · MINNEAPOLIS, MINNESOTA 55455

April 9, 1968

Mr. Peter Sammond
Associate Director
University of Minnesota Hospitals
Minneapolis, Minnesota 55455

Dear Mr. Sammond:

I am writing this letter in response to the memorandum to members of the Outpatient Committee from the Facilities and Service Subcommittee in regard to a review of space requests dated April 5, 1968.

I have reviewed these space requests for the Division of Family Medicine and Community Health in considerable detail. I will address my remarks to the specific questions raised in the memorandum.

Question A. How much space can be deleted in entirety or deferred until later construction? In considering this question as it relates to the space requirements for the Division of Family Practice and Community Medicine, I am forced to say that the amount of space that can be deleted in entirety will be dependent on a new decision relative to what the size of the training program should be. In the original request for space, the numbers of offices and examining rooms requested were based on decisions made by the Subcommittee on Family Practice and Community Health relative to the desirable numbers of permanent staff and resident staff for the program based within the University of Minnesota Medical Center. I want to remind the Subcommittee that this request was not submitted in terms of numbers of square feet required but rather in terms of numbers of rooms for various purposes required and it was left to the architects to establish the size of the rooms, depending on their function.

Question B. How much space originally requested as special space could be adapted to modular space? As I look at Appendix B describing the standard module, it would be my feeling that all of our examining room space could be modular space. If I understand the description correctly, each module would have sixteen examining rooms. Consequently, the Division of Family Medicine and Community Health would require two standard modules for its examining space and this would seem to be satisfactory. I would like to reserve the option of carefully reviewing this change with the architects if it is decided upon.

Question C. This relates to office space and clinics being confined to personnel whose major responsibility is outpatient care, and it states that this should not be auxiliary offices. The offices in the clinic space for the staff of the Division of Family Medicine and Community Health would be primary offices. This division would not have any offices in any other location in the

medical center.

It seems to me that the space requirements for the Division of Family Medicine and Community Health are somewhat unique in keeping with its unique function. I think that the best way to approach any change in the requests for the space needed for this program would be through consultation with the architects at whatever time they think appropriate.

I will conclude by reemphasizing that any reduction in total numbers of rooms provided for this program would amount to a reduction in the overall size of the program. I will be glad to cooperate in any other way that I can but I can not take personal responsibility for reducing the size of the program from what the Subcommittee on Family Medicine and Community Health decided during their deliberations.

Sincerely,

B F Fuller

B. F. Fuller, M.D.

BFF:jw

UNIVERSITY OF Minnesota

DEPARTMENT OF FAMILY PRACTICE AND COMMUNITY HEALTH
MEDICAL SCHOOL · MINNEAPOLIS, MINNESOTA 55455

February 14, 1969

Mr. David Preston
Associate Director
Box No. 606
University of Minnesota Hospitals
Minneapolis, Minnesota 55455

Dear Dave:

Reference is made to our conversation last week regarding the location of the adult beds for the Department of Family Practice and Community Health in the new construction. As you recall, the beds originally were placed adjacent to Department of Medicine beds. You inquired of me whether it would be preferable to have these beds associated adjacent to Department of Pediatric beds. I am writing this letter to confirm that I would look unfavorably on such a move. There are many cogent reasons why the adult beds of the Department of Family Practice should be adjacent to Department of Medicine beds. Among these are the following.

1. A large portion of our adult patients who are hospitalized would fall into an elderly age group. The problems of caring for hospitalized patients in this age group are different from the problems associated with caring for patients in the pediatric age group. Consequently, it would be easier for the personnel on both nursing stations if their function were similar. In addition to this, those patients who were semi-ambulatory and who occasionally left their rooms would be in association with others who would have common problems and would share common interests.

2. It is almost certain that from time to time there would be opportunity for an overlapping use of beds in that there may be certain occasions when we would

need to use some of the empty Medicine beds and there may be other occasions when the Department of Medicine would be crowded and would want to use some of our beds. Having the nursing stations in apposition to each other would make for a more efficient utilization of beds under these circumstances.

As we also discussed, we will have certain need to utilize Pediatric beds for our patients in this age group. It is my understanding that it is satisfactory to the Pediatrics Department for us to use beds on their service for infants and young children. This would seem to be a better arrangement than having a separate Pediatric unit associated with the Department of Family Practice.

If there are any questions regarding this, please call me and we can discuss it further.

Sincerely,

B. F. Fuller, M.D.
Professor and Chairman
Department of Family Practice
and Community Health

BFF:jw
cc: Mrs. Karen Levin

DEPARTMENT OF FAMILY PRACTICE AND COMMUNITY HEALTH

UNIVERSITY OF MINNESOTA HOSPITALS

STRUCTURE AND ORGANIZATION

SEPTEMBER, 1970

Department of Family Practice
and Community Health
University of Minnesota Hospitals
412 Union Street, S.E.
Minneapolis, Minnesota 55455

UNIVERSITY OF Minnesota

UNIVERSITY HOSPITALS • MINNEAPOLIS, MINNESOTA 55455

February 19, 1969

Mr. Robert Turner
The Architects Collaborative
46 Brattle Street
Cambridge, Massachusetts

Dear Mr. Turner:

This letter is in reference to the location of the Family Practice inpatient bed unit in new construction on the floor with the adolescent pediatric unit. As you recall, we had discussed this location after Dr. Fuller's review of the plans, during which he indicated a preference for location adjacent to an adult medical unit. Dr. Fuller subsequently sent the attached letter outlining the reasons for his feelings in the matter.

I have since reviewed the new inpatient unit plans with Dr. Fuller. He feels that while the new configuration alleviates the problem of intermingling the very old with the very young patients, it does not solve the other problems which he outlined, in essence, he feels that his objections are still appropriate.

One possible alternative would be to interchange the location of the Family Practice unit and the School of Nursing experimental unit. This possibility would, of course, depend upon several unanswered questions relating particularly to physician staff coverage of the School of Nursing experimental unit. It is my understanding that a joint hospital-School of Nursing committee is to be formed to work out the answers to these questions.

Please contact me if you would like additional information.

Sincerely yours,

David R. Preston
Associate Director

DRP/js
Enclosure
cc: Dr. French Dr. Fuller
Mr. Sammond Mrs. Levin

DEPARTMENT OF FAMILY PRACTICE AND COMMUNITY HEALTH

STRUCTURE AND ORGANIZATION

INTRODUCTION

The primary goal of the Department of Family Practice and Community Health is education of the physician in all aspects of primary health care. Designed as "A Community-University. . .Internship and Residency Program in Family Practice and Community Health,"[1] the educational program of the department offers a flexible graduate training design. This includes a three-year combined internship and residency, and provides an opportunity to pursue graduate work toward a Master of Science Degree in Family Practice and Community Health. The candidates have the option of following a sequence from internship into residency or to terminate their formal training after internship and enter practice. In this respect, the internship can be a self-contained experience or can serve as the first year in a three-year in-depth educational program.

Having negotiated limited affiliation agreements with six Twin Cities area hospitals,[2] the department has sought to develop an educational continuum in Family Medicine. The full resources of these participating hospitals combine with the educational resources of the University for a total community-university experience. Internships in Family Practice and Community Health are sponsored by these hospitals in contrast with the traditional rotating internships. The overriding goal of this year of internship will be to provide an environment in which the intern will develop both a disease expertise in these areas encompassed by family medicine and a behavioral expertise enabling him to apply his knowledge more effectively for the benefit of his patient. In addition, the program is structured to prepare the intern for progression into the residency program in Family Medicine.

The residency program is planned in such a way that residents are given responsibility as primary physicians for a patient population. They will be responsible for both inpatients and outpatients from their population throughout the period of their tenure with the program. They will be supported by the faculty of the department and will have access to appropriate consultants as they need them.

There will also be opportunities for the resident to spend discrete periods of time in certain areas such as obstetrics, emergency room, coronary care units, and other areas as he needs them. This selection will be made to comply with the particular interests of the resident, the locus of his future practice and his previous experience.

At present the provision of a patient population for the residency program is made through the department's development of its own "model" primary health care clinic. Through this Clinic, the department has sought to develop a patient population consisting of: (1) fee for service patients, and (2) patients who would subscribe to a prepaid comprehensive health insurance program.[3] Located within one wing of the University of Minnesota Hospitals, the clinic will serve as a setting in which to train residents in the aspects of primary health care.

ORGANIZATION

To suggest a formal organization for the Department of Family Practice and Community Health, each area of responsibility relating to the implementation of the program of the department must be identified. The role of the FPCH Clinic, which assumes a responsibility for patient care, is best defined if it is viewed as one "model" with which to demonstrate primary health care delivery. The development and operation of the clinic can then be isolated

as one specific area of responsibility of the department. Both the department and the clinic must be formally organized: the former, to accomplish its responsibility of overall program and curriculum development; the latter, to accomplish its more specific responsibility of patient care.

THE DEPARTMENT

There are 15 areas of responsibility relating to the implementation of the program of the department. Not listed in any specific order, they are:

Curriculum Development
Undergraduate Programs (e.g., tutorials, externships)
Internships
Residencies
Advising
Teaching
Staffing
Recruiting (students)
Public Relations
Planning and Coordinating Programs
Community Health Program Development
Research
FPCH Clinic Development and Operation
Office Organization and Supervision
Equipment and Facility Needs

This list can be somewhat condensed by grouping certain items. It is then feasible to suggest a committee structure of organization with each committee delegated responsibility for the development and implementation of a particular segment of the program. In so doing, seven such formal committees emerge. It is suggested that each committee operate under the guidance of a chairman who may or may not be a full-time staff member of the department, but, who in any case, has a vested interest in the programs of the department. These committees, through their chairman, usually report to an "exectuve committee" for review of proposals. When designated, they may report directly to the head of the department.

Figure 1 depicts the general concepts of this organization. The executive committee is included in this organization--its composition and

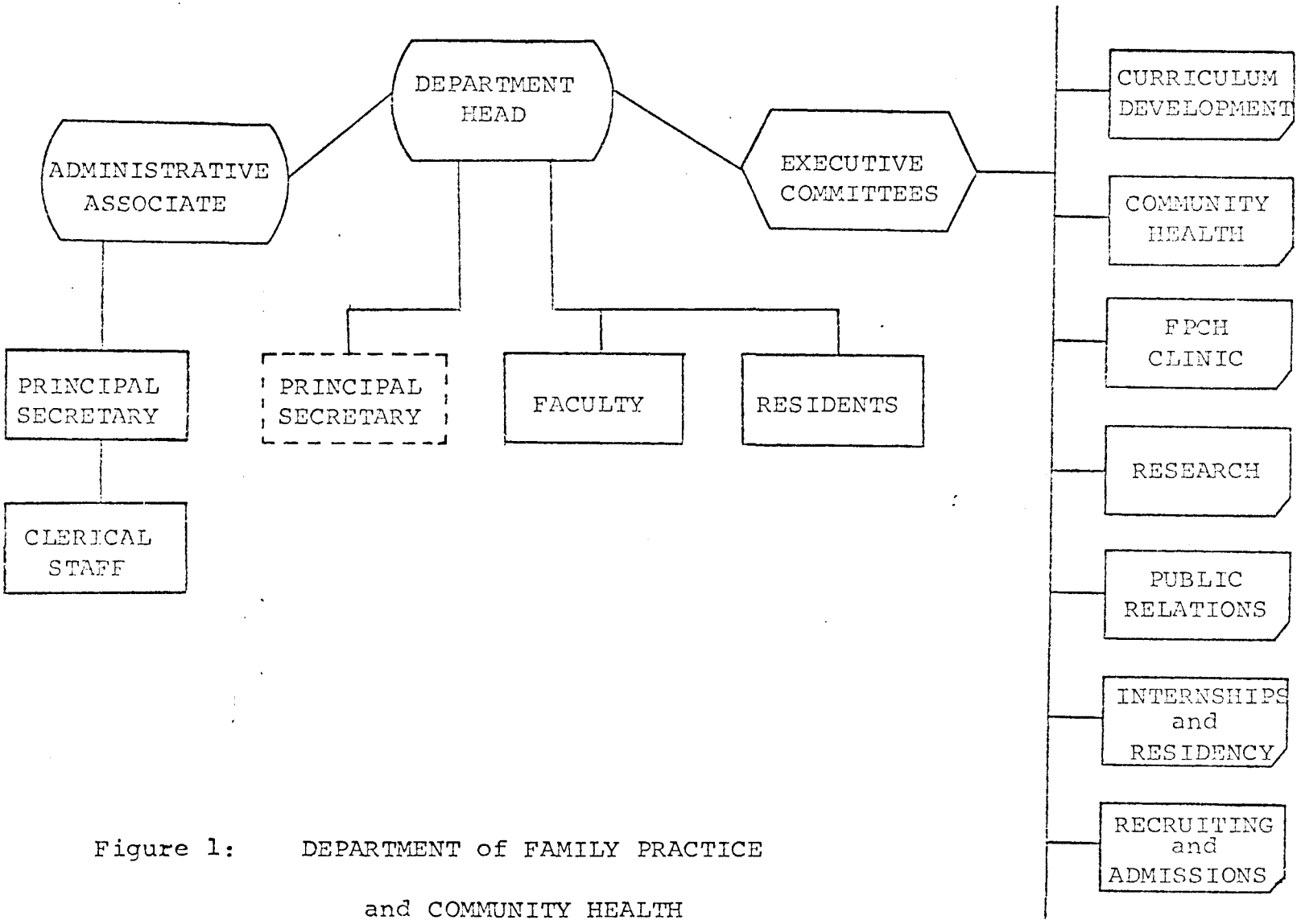


Figure 1: DEPARTMENT of FAMILY PRACTICE

and COMMUNITY HEALTH

function to be developed later. In brief summary form, the role of various personnel in the department as well as the role of the various formal committees is described below.

a. The Department Head

- Provide overall guidance and direction in the implementation of FPCH programs.
- Provide overall guidance and direction in the planning and development of new programs.
- Function in the area of public relations; intra-inter department relationships, medical community, lay community, etc.
- Attend to staffing, teaching, advising and recruiting functions of the department.

b. The Administrative Associate

- Supervise departmental financial activities; budget preparation, allocation.
- Function as department liaison; interpreter of departmental activity to outside groups, University Hospital, new staff members, etc.
- Prepare studies and reports on department operation and overall activity at the request of the department head.
- Act in capacity of a special staff assistant to department head to perform administrative duties upon request.
- Supervise planning and organization of equipment and facilities.
- Supervise office personnel.

c. The Principal Secretary

(See appendix: Office Personnel Guidelines)

- Dual role

(1) personal secretary to department head
(2) office supervisor

d. Clerical Staff

(See appendix: Office Personnel Guidelines)

e. Faculty

- Accept assignments on committees and responsibility for committee functions.

- Provide instruction and advising for the departmental program.

- Perform project assignments, speaking assignments, patient care responsibility, etc. at the request of the department head.

f. Residents

- Assume responsibility in total for primary health care of patient population (both ambulatory and in-hospital care) with faculty support and supervision.

- Become familiar with all of the resources of the community in which he is practicing which contribute to better total patient care.

- Monitor their own educational development.

g. Formal Committees

1. Curriculum Development Committee

The Curriculum Development Committee will be one of the larger committees in the department. It will be expected to take an over-view of the total educational program in the department. Its three areas of responsibility will be:

1. To coordinate the undergraduate curriculum and develop areas relevant to family practice. Among other tasks, this will involve implementing the Man and His Community Program and the Student as Physician Program in the Phase A and B parts of the undergraduate curriculum.

2. To coordinate and develop the graduate program as it relates to the combined internship and residency.

3. To develop and formalize some postgraduate educational programs that may be offered by the department.

2. Community Health Committee

The Committee on Community Health will be charged with conceptualizing a program in community health to be a major component of the Department of Family Practice and Community

Health. It will address itself to such areas as Man and His Community and the undergraduate curriculum. It will develop a component of the department which will address itself to those matters relating to what ultimately will be community health as a course content and subject area. The primary objective of this committee will be to attract new and young ideas towards the development of concepts of Community Health, such as was done in framing the components of the Family Practice Program.

3. FPCH Clinic Committee

The Family Practice and Community Health Clinic Committee will serve as a liaison between the department and the clinic. It will consist of at least three individuals: the Clinic Manager, the Medical Director of the Clinic, and the Administrative Assistant of the department. It is anticipated that each of these individuals will have academic appointments to the staff of the department. Reference should be made to Figure 2, the organizational structure of the FPCH Clinic, and to Section 2 of this outline.

4. Research Committee

The function of the Research Committee can be summarized as follows:

1. To channel and focus the research efforts of the department.
2. To develop mechanisms for recruiting and management of research funds.
3. To assist individuals in research and project development.

5. Public Relations Committee

Public relations is a responsibility to be shouldered by all members of the department. In particular, this responsibility rests with the Department Head. The Committee on Public Relations has been structured so as to provide the Department Head with a means of channeling certain public relation assignments or requests to other individuals. It is suggested that membership on the committee represent administrative, medical, and behavioral aspects of the department's program.

6. Internships and Residency Committee

The Committee on Internship and Residencies, at the outset, will undoubtedly work closely with the head of the Family Practice Department in the integration of the Internship-Residency Program with affiliated institutions. It will be the duty of the head of the department and the committee to see that the associated institutions and their staffs comply with the proper curriculum, proper teaching, and required care delivery in this program. It may also serve as a sounding board for the interns and residents in these various institutions to get an input to the head of the department on any suggestions or problems occurring in their institutions and where they are unable to get an effective listening post.

7. Recruiting and Admissions Committee

The Committee on Recruiting and Admissions will undoubtedly work closely with the intern and resident committee. It will take care of the basic administrative policies and implementations of the recruitment of interns and residents into

the total program and the follow through with their applications and recommendations to the Executive Committee and head of the department for those that they deem fully worthy to be accepted into the training program. Along with this committee, the principal secretary will undoubtedly form an important part since she will be the office resource for much of the help to this committee.

THE FAMILY PRACTICE AND COMMUNITY HEALTH CLINIC

The Family Practice and Community Health (FPCH) Clinic is designed to be a "model" clinic in which to demonstrate primary health care. This means that it must serve various purposes. One, it must serve as a setting in which to deliver primary health care to a patient population. This will include both ambulatory care and in-hospital care. Second, it must serve as a setting in which to educate resident physicians who will assume responsibility for total care of the patient population over a prolonged period of time. Third, it must serve as an exemplary model of medical practice. In this respect, it may serve as a setting in which to investigate various systems of health care delivery in an effort to redefine medical practice.

To serve these purposes, the clinic must be responsible for three functions: (1) patient care, (2) education, and (3) research. Patient care is its primary responsibility. Before the clinic can serve as a setting for education and research, a patient population must be developed and maintained. To do so, service in the clinic must be competitive with that rendered by organized practices located within the marketing area of the insurance program.[4]

The organizational chart contained in Figure 2 presents a structure for the FPCH Clinic. The clinic is a branch of the department, headed by two individuals who are depicted as equals: The Medical Director and the Clinic Manager. These individuals are charged with the responsibility of delivering health services to a patient population. Professional medical and supporting services as well as administrative services will be brought together cooperatively by these individuals in such a manner as to provide patients with quality health care.

The Medical Director and the Clinic Manager function together in an effort to accomplish this same end. Yet, each is to some degree autonomous. The Medical Director is a physician. His responsibility lies largely with the provision of medical and supporting services within the clinic. In addition, he is responsible for the education of the resident physician to the extent that it is provided in the FPCH Clinic.

The Clinic Manager is a non-physician. He is primarily an administrator. His responsibility is to provide a system of efficiently managing the business of the clinic. From a logistics point of view (patient processing), he is also concerned with patient care. It is likely, also, that the Clinic Manager will be vested with a responsibility for education of the resident physician, particularly as it may apply to setting up and managing a practice.

The concept of administrative equality between the Medical Director and the Clinic Manager is one of critical importance to the smooth operation of the clinic. Each individual is skilled in a somewhat separate phase of health care delivery. Yet, both function to accomplish the same end: the provision of quality health care. Neither, alone, can be expected to accomplish this same end which consists of quality and efficiency in both medical

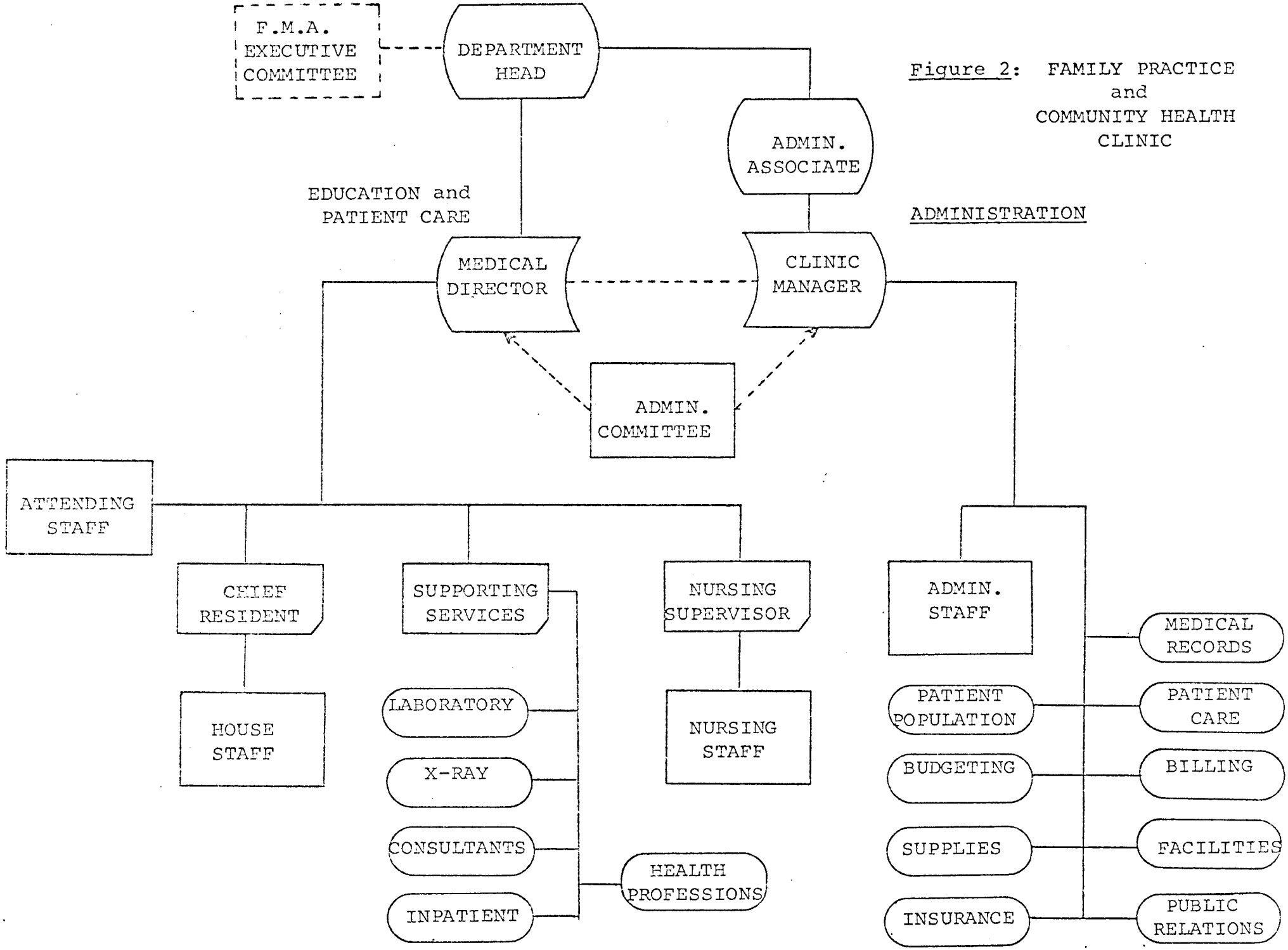


Figure 2: FAMILY PRACTICE and COMMUNITY HEALTH CLINIC

and administrative services. They must function together, and each must have an appreciation and a knowledge of the other's role.

Where such equality in organization prevails, however, a supportive system must be devised to resolve conflicts which may result between any two equals. Such a supportive system is suggested for the FPCH Clinic by: (1) making the Clinic Manager administratively responsible to the Administrative Associate in the Department of Family Practice and Community Health, and (2) making the Medical Director administratively responsible to the Department Head. The Administrative Associate, of course, is responsible to the Department Head much as any other staff member is.

Also depicted in Figure 2 in an Administrative Committee. This committee is composed of the Medical Director, the Clinic Manager and other key personnel who staff the FPCH Clinic. Examples of these other key personnel are: the Chief Resident, the Nursing Supervisor, the Medical Records Librarian, and certain other Health Professionals. This committee will likely schedule regular meetings to discuss matters pertaining to the daily functioning of the clinic. Its members will concern themselves with issues relating to service and patient care including mechanisms for improving the same. As such, the Administrative Committee will be advisory to both the Medical Director and the Clinic Manager.

As a supervisor, the Medical Director will be responsible for four groups. First, he will be responsible for the Attending Staff. These will be physicians who are faculty members of the department. They will be responsible for the education of the resident and in that context will also assume responsibility for patient care.

A second supervising responsibility of the Medical Director will be that connected with the House Staff and the Chief Resident. The House Staff

will consist of resident physicians who are first and primarily responsible for total care of the patient population. They will act under the guidance and supervision of the Attending Staff and the Medical Director. One such resident will be chosen periodically as the Chief Resident and will assume, among other responsibilities, the responsibility of a liaison between the House Staff and the Medical Director. He will also be a member of the Administrative Committee.

A third group, responsible to the Medical Director for supervision, will be the Nursing Staff. Acting under an immediate supervisor, the nursing staff will function under the general direction of the Medical Director. The Nursing Supervisor will assume an administrative responsibility similar to that of the Chief Resident and will be a member of the Administrative Committee.

The last category of services supervised by the Medical Director are titled Supporting Services. Included in this group are Laboratory and X-Ray services, the services of Consultants in various medical specialties in In-hospital services. Also included are the services of various Health Professionals. Examples of such personnel are: Pharmacists, Social Workers, Dietitians, and Public Health Nurses. In this area, the responsibility of the Medical Director will be one primarily of planning and coordination.

The Clinic Manager, as a supervisor, will be responsible for the Administrative Staff. This staff will perform the duties necessary for: (1) the development and maintenance of a patient population, (2) budgeting for clinic operations (to include the development and maintenance of a cost-accounting system), (3) medical and business supplies, (4) insurance coverage, (5) medical records, (6) patient processing and care, (7) billing and maintaining accounts payable, (8) medical and business facilities, and

(9) public relations (clinic-University, clinic-lay community, etc.).

Members of the Administrative Staff may include all or some of the following: Receptionists, Medical Records Librarian, Service Representative, Accounting Clerks, and Marketing Personnel.

One additional group is represented in the organizational structure of the FPCH Clinic. This is the Family Medicine Associates (F.M.A.) Executive Committee. Consisting of physicians who hold full-time faculty appointments to the University of Minnesota, Department of Family Practice and Community Health, all of whom are licensed to practice medicine in Minnesota, this committee is responsible for the distribution of net income from the FPCH Clinic.[5] It has no authority, however, for setting policies and determining management procedures.

LIST OF REFERENCES

1. "Family Medicine, a Community-University. . .Internship and Residency Program in Family Practice and Community Health," University of Minnesota Medical School.

2. Ibid.

3. "Minnesota Family Health Plan," Department of Family Practice and Community Health, University of Minnesota, 1970.

4. Ibid.

5. "Articles of Partnership," Family Medicine Associates, University of Minnesota, July 1, 1969.

STAFF: DEPARTMENT OF FAMILY PRACTICE AND COMMUNITY HEALTH SEPTEMBER, 1970

FULL TIME FACULTY

Jack Verby	M.D.	Associate Professor, Acting Head
John O'Leary	M.D.	Associate Professor
Joseph Connolly	M.D.	Assistant Professor
Dave Spencer	M.D.	Assistant Professor
Gary Peterson	M.A.	Administrative Associate (Hospital Administration)
Jim Kenney	Ph.D. Candidate	Instructor (Educational Psychology)
Emil Berkanovic	Ph.D.	Assistant Professor (Medical Sociology)

PART TIME FACULTY

Richard Bendel	M.D.	OB&Gyn.
Meridel Fahsl	M.A.	Health Education
Joseph Gendron	M.D.	Psychiatry
Jean Smelker	M.D.	Pediatrics
Vernon Weckwerth	Ph.D.	Biometry
Joseph Westermeyer	M.D.	Psychiatry
Harold Ireton	M.D.	Psychiatry-Neurology

RESIDENTS

Dale Dobrin	M.D.	Second Year
David Frederickson	M.D.	First Year
David Maas	M.D.	First Year

OFFICE PERSONNEL

Lavonne Weschske	Principal Secretary
Bonnie Braxtan	Sr. Clerk Typist
Linda Marksbury	Sr. Clerk Typist

CONSULTANTS

Ben Fuller	M.D.	Medicine
Reynold Jenson	M.D.	Child Psychiatry

Eric Dardinger, Grad. Stu., Management-Accounting
Clyde Neu, Grad. Stu., Operations Research-Finance

CLINICAL APPOINTMENTS

Kenneth Ahola	M.D.	Hibbing
John Anderson	M.D.	Blue Earth
E. P. Donatelle	M.D.	Minneapolis
Herman Drill	M.D.	Hopkins
Herman French	M.D.	Hibbing
Harris Hinderaker	M.D.	Wilmar
Matt Plasha	M.D.	Coon Rapids
Harley Racer	M.D.	St. Louis Park
Robert Reif	M.D.	St. Paul
Orris Rollie	M.D.	St. Paul
Robert Rotenberg	M.D.	Minneapolis
Richard Williams	M.D.	Minneapolis
Eldon Berglund	M.D.	Hennepin County General Family Practice Dept.
Vince Hunt	M.D.	(same)
Stuart Thorson	M.D.	(same)

DIRECTORS: INTEGRATED INTERNSHIPS

Al Belsito	M.D.	Bethesda
John Flinn	M.D.	Methodist
John LaBree	M.D.	St. Mary's
Dawes Miller	M.D.	Fairview
Harley Racer	M.D.	St. Louis Park
Robert Reif	M.D.	St. John's

COMMITTEES: DEPARTMENT OF FAMILY PRACTICE AND COMMUNITY HEALTH

CURRICULUM DEVELOPMENT	Jim Kenney	Emil Berkanovic
	Dave Spencer	Joe Gendron
	Ben Fuller	Dale Dobrin
COMMUNITY HEALTH	Dave Spencer	Jean Smelker
	Emil Berkanovic	Joe Gendron
	Ben Fuller	John O'Leary
FPCH CLINIC	Gary Peterson	Rosie Acton
	Joe Connolly	Diane Spain
	Dave Spencer	
RESEARCH	John O'Leary	
	Emil Berkanovic	
	Dave Spencer	
	Gary Peterson	
PUBLIC RELATIONS	Jack Verby ...	(plus staff)
	Gary Peterson	
	John O'Leary	
	Jim Kenney	
INTERNSHIPS AND RESIDENCY	Joe Connolly	John LaBree
	Gary Peterson	Dawes Miller
	Al Belsito	Harley Racer
	John Flinn	Robert Reif
RECRUITING AND ADMISSIONS	Joe Connolly	
	Jack Verby	
	Jim Kenney	

UNIVERSITY OF Minnesota

UNIVERSITY HOSPITALS · MINNEAPOLIS, MINNESOTA 55455

September 1, 1970

Mr. Kenneth Taylor
The Architects Collaborative
46 Brattle Street
Cambridge, Massachusetts

Dear Ken:

As a result of conversation with Drs. Gedgaudas and Fuller relating to the proposed provision of x-ray facilities in the Family Practice Clinic, I would like to summarize my understanding of the situation at this time. Essentially, Dr. Fuller did not change his original position that in order to provide a model ambulatory health care environment for his students and house staff, he would need x-ray facilities in his clinic. Likewise, Dr. Gedgaudas did not change his principle that diagnostic radiology can be provided more efficiently and to a higher level of quality by centralizing the facilities. Dr. Fuller indicated that he was willing to be shown by the Radiology staff between now and the opening of the new Family Practice Clinic (in 1973) that they would be able to provide the kind of service he feels necessary for his program. If they are able to do so, he would be willing to forego separate radiology facilities. In the meantime, he would not wish to delete the programmed radiology unit in the Family Practice Clinic area. Dr. Gedgaudas and I agree that probably the best way to settle this for now is to include the planned radiology facility in Family Practice with the definite intention of reviewing the situation prior to installation of lead sheilding etc. with an eye to the possibility of changing the use of the room during construction. This would allow time for the Family Practice staff to have experience using the present centralized radiology facility. Therefore, I would ask your office and our planning office to make a note that this subject be reviewed in about 2 years.

There are two things that have been changed since the above conversations took place.

1. Family Practice is now planned on Floor 3 rather than Floor 7 bringing it much closer to the satellite radiology on Floor 1.

2. Dr. Fuller has resigned as chairman of Family Practice, and I do not fully know the feelings of his successor on this subject.

Either of these events may serve to alter the above conclusions. If they do, I should like to hear from an appropriate member of his staff as to their present view of the situation.

Sincerely,

Peter H. Sammond
Associate Director
University of Minnesota Hospitals

PHS/lml
cc/Dr. Gedgaudas
Dr. Fuller
Jane Felder

FAMILY PRACTICE

Minutes of Meeting September 3, 1970

Present: Dr. Spencer, Miss Spain, Miss Acton, Mr. Block, Mr. Finzen

Dr. Spencer finds present Family Practice module of 9,416 sq. ft. net unsatisfactory and indicates the Department will pursue additional space of approximately 2,000 sq. ft. A possible solution could be moving departmental space to separate floor and maintain clinic on floor 3.

THE ARCHITECTS COLLABORATIVE

23 September 1970

Mr. Peter Sammond
Associate Director
University Hospital
Minneapolis, Minnesota 55455

Re: University of Minnesota
Health Sciences Expansion
Unit B-C
Job No. 70046

Dear Peter:

In response to your letter regarding the provision of x-ray facilities in the Family Practice Clinic it is necessary to consider the bidding procedures of your proposal. We will design the Family Practice Clinic both with and without x-ray unit, but we recommend that the unit be bid as an add alternate in the Unit B-C contract. By doing this, you will get a much fairer estimation of the cost of the x-ray unit than you would if you deleted the x-ray unit during construction. This recommendation would require that you make the determination whether to include the x-ray unit or not by the date of award of the B-C contract, which according to the current schedule will be July 1972. We will proceed on this basis unless we hear otherwise from you.

Yours very truly,

THE ARCHITECTS COLLABORATIVE, Inc.

Kenneth Taylor

KT/bb

cc: Dr. Gedgaudas
Dr. Fuller
Hugh G. S. Peacock
C. Thomas Smith ✓

46 BRATTLE STREET, CAMBRIDGE, MASSACHUSETTS 02138
TELEPHONE: (617) UNIVERSITY 8-4200 CABLE: TACCAM CAMBRIDGE

UNIVERSITY OF Minnesota

Jerry Plamann
Family Practice Clinic

UNIVERSITY HOSPITALS · MINNEAPOLIS, MINNESOTA 55455

Family Practice Clinic

December 1, 1970

TO: Ken Taylor and Peter Sammond

FROM: C. Thomas Smith, Jr.

SUBJECT: FAMILY PRACTICE X-RAY FACILITY

I discussed this subject with Hugh Peacock last week and he concurred that it should be handled as an add alternate in the general B/C contract.

cc: Mr. Peacock

CTS:slt

Jerry - Planning

THE ARCHITECTS COLLABORATIVE, INC.

UNIVERSITY OF MINNESOTA
HEALTH SCIENCES EXPANSION 70046

20 November 1970

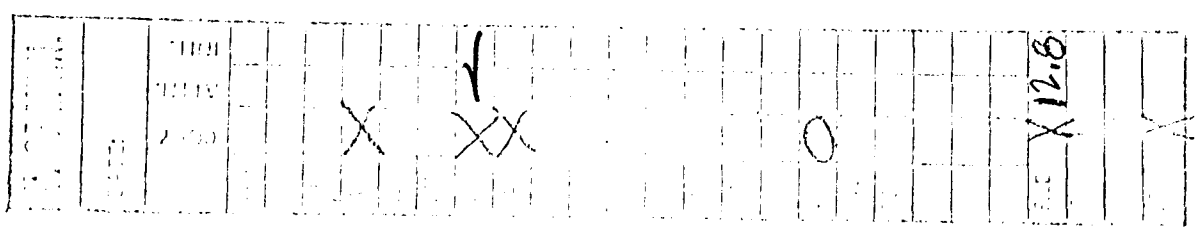
PROPOSED FAMILY PRACTICE CLINIC

		Net Area
Reception/Clerical		300
Waiting (inc. Child Wait)		575
Business Office	2 @ 108	375
Clinical Psychologist		216
Social Worker		108
Psych Test		108
Exam Rooms	26 @ 108	2808
OB/Gyn Exam Rooms w/Toilet	4 @ 108 + 30 = 138	552
Treatment Room	2 @ 216	452
Consultation Room	6 @ 108	648
Procto Room w/Toilet	144 + 25	169
Procto Clean-Up		60
Nurses Station	2 @ 200	400
Drs. Dictating		250
Soiled Utility	1 @ 200 or 2 @ 100	200
Clean Utility	2 @ 100	200
Laboratory	1 Module Urinalysis @ 200 1 Module Hematology @ 200	400
Staff Toilets	4 @ 30	120
Janitor		50
Storage		240
TOTAL		8241

Original Program = 5842
Added Area = 2400

TOTAL 8242

JB/bb

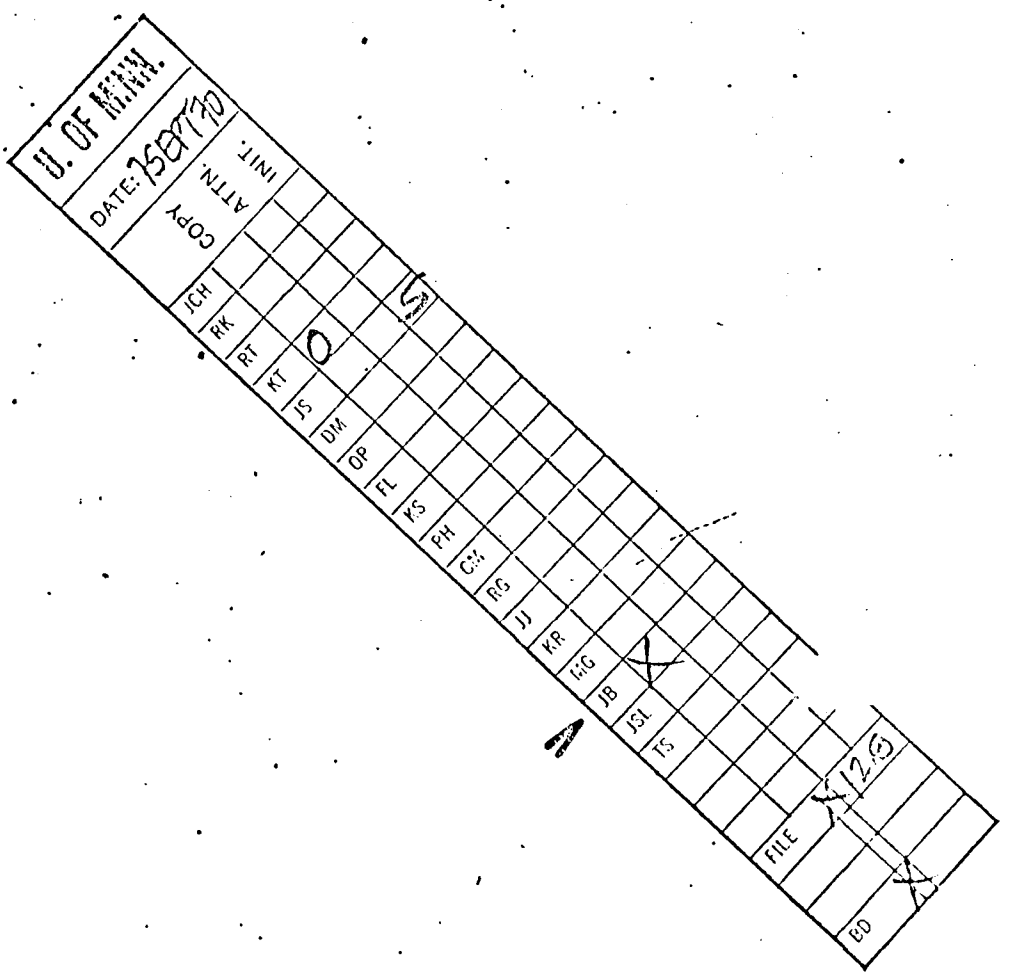


		TOTAL
12.8.1	Department Facilities	3,574
12.8.2	Family Practice Clinic	5,842
TOTAL		9,416

Notes: This clinic serves ambulatory patients in a comprehensive plan of family medicine and community health, diagnosing and teaching adults and children.

This clinic should be conveniently located to the departments of Radiology and Laboratory Medicine.

The unit should be designed as a completely separate function, and if possible have its own identifiable entrance. The unit is essentially self-contained, referring to other specialties only when more sophisticated procedures are required.



21 January 1969

Vb SUMMARY OF REQUIRED SPACE:

SPACE	AREA	NUMBER	TOTAL
Staff Physician Office	100	18 10	1,800
House Staff Office (4 man)	200	4	800
Chief Resident's Office	120	1	120
Study Carrell	34	6	204
Library-Conference Room	300	1	300
Secretarial Area	350	1	350
TOTAL			3,574

SPACE AS SHOWN ON PLAN 31 August 1970

Clerical & Reception	300	1	300 - 50
3 Man Offices	150	4	600 - 200
Seminar Room	450	1	450 + 100
Study Carrells		6	180 - 24
Staff Offices	117	11	1,347 - 153
Staff Offices	100	3	300
TOTAL			3,147

31 August 1970
20 January 1969

12 OUT-PATIENT CLINICS — 12.8.2 FAMILY PRACTICE CLINIC

Vb SUMMARY OF REQUIRED SPACES:

SPACE	AREA	NUMBER	TOTAL
Reception and Waiting	600	1	600
Business Office	400	1	400
Psychologic Testing	108	1	108
Clinical Psychologist	108	1	108
Clinical Psychologist	108	1	108
Social Worker	108	1	108
Examination Room	108	30	3,240
Nurses Station	200	1	200
X-Ray Suite	400	1	400
Treatment Room	150	1	150
Procto Room	108	1	108
Laboratory	300	1	300
Storage	120	1	120
TOTAL			5,842

SPACE AS SHOWN ON PLAN 31 AUGUST 1970

Reception and Waiting	930	1	930	+194
Business Office	264	1	264	
Exam Room	117	13	1,521	-1323
Exam Rooms	132	3	396	
Psy Test	130	1	130	+ 22
Storage	50	1	50	- 70
Proctology	132	1	132	+ 22
Clinical Psych	117	2	234	+ 18
Doctors	264	1	264	+264
Nurses	132	2	264	+ 64
Treatment	264	1	264	+164
Utility Rooms	132	2	264	+264
Social Worker	100	1	100	- 8
Lab	270	1	270	- 30
X-Ray	450	1	450	+ 30
Toilet (specimens coll)	111	1	111	+111
Seminar	190	1	190	+190
TOTAL			5,834	

45
15
275
95

1194
675
519

31 August 1970
21 January 1969

THE ARCHITECTS COLLABORATIVE, INC.

UNIVERSITY OF MINNESOTA
HEALTH SCIENCES EXPANSION #70046

8 December 1976

PROPOSED FAMILY PRACTICE CLINIC
Revised to Include X-Ray Suite

			Net Area
Reception/Clerical			224
Waiting (inc. Child Wait)			500
Business Office			350
Clinical Psychologist	2 @ 108		216
Social Worker			108
Psych Test			108
Exam Rooms	23 @ 108		2484
OB/Gyn Exam Rooms w/Toilet	4 @ 108 + 30 = 138		552
Treatment Room	2 @ 216		432
Consultation Room	5 @ 108		540
Procto Room w/Toilet	144 + 25		169
Procto Clean-Up			60
Nurses Station	2 @ 175		350
Drs. Dictating			200
Soiled Utility	1 @ 200	or 2 @ 100	200
Clean Utility	2 @ 100		200
Laboratory	1 Module Urinalysis @ 200		400
	1 Module Hematology @ 200		
X-Ray Suite	1 X-Ray Room (Extremities 14 x 18) = 252		622
	1 X-Ray Room (Chest) 100		
	Storage 50		
	Reading & Assembly 100		
	Dark Room 50		
	3 Dressing Rooms 70		
Staff Toilets	4 @ 200		120
Janitor			50
Storage			200
TOTAL			8241

Original Program = 5842
Added Area = 2400

TOTAL 8242

JB/bb

THE ARCHITECTS COLLABORATIVE, INC.

UNIVERSITY OF MINNESOTA
HEALTH SCIENCES EXPANSION 7009 G

20 November 1970

PROPOSED FAMILY PRACTICE CLINIC

		Net Area
Reception/Clerical		300
Waiting (inc. Child Wait)		575
Business Office	2 @ 108	375
Clinical Psychologist		216
Social Worker		108
Psych Test		108
Exam Rooms	26 @ 108	2808
OB/Gyn Exam Rooms w/Toilet	4 @ 108 + 30 = 138	552
Treatment Room	2 @ 216	432
Consultation Room	6 @ 108	648
Procto Room w/Toilet	144 + 25	169
Procto Clean-Up		60
Nurses Station	2 @ 200	400
Drs. Dictating		250
Soiled Utility	1 @ 200 or 2 @ 100	200
Clean Utility	2 @ 100	200
Laboratory	1 Module Urinalysis @ 200 1 Module Hematology @ 200	400
Staff Toilets	4 @ 30	120
Janitor		50
Storage		240
TOTAL		8241

Original Program = 5842
Added Area = 2400

TOTAL 8242

JB/bb

THE ARCHITECTS COLLABORATIVE, INC.

UNIVERSITY OF MINNESOTA
HEALTH SCIENCES EXPANSION
TAC JOB NO. 70046

20 November 1970

PROPOSED FAMILY PRACTICE CLINIC PROGRAM

The Family Practice Clinic Program has increased 2,400 S.F. The following items concerning Family Practice Clinic Program should be resolved as soon as possible.

1. Some of the specialized areas originally programmed in the Family Practice Clinic are already provided within the building under different programs i.e. diagnostic x-ray, proctology, and clinical laboratories. These areas are relatively close to the Family Practice Clinic and possibly could be shared with Family Practice personnel. The enclosed program assumes that only the x-ray facilities are shared. Our original approach was to design the clinic both with and without x-ray facilities and postpone the final decision until after the bidding of the building. This approach has been questioned and it has been decided to push for a decision as soon as possible. If these special areas are included in the clinic they must be staffed by personnel trained for these procedures. Consideration must be given to obtaining these technicians and coordinating their activities with the same disciplines in the other areas of the health complex.

2. The 450 s.f. originally programmed for the x-ray suite may have to be expanded to about 750 S.F. if procedures more elaborate than chest work are anticipated, unless only one large x-ray room is used.

3. The proctology room has been expanded to include a separate toilet and clean-up room in order to contain septic material in one area and avoid cross-contamination of the rest of the clinic.

4. Four exam rooms with toilets have been provided for OB-GYN procedures.

5. The laboratory has been divided into two sections or modules to accomodate Urinalysis and Hematology somewhat separately.

6. A list of questions concerning the operational aspects of the typical clinic module has been developed and is attached. Many of these questions are applicable to your specialized clinic, i.e. records handling, the breakdown and distribution of supplies, the handling and pick-up of soiled material and wastes, etc. Answers to these questions will help to verify or modify the program.

7. The Family Practice Clinic is to be considered as an experimental clinic. In order to plan the clinic we need information defining the extent of experimental activities which are envisioned such as patient exam procedures, clinic administration, etc. We will want to plan maximum flexibility for areas where changes in function or approach are anticipated.

8. Since pediatrics patients will be treated in the clinic should a pediatircs toilet room be provided or would child size fixtures in the main toilet rooms suffice?

9. We are assuming that the original program for Family Practice departmental space is still valid.

JB/bb

		TOTAL
12.8.1	Department Facilities	3,574
12.8.2	Family Practice Clinic	5,842
TOTAL		9,416

Notes: This clinic serves ambulatory patients in a comprehensive plan of family medicine and community health, diagnosing and teaching adults and children.

This clinic should be conveniently located to the departments of Radiology and Laboratory Medicine.

The unit should be designed as a completely separate function, and if possible have its own identifiable entrance. The unit is essentially self-contained, referring to other specialties only when more sophisticated procedures are required.

21 January 1969

12 OUT PATIENT CLINICS 12.8.1 DEPARTMENT FACILITIES

V5 SUMMARY OF REQUIRED SPACE:

SPACE	AREA	NUMBER	TOTAL
Staff Physician Office	100	18	1,800
House Staff Office (4 man)	200	4	800
Chief Resident's Office	120	1	120
Study Carrell	34	6	204
Library-Conference Room	300	1	300
Secretarial Area	350	1	350
TOTAL			3,574

SPACE AS SHOWN ON PLAN 31 August 1970

Clerical & Reception	300	1	300
3 Man Offices	150	4	600
Seminar Room	450	1	450
Study Carrells		6	180
Staff Offices	117	11	1,347
Staff Offices	100	3	300
TOTAL			3,147

31 August 1970
20 January 1969

12 OUT-PATIENT CLINICS — 12.8.2 FAMILY PRACTICE CLINIC

Vb SUMMARY OF REQUIRED SPACES:

SPACE	AREA	NUMBER	TOTAL
Reception and Waiting	600	1	600
Business Office	400	1	400
Psychologic Testing	108	1	108
Clinical Psychologist	108	1	108
Clinical Psychologist	108	1	108
Social Worker	108	1	108
Examination Room	108	30	3,240
Nurses Station	200	1	200
X-Ray Suite	400	1	400
Treatment Room	150	1	150
Procto Room	108	1	108
Laboratory	300	1	300
Storage	120	1	120
TOTAL			5,842

SPACE AS SHOWN ON PLAN 31 AUGUST 1970

Reception and Waiting	930	1	930
Business Office	264	1	264
Exam Room	117	13	1,521
Exam Rooms	132	3	396
Psy Test	130	1	130
Storage	50	1	50
Proctology	132	1	132
Clinical Psych	117	2	234
Doctors	264	1	264
Nurses	132	2	264
Treatment	264	1	264
Utility Rooms	132	2	264
Social Worker	100	1	100
Lab	270	1	270
X-Ray	450	1	450
Toilet (specimens coll)	111	1	111
Seminar	190	1	190
TOTAL			5,834

31 August 1970
21 January 1969

B/C file

THE ARCHITECTS COLLABORATIVE, Inc.

OFFICE MEMORANDUM

TO: C. Thomas Smith

FROM: Ken Taylor

SUBJECT: Family Practice Space, Unit B-C

DATE: 16 January 1971

In response to your request to separate out a cost for Family Practice in Unit B-C, we have developed a total cost of $2,097,155 for the Family Practice Clinic and department space on the following basis:

Total cost, B-C new construction	$47,607,888
Less total moveable equipment	6,276,000
	$41,331,888

Total net space, B-C new construction	243,680 SFN
Total net space, Family Practice Clinic	8,214 SFN
Total net space, Family Practice Department	3,527 SFN
Total net space, Family Practice	11,741 SFN
Family Practice % of total space	4.818%
Family Practice % of total cost (not including moveable equipment)	$ 1,991,370
Family Practice Dept. moveable equipment	15,090
Family Practice Clinic moveable equipment	90,695
TOTAL COST FAMILY PRACTICE	$ 2,097,155

KT:cf

B/C

January 22, 1971

Mr. Dale Melver
Assistant to Congressman Fraser
332 House Office Building
Washington, D.C. 20515

Dear Mr. Melver:

At your request, I asked our architects to estimate the cost of Family Practice space which is slated to be located in the proposed Unit B/C in the Health Sciences expansion. As you know, this unit is the subject of a grant application that is currently being reviewed by the Bureau of Health Manpower. Action on this grant application will be taken by the Advisory Council to the Bureau some time in late February or early March, 1971. Of approximately $47.6 million for construction and equipment the Family Practice Department and clinic would require approximately $2.1 million.

I hope this information will be of value to you.

Yours very truly,

C. Thomas Smith, Jr.
Associate Director

CTS:slt

cc: V.P. French

THE ARCHITECTS COLLABORATIVE, INC.

cc. R Acton

UNIVERSITY OF MINNESOTA
HEALTH SCIENCES EXPANSION

MEETING NOTES

DATE: 2 February 1971

PLACE: Powell Hall 4112

TAC JOB: Unit B-C, #70046

PRESENT: Dr. Spencer, James Block, Ken Taylor, Dr. Peterson

SUBJECT: Family Practice Clinic

BY: Jim Block

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DATE: 9FEB71

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Floor plans of Unit B-C, 3 and 6, dated 1 February 1971, were presented. A new program dated 13 January 1971 was also presented. There were no objections to any part of the program presented. However, there were some modifications suggested for the layout of the Clinic area. In the reception area the Business Office should be expanded and have a more direct relationship to the reception area. The Doctors' Dictating area which is shown adjacent should probably be reduced, because there are several offices within the clinic where dictating would take place. The Utility Rooms which were located at one end of the clinic should be divided so that they occur on each end of the Clinic Plan. The clinical labs and x-ray facilities should be located more centrally than they now are. The major teaching facilities should be located to one side where the clinical labs and x-ray were located. This would put the seminar rooms, staff observation rooms, patient information gathering in this location. The Social Service Office and Clinical Psychologist's Office and Psychological Testing area will be located also in this area. Two more offices should be interspersed in the exam rooms on the north side of the clinic plan. One office should remain in the Reception - Business Office area for a supervisor.

The Family Practice departmental space on Floor 6 was discussed. The major question was the relationship of clerical or secretarial spaces to the offices. The reassignment of some offices to secretarial space seemed to be the most logical solution. The overall arrangement of the departmental spaces and the numbers of rooms seemed to be acceptable.

JB/bb
9 February 1971

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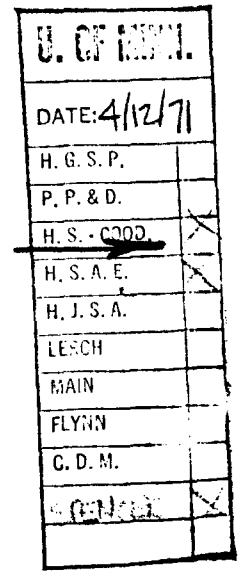
SPENCER

THE ARCHITECTS COLLABORATIVE, INC.



UNIVERSITY OF MINNESOTA
HEALTH SCIENCES EXPANSION

MEETING NOTES

DATE: 8 April 1971

PLACE: Powell Hall 4112

TAC JOB: Unit B-C, #70046

PRESENT: Dr. Spencer, Jim Block, Marion Quist

SUBJECT: Family Practice Clinic

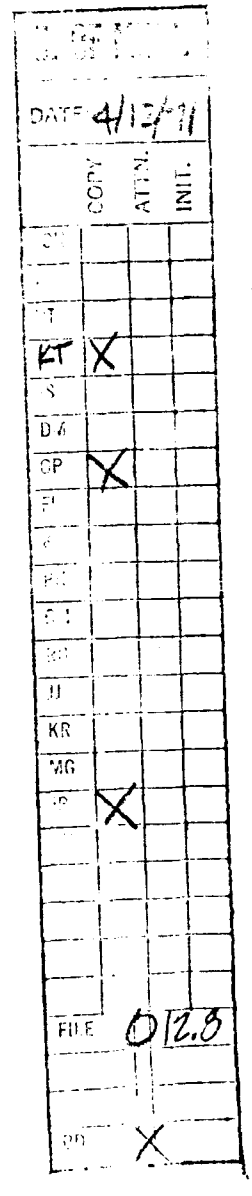
BY: Jim Block

An eighth inch scale plan of floor 3 was presented and supplemented by a 1/4" scale development of the clinical lab and x-ray area.

The x-ray area was found to be acceptable as drawn. The only question was whether the developing consultation and reading room was too large.

The overall layout of the clinical lab was acceptable with the exception of the clerical supervisor's area. This should not be completely outside of the clinic as shown but should be more integrated. A sketch was developed which began to achieve this.

Two colored prints of floor three were also presented, which showed alternate locations for clean and soiled utility rooms and nurses' areas. Dr. Spencer again outlined his former position on the combination of clean utility room and nurses' station. He also felt the switch to disposables would greatly reduce the size of the soiled utility room, which now would be used only for cleaning an occasional instrument. He would also prefer the nurses' rooms to be referred to from now on as physicians assistants. He feels that they will share equally the consultation and exam rooms throughout the clinic for their own staff teaching and patient consultation. This would eliminate the need for a specific room to be assigned to the nurses for their own consultation. The plan will be changed to reflect this philosophy. The exam rooms located adjacent to the teaching area are going to be considered as teaching/exam rooms and should not be the major factor in locating the clean utility-physicians assistant room, but rather the proximity to the waiting area for control functions.



JB/bb
12 April 1971

THE ARCHITECTS COLLABORATIVE, Inc.

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University of Minnesota
Health Sciences Expansion

MEETING NOTES

Date: 28 April, 1971

Place: Powell Hall, 4107

TAC Job: 70046

Present: Dr. Spencer, Jim Block

Subject: Family Practice Clinic

The minor revisions suggested at the last meeting had been made to the 1/8 in. scale plan. The lab bench for testing OB – gyn urine samples was placed at the end of the clinic in the cart storage area. One of the rooms adjacent to the staff teaching area has been designated for audio-visual equipment. The exam rooms had been clustered as much as possible to relate to the new soiled and cleaned utility locations.

The only changes specifically requested during the meeting was in the staff teaching area. Here one of the exam rooms should have an interconnecting door into the teaching space.

With this minor change Dr. Spencer approved both the 1/4 in. scale drawing of the x-ray and clinical lab area and the 1/8 in. scale drawing of floor 3.

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SPENCER	X
SAMMONS	X

Dr. Spencer would like to see a plan which further develops the business office showing desk layouts, file space and two or three mechanical file holders similar to a Soundex.

A 1/4 in. scale drawing of the proctology area should be developed which would be very similar to the proctology rooms shown on the first floor with identical equipment and a similar layout.

Both the patient-monitoring area and the staff-teaching area were approved as indicated on the 1/8 in. scale drawing. The sizes of the rooms shown and their relationships to the rest of the plan and the potential flexibility seemed ideal for the number of projected procedures anticipated in this area. No 1/4 in. scale development of these two areas will be made at this time, eventhough many of the suggested procedures will require sophisticated equipment. Some of the suggested patient-monitoring devices simply haven't been developed at this point. The number of computers on campus and their capacities will determine whether or not family practice will have its own computer in 1975. Some video taping is anticipated in the staff education area, the extent of the equipment and the detailed procedures are still in question. Since family practice is a relatively new department at the university, and many of the programs anticipated are new and unique to family practice; the final development of these two areas will occur after further experimentation and evaluation.

I talked to Paul Maupin before the meeting to discuss future changes to approved BC plans. I told him of the specific problems in finalizing the equipment in these two rooms in the Family Practice Clinic. We assumed that a review mechanism for changes and additions to BC plans would be set up during Working Drawings and would be coordinated through his office.

JB:ep

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THE ARCHITECTS COLLABORATIVE, Inc.

UNIVERSITY OF MINNESOTA
HEALTH SCIENCES EXPANSION

MEETING NOTES

DATE: 21 May 1971

PLACE: Powell Hall 4107

TAC JOB: Unit B C, #70046

PRESENT: Dr. Spencer, Jim Block

SUBJECT: Pratt Family Practice Clinic and Departmental Space

The plan of Floor 3 and Floor 6 dated 17 May 1971 were presented along with a quarter-scale development of the proctology room, soil utility rooms and the OB lab bench.

The quarter-scale drawing was approved with no modifications. The proctology room was organized in a similar way to the proctology rooms on the first floor with the same equipment shown. The utility rooms were organized as similar as possible to the typical utility rooms with adjustments made for the new distribution of area.

Next the business office on floor three was discussed and the location of the power files was questioned. We also took a quick look at the layout of the departmental space on floor 6, but Dr. Spencer preferred to wait until the business office person had reviewed the plans before approving them.

During a previous meeting the layout of the utility rooms and their relationships to the exam rooms was approved by Rosie Action of the nursing staff. The reception and waiting areas were discussed and approved by Bob Baker as to their general configuration and layout. During the same meeting Peter Sammond also approved the general layout of the floor and the contents.

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THE ARCHITECTS COLLABORATIVE INC.

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UNIVERSITY OF MINNESOTA
HEALTH SCIENCES EXPANSION

MEETING NOTES

DATE: 3 June 1971

PLACE: Powell Hall 4112

TAC JOB: Unit B-C #70046

PRESENT: Dr. Spencer, Ken Taylor

SUBJECT: Family Practice Clinic and Departmental Space

BY: Jim Block

The only unresolved issue in the Family Practice Clinical Space was the size and the layout of the business office. Three alternatives for the business office layout were presented. See attached sheets. After reviewing these particular alternatives with the original layout shown on the original drawings, Dr. Spencer and his business office Supervisor agreed that plan shown on the original drawing was the best one. This particular plan offers some future flexibility. The adjacent exam room could be the Supervisor's office and the Supervisor's office would then become the Insurance office. Dr. Spencer will confirm this selection by a letter.

It was agreed that the power files should be located inthe business office and not in the reception area as shown on the present Family Practice Clinic plan. This scheme also provided a third location for a future power file.

The departmental space on Floor 6 had been reviewed by Dr. Spencer with his family practice staff during the previous week. He had no suggestions for further changes in this area and approved the drawing as shown dated 27 May 1971. Two changes which were not indicated on the plan which Dr. Spencer reviewed with his department were: 1) the seminar rooms are now divisible into two separate seminar rooms and 2) two offices have been added to the departmental space which were formerly assigned to the Psychology Clinic.

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SPENCER	X

JB:lh

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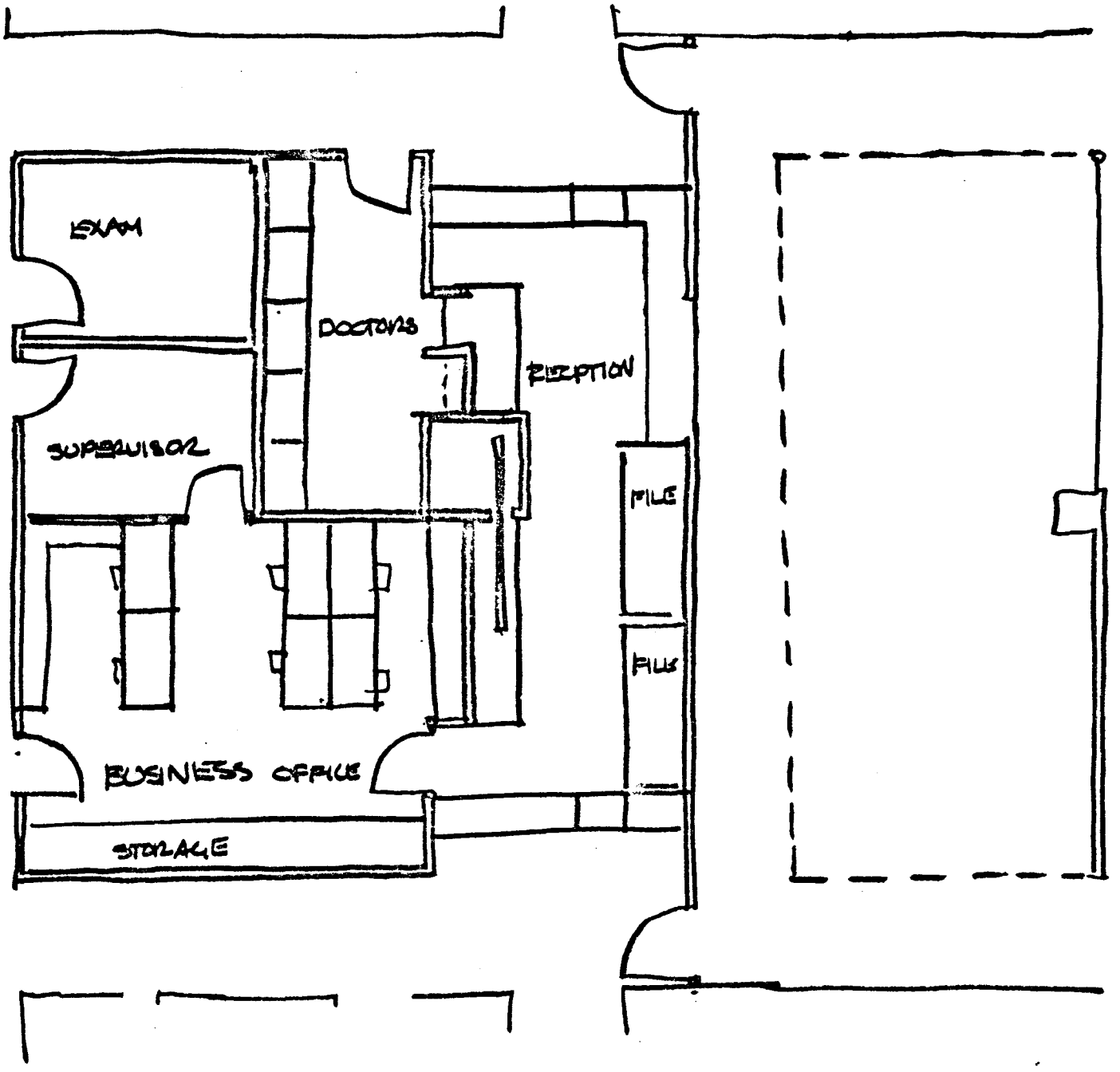
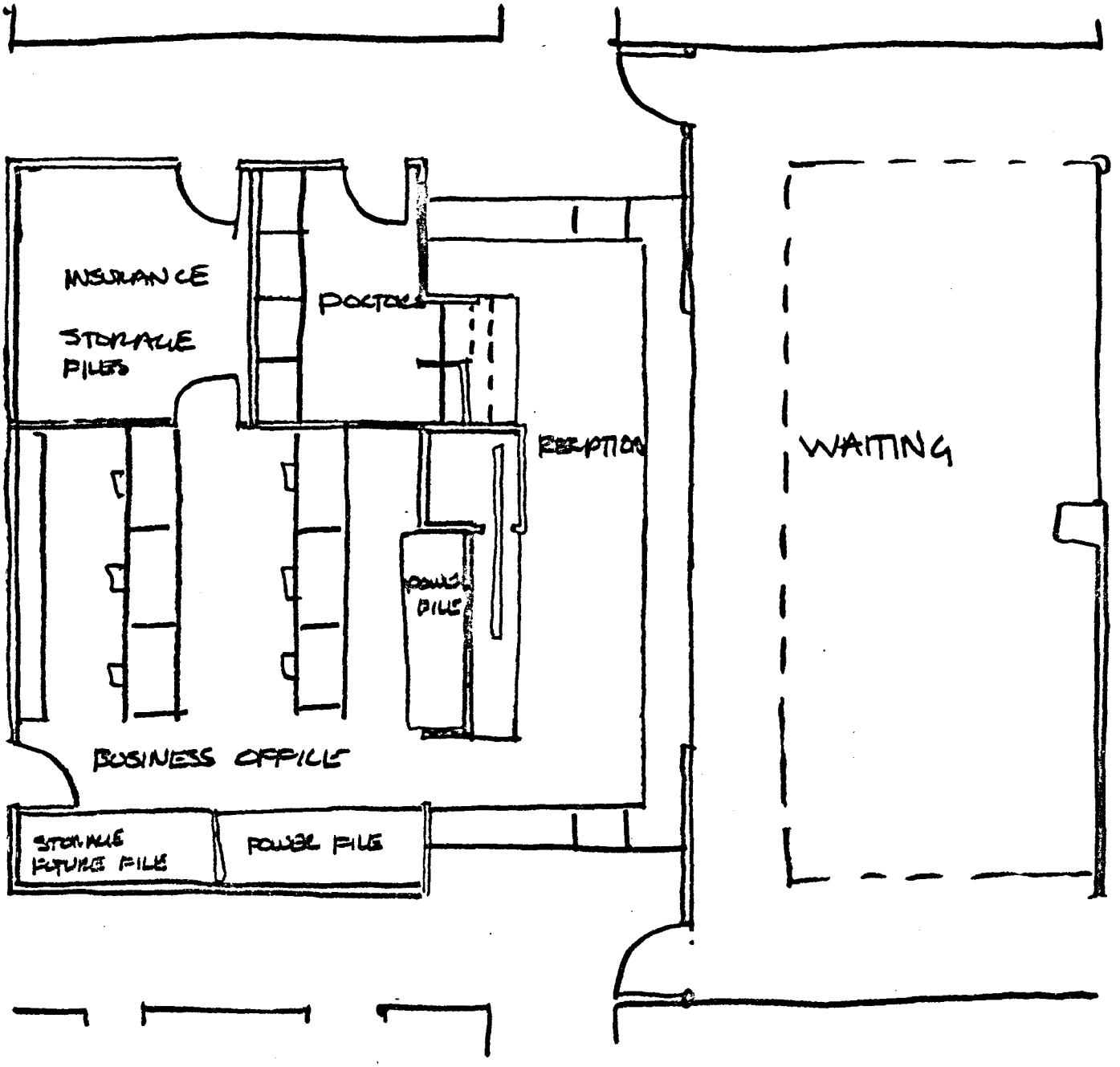


ALT #2

MOVE FILES INTO RECEPTION AREA

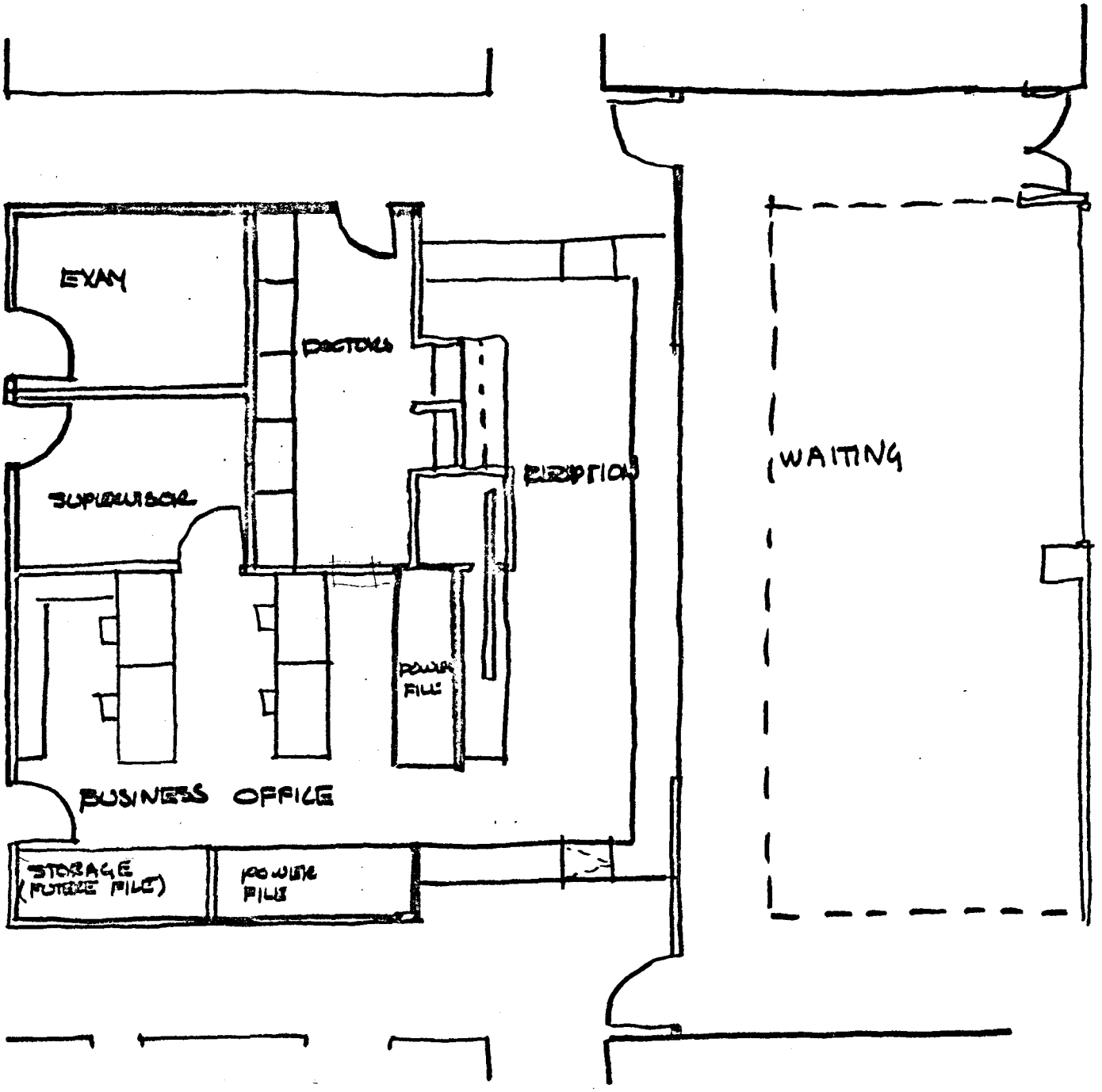
FAMILY PRACTICE CLINIC
FLOOR 3
2 JUNE 1971



ALT 3

INCREASE SIZE OF
BUSINESS OFFICE

FAMILY PRACTICE CLINIC
FLOOR 3
2 JUNE 1971



ALT #1

BUSINESS OFFICE OPEN TO RECEPTION W/ POWER FILES CLOSE BY

FAMILY PRACTICE CLINIC
FLOOR 3
2 JUNE 71

FAM PRAC CLINIC 4.18

UNIVERSITY OF *Minnesota*

UNIVERSITY HOSPITALS · MINNEAPOLIS, MINNESOTA 55455

June 9, 1971

TO: DAVID L. SPENCER, M.D.

FROM: JAMES LAWSON, CLINIC MANAGER

SUBJECT: SPACE UTILIZATION - FAMILY PRACTICE CLINIC - 3RD FLOOR

I suggest that alternative #3 on the floor plans of alternatives available be adopted for the Family Practice Clinic. This alternative is desirable for a number of reasons. These include: the ability to handle large volumes of patiants easily; the room to expand clerical staff as needed as the volume of patients increase; a functional practical approach to patient flow and meeting the demands of this flow with the file space, dictation, and chart availability and accessibility by physicians and clerical staff.

Dictation equipment in the Doctor's dictation room and in the clerical area should include a nye-matic system to complement the protable dictators the residents and physicians will be using. The dictation room is advantageous because of the time saved in having clerical staff looking for charts over the entire clinic area. A pass-way for charts from the dictation room to the clerical area should be built in the partition = soafter charts have been processed by physicians they can be passed through to the clerical area.

The "Business Office" should be arranged differently than shown on the chart. I suggest desks being placed together as in the attached rough diagram. The acoustics of the room are important as much as possible sould absorbing materials should be used in this room to cut down on noise. Carpet for the floor would help in this. I think seven people could occupy this office comfortably. As you notice a small coffee table and two chairs are added to allow the staff small stretch breaks. Electrical outlets should be planned for the floor appropriate for the desk arrangement.

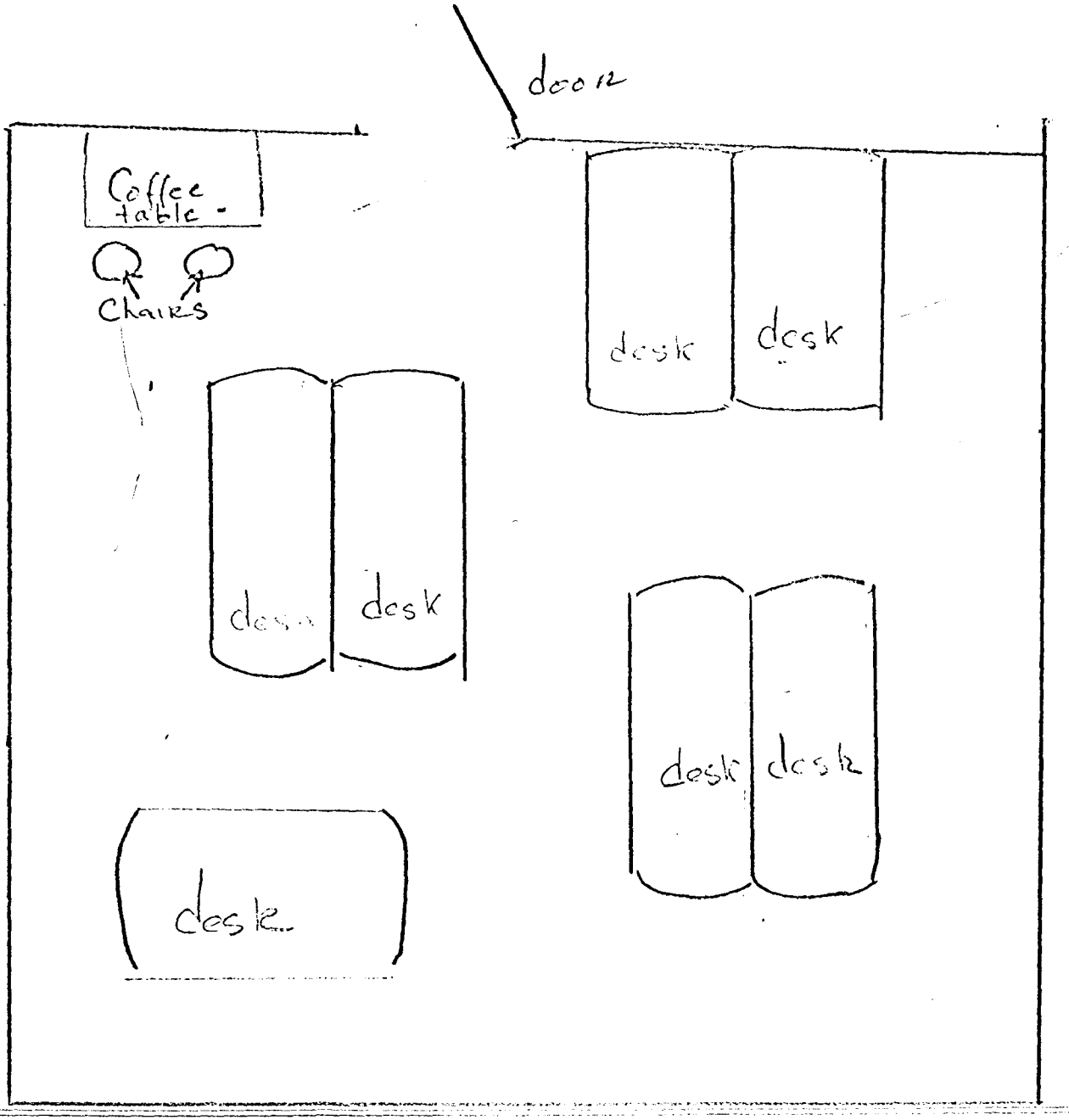
The insurance storage files room should remain as is. This room can accommodate two billing clerks and the necessary space for file, etc.

Across from this area two rooms will be needed. One will be for a social worker to handle interviews, counseling, etc.; the other for the Clinic Manager.

I think that the space utilization as listed above is a realistic appraisal of the business needs for space to support the Family Practice Clinic adequately.

HEALTH SCIENCES CENTER

cc: Dr. E. Ciriacy
Dr. J. Connolly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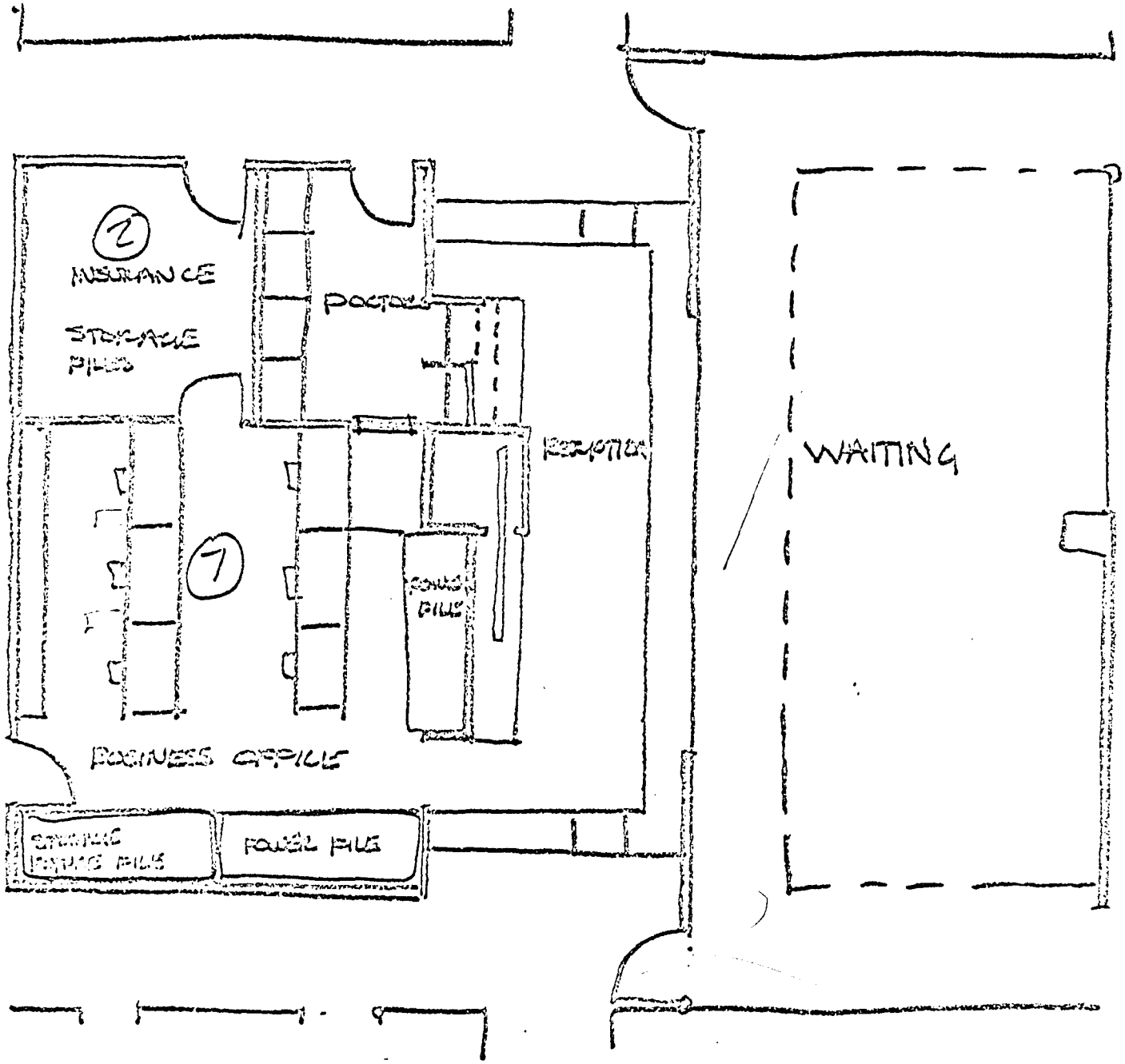

ALT 3

INCREASE SIZE OF BUSINESS OFFICE

FAMILY PRACTICE CLINIC
FLOOR 3
2 JUNE 1971