FAMILY MEDICINE at HMS:

A guide for medical students

Written by former and current HMS students,
maintained by Kathe Miller, MD, Harvard Medical School Family Medicine Advisor

Table of Contents:

1. Why family medicine?

If you have already chosen to apply in family medicine, you have made an excellent choice. If you are still undecided about your specialty, please consider that family medicine is an intellectually challenging, personally fulfilling specialty that is flexible enough for you to bring your own interests to the forefront. All FM residencies will give you basic training in primary care and bread-and-butter secondary care, but your professional focus will depend on your own passions - adolescent medicine, women's health, community medicine, addiction medicine, health policy, global health, clinical trials, public health and health services, working with the underserved, and so on. Rather than letting a specialty dictate what

your career will be like, family medicine provides a platform from which you can choose the details of your professional life.

No one person can encompass all the possibilities in family medicine. Rather, different family medicine doctors have very different careers; some focus on broad-spectrum primary care, others on maternity and newborn care, reproductive health, hospital medicine, sports medicine, urgent care, advocacy, or research and other academic pursuits. Because of its flexibility, family medicine is also the ideal choice for approaching problems in the healthcare system - you will be able to address whatever needs your patient community suffers from most.

You will find as you research programs that there are many excellent choices, and each program has a unique profile. While all programs must follow the ACGME family medicine residency training guidelines There are important differences as well. This document is intended to help you think, both before and during the interview process, about which family medicine program is right for you.

If you are still wondering about whether to apply in family medicine, reach out to the HMS alumni listed at the bottom of the list, attend the AAFP national conference in August, or visit a few of the family medicine programs which seem most compatible with your interests beforehand. You may just find a program that will allow you to realize your goals, while surrounding you with people who share your desire to make a difference in healthcare.

Also, HMS has a Family Medicine liaison for each of the PCE sites, in addition to the folks who direct the HMS Home for Family Medicine. Reach out to Kathe Miller or Aaron Hoffman to get connected!

Resources:

- Article that gives a good overview of family medicine for curious medical students: http://www.aafp.org/afp/2016/0201/od1.html
- AAFP approach to choosing a specialty

  https://www.aafp.org/students-residents/medical-students/begin-your-medical-education/deciding-on-specialty.html

2. FM experience at HMS/preparing for an FM match

Timeline

General

- Become an American Academy of Family Physicians (AAFP) member (free)
- Attend annual AAFP National Conference in Kansas City (scholarship deadline ~May 1st)

- Attend Massachusetts AFP events: Annual Meeting (March) and Advocacy Day (April)
- Get involved with FMIG, the HMS Home for Family Medicine, the SLC and/or the Center for Primary Care!
- Shadow in Family Medicine clinics and work with an FM mentor

Pre-Clinical/PCE Opportunities

Given that HMS does not have a core clerkship in family medicine and three of the four hospitals do not have family medicine departments, clinical experience in family medicine within the formal curriculum in the first two years will likely be minimal unless you are paired with a family physician for your Foundational Continuity Clinic first year or your Primary Care Continuity Clinic second year. Below are some opportunities to get clinical exposure to FM during your first and second year:

- Crimson Care Collaborative CHA Union Square Family Health (family medicine clinic in Somerville)
- Family Medicine Interest Group- Student organization that plans various events to increase exposure and knowledge of family medicine. Contact Megan Lenneman (megan_lenneman@hms.harvard.edu) or Dr. Kathe Miller (kmiller@challiance.org) to learn more.
- Shadowing- Contact the HMS Home for Family Medicine (Megan Lenneman) if you would like to be connected with different sites where you can shadow family medicine physicians
- AAFP Annual Conference (July) for Medical Students and Residents http://www.aafp.org/events/national-conference.html
    - Funding and scholarships are available! Every year, several HMS students are awarded scholarships to travel to the conference. More information can be found at the link above. Deadline for scholarship application is typically May 1st.

Required Courses in order to Apply in FM

1. **CHA FM Elective OR Advanced Clinical Elective in FM**
2. **Medicine Sub-Internship**
3. **Family Medicine CAPSTONE! (ok, not required but VERY COOL)**

Anybody applying in FM should plan to do EITHER the CHA FM elective OR the HMS

Advanced Clinical Elective in Family Medicine. The former is a typical month-long clinical clerkship with a few assignments, and is based at CHA. The latter is a "sub-internship" level rotation (though it is all outpatient other than newborn nursery and L&D, so does not get the "sub-I" title) which includes high-responsibility clinical care as well as a few projects, and is offered at multiple sites within the HMS network of FM attendings.

Other FM specific Courses

There are 2 additional FM specific options in the HMS course catalog:

- HMS Indian Health Service FM elective in Shiprock, New Mexico - students from all over the US travel to this site, and spaces are very limited so sign up early!
- Rural New England family medicine - available in the warmer months only. This is a new and very exciting elective, it DOES take some significant pre-planning and you need to have a car for the month

It can also be wonderful to experience a family medicine program through an away elective, often done through an existing residency program. One very popular local experience is at the Greater Lawrence Family Health Center Residency. Strong Spanish skills are highly recommended.

Other General Recommendations

If you are applying in FM, meet with your HMS FM advisor to plan out your electives for third and fourth year to prepare you for residency. The details will depend somewhat on your past experiences as well as interests, however common recommendations are additional experience in OBGYN (sometimes with midwives!), pediatrics, dermatology, outpatient cardiology and emergency medicine. Sub-internships in these areas can be very helpful for transition to intern year, especially at a program that is inpatient heavy. The AAFP Rotations and Electives page has recommendations for helpful electives to take during your fourth year which can be during or after your residency application. Specifically, there is a Suggested Fourth Year Electives article (from 2004 but still good suggestions) where FM residency directors and faculty were asked which electives they suggest for students applying into FM.

Another helpful document is the HMS Post Match Survey where students who have graduated from HMS and matched into residency respond to specialty specific questions regarding recommendations for elective courses, mentors, career resources, and general

tips as well as data on number of programs applied to/interviews etc. This document can be found at https://collaborate.hms.harvard.edu in Residency Advising/HMS Match Data/Post Match Surveys:
https://collaborate.hms.harvard.edu/display/hmsadvising/Post+Match+Survey

Popular HMS courses:

- ME528M.40s Indian Health Services - Shiprock **Family Medicine:** Heather Kovich - heather.kovich@ihs.gov

feedback from students (Anna Morenz - rotated 2017 anna.morenz@gmail.com), and Elizabeth Noyes and Sam Doernberg (sdoernberg@gmail.com) - rotated in 2022) -write to Kathe Miller for more info.

-*Clinical*: The general schedule that Dr. Kovich sets up for you is a variety of half-day clinics with different family med preceptors (there are a total of 18 at Northern Navajo Medical Center, or NNMC). Clinics run from 8:30-12 and 1-4. Most clinics will be at NNMC with a variety of different preceptors. Occasionally students will have the opportunity tol travel to one of the "field clinics" (a double-wide trailer in a remote area) or more rural clinics in the Shiprock area. These are extremely interesting days that have a particular 'flavor' – street medicine, a Navajo nursing home, a women's and children's clinic, etc. Most of the FM docs at NNMC practice full-spectrum family medicine, from outpatient medicine with plenty of procedures (toenail removals, joint injections, IUDs, and Nexplanons) to inpatient medicine (performing thoras, paras, and placing central lines) to delivering babies. They are thoughtful about specialty referrals because patients often have to travel to Farmington, Durango, or even Flagstaff for specialty access depending on their insurance, so the PCPs will often do an extensive work-up of an issue before referring out, or will manage complex conditions in collaboration with subspecialists rather than making patients travel regularly . In-house specialties include neurology (which is relatively new), rheumatology every other Monday, PT/OT, behavioral health (unfortunately not integrated with primary care), dental, optometry, audiology,gen surg and ob/gyn.

Dr. Kovich also sets up students for a session or two in the family medicine-run dermatology clinic (supported by the dermatologists at the Brigham through telemedicine when needed), which is one of the many inspiring examples of family med doctors tailoring their skills to meet the community's needs. Other experiences include a session with the hepatologist Dr. Runyon who comes about 1x month, the FM-run hepatitis C clinic, and the walk-in/same-day clinic. You have the option of taking medicine or OB call any night that works for you (not required but a lot of fun). Midwives run L&D during the day, and the FM docs run it overnight with the ob/gyns on back-up for C-sections. They do about 30-40 deliveries/month. The FM docs also go to ICU rounds every morning at 8 am before clinic. You should attend ICU rounds sometimes to learn how they help IM manage the patients, but I didn't feel the need to go every day (the ICU census is low, often 1-2 patients).

- AC513.M40 Rural New England Family Medicine;

Sites: Jackman Family Health Center 376 Main St Jackman, ME 04945 Branch of Penobscot Community Health Centers Contact: Patricia Doyle, MD pdoyle@pchc.com Northern Maine Medical Center 194 E Main St Fort Kent, ME 04743 Contact: Dr. Alexandra Roberts, Alexandra.roberts@nmmc.org Barre Family Health Center 151 Worcester Rd Barre, MA 01005 Contact: Dr. Stephen Martin stmartin@gmail.com Community Health Center of Franklin County 102 Main St Greenfield, MA 01301 Contact: Rachel Katz, NP Rachel.katz@chcfc.org

Director(s): Katherine Miller

Prerequisites: PCE

Offered: May, June, July, August, September

Location: OTHER

Description: Students may add themselves to the waiting list for this course during add/drop periods but not during lottery periods. Prior approval required, please email Dr. Katherine Miller: kmiller@challiance.org, forward approval to registrar@hms.harvard.edu. This 4 week clinical elective will take place in rural Family Medicine practices in Western Massachusetts and Northern Maine. Participants will need access to a car to reach sites. Housing is frequently available at each site for no or low cost. Students will participate in outpatient clinic visits, and may also be included in inpatient rounding, community outreach events, and clinical team meetings. The rotation will not include overnight call, though weekend clinic, rounding and other activities may be included. Students will be expected to work 40 hours of work per week, which may include home visits, inpatient rounding, group visits and in office visits. Community outreach, clinical and community planning meetings and care team meetings may also be included. Students will be expected to independently evaluate patients and create treatment plans to present to their attending clinician. The course will include required written reflections and a final paper.

Incorporation of Basic Science Content and Evidence-Based Medicine:

The course will include weekly evidence based medicine assignments for "just in time" use of EBM resources. These will be reviewed on a weekly basis via email or video conference with the course director.

Grade Criteria:

Students will independently assess patients of all ages, genders, and initial presentations, and present a well thought out diagnostic and/or treatment plan with minimal preceptor input. These plans will take into account both the clinical and the biopsychosocial contributors to the patient's condition, and will also be sensitive to the available medical resources. Students will use shared decision making to ensure that the plan is acceptable to the patient as well. Students will follow up with their patients with lab or other test results, or to check in about treatment plans when possible. They will be self directed in their learning, and use EBM resources during patient care sessions when indicated. Their documentation will need few to no edits to admit to the medical record, and oral presentations will be complete, concise, and account for the clinical, social, cultural and economic realities of the patient. The final reflection paper and patient presentation will reveal nuanced understanding of the challenges and opportunities for rural medical practice, and the role of primary care/family medicine in these settings.

3. Choosing where to apply

There are over 450 residency programs in family medicine. Somehow, you will need to narrow it down. The first pass is usually through geography - look in areas where you (and anybody who will be with you for residency, like family or partner if applicable) want to live. Many websites giving information on residencies are organized by geography. In addition to the usual residency websites for all the specialties, try the AAFP's helpful Residency Finder website. The individual programs' websites are often extremely helpful in giving you a flavor of the program.

You may find yourself overwhelmed by the number of programs even in a single city or region. In this case, make an effort to find someone who knows the area well enough to tell you where you might want to apply - ideally, a current resident or recent graduate. Take a look at the list of HMS graduates at the end of this document, you may find a great mentor! Although the reputation of a hospital or medical school associated with a program does tell you important information, there are also some excellent programs in small, unaffiliated community hospitals. Someone familiar with the area can point these out to you. Also be aware that family medicine doctors that are further along in their careers may not be familiar with recently established programs. Look at which medical schools the current and previous residents came from: if you see plenty of reputable U.S. medical schools, you likely have found a good program. If there are zero U.S. medical schools there, beware. That said, do not discount the program because of a couple of IMGs (International Medical Graduates): Some programs seek out IMG's to improve diversity and strengthen their programs.

Remember that programs that are traditionally considered prestigious for other specialties might not provide the best training in Family Medicine. Similarly, US News and World Report rankings include parameters such as NIH funding in their calculations -- factors that are not usually relevant to the quality of a FM program.

Many people - even those who know little about family medicine - may tell you that you should apply on the West Coast. While there are indeed excellent programs out West that may be worth a visit, there are good programs all over the country. Programs in some regions (rural, Midwestern, and Western) are more likely to give you training in high-risk OB, and even experience in procedures such as appendectomies and C-sections. If this is a priority for you, then this may influence your geographical preferences. That being said, the Boston Medical Center FM residency has an affiliated high risk OB fellowship, and their residents all get trained in high-risk OB.

Another factor to consider when looking at programs is their affiliated fellowship programs. Family medicine graduates can pursue fellowships in many areas including geriatrics, addiction medicine, palliative care, adolescent medicine, advanced obstetrics, hospital medicine, sports medicine, emergency medicine, and integrative medicine. Programs tend to favor their own graduates when selecting fellowship applicants, however you can certainly go to a different program for fellowship.

The annual American Academy of Family Physicians (AAFP) conference for medical students in Kansas City is an excellent way to get a quick glimpse of a large number of programs. It is typically held in late July. There is a large exhibit hall with information on almost every program in the country, as well as residents from the programs who are happy to meet you and answer your questions. The conference is a great way to learn about new programs, build your list of places to apply, and start relationships that will likely continue in residency and beyond. The AAFP offers many scholarships that make it feasible for medical students to attend -- plan ahead! Also there is a direct flight on Delta and Jetblue from Boston to Kansas City that can make the trip fairly painless.

Resources:

- The American Academy of Family Physicians guide to residencies. Make sure to download *Strolling through the Match*, the AAFP's guide to applying into FM http://www.aafp.org/residencies
- A new Doximity site that allows former and current residents to rate their programs https://www.doximity.com/residency/programs?specialtyKey=4fdbd5be-62fb-4757-99d2-edf76b72d4c9-family-medicine&sortByKey=reputation&trainingEnvironmentKey=&intendedFellowshipKey=
- standardized info on ACGME accredited residency programs "FREIDA" http://www.ama-assn.org/ama/pub/education-careers/graduate-medical-education/freida-online.page (note that if you click on a residency's page, there might be multiple tabs that have quite a lot of information embedded within them)
- AAFP Annual Conference in July for Medical Students and Residents http://www.aafp.org/events/national-conference.html

4. Differences in clinical teaching between programs

Overview

All residencies must follow the ACGME program requirements in order to maintain accreditation. This ensures that, to a point, all residents have a similar experience. There is still a lot of room for variability within residency programs, detailed below.

Clinics

The centerpiece of any FM residency is the family medicine clinic. In most residencies, you will spend an increasing amount of time in clinic as the residency progresses (and the scheduled time per patient will become shorter!). For example, you may be in clinic for 1 half-day per week in internship, 3 half-days per week in second year, and 5 half-days per week in third year. Certain residencies offer more total clinic

time, above the minimum requirement, while at other programs you will have more inpatient months than the minimum required.

Some programs have more than one clinic site, but you will be assigned to one site at the beginning of your residency that will be 'your clinic' (often there is a lottery process during which you indicate your top choice clinic, either at the time of submitting your rank list or after you have matched to the program). The AAFP requires that you spend your final two years of FM clinic at a single site.

Because the first step in residency is internship, which is heavily weighted towards inpatient rotations, it is easy to forget how central your clinic will be to your residency experience. However, the nature of the patient population you work with (e.g. how many kids and pregnant women you will see, how many elderly) and your colleagues at the clinic are extremely important! Residents often are 'bonded' with their clinic population and are proud of their work there. Because of the large amount of time you will spend in clinic, it is a good idea to tour all clinic sites when you interview. Sometimes a program will schedule tours of only one site, and if you do not end up at that clinic, you could be in for a surprise! Clinics can vary widely, even within the same program, in terms of computer access, EMR, resident workspace, types of procedures performed, faculty-resident ratio, and number of support staff, i.e. number of residents per RN or MA. You want to get a sense of how dialed in the program is with new innovations in clinic design, because the future of Family Medicine depends on preventing physician burnout and improving the quality of patient care.

Questions to think about include whether the clinic has taken steps to provide patient-centered care, special services available at each clinic (e.g. Suboxone prescribing, integrative medicine, OB ultrasound), if the clinic has achieved PCMH status, whether faculty rotate through all of the clinics and if not, which faculty are assigned to each clinic, if it is a federally qualified health center (which means that patients without insurance can receive care), and how long your commute will be between clinic and the hospital (often residents work the morning at the hospital and go to the clinic in the afternoon).

Inpatient services

Clinic time aside, you will rotate through a variety of services. Most residency websites will show you, under 'curriculum,' the number of months allocated to each component of the family medicine curriculum (adult medicine, OB, pediatrics, surgery, subspecialty rotations). There is limited variation on this point between programs, due to the ACGME requirements referenced previously. That said, the nature of clinical training varies between programs.

One major difference is whether the program is 'opposed' (i.e., there are other residency programs who share the services with you) or 'unopposed' (in its strictest sense, this means that family medicine residents are the only residents in the hospital). Many programs are somewhere in the middle on this spectrum - for example, they may share the medicine floor with internal medicine residents, but their obstetrics service is for family medicine residents alone. The benefits of sharing a hospital with multiple other residency programs include often more formal learning opportunities, and having on site support

via senior trainees. Down-sides can include less independence and competition for procedures in the hospital. A lot of this decision will have to do with your preferred style of learning. Are you someone who prefers to collaborate and work with a team all the time, or do you prefer more independent learning?

Another difference is how much call and inpatient time is required, which translates to how "hard" the program is perceived as being. Some programs are more front-loaded, with heavy call and inpatient rotations in the first year and very little call third year, whereas others are more evenly distributed throughout the three years. Some are just intense all three years; others have home call on low volume services. At some programs you never have to show up earlier than 7:30am, whereas others require you to pre round at 5 or 6 throughout most of your internship. You may notice at your visit whether the interns appear sleep deprived (or are even able to show up to the lunch and dinner). Some programs you consider may be participating in studies comparing the new “night float” system with the old model of more continuous call.

The ACGME has instituted work hour limitations, which include a maximum of 80 assigned work hours per week (averaged over some months), no more than 24 continuous hours of patient care responsibilities, as well as some built in recovery time. More information here if you are interested - it’s in evolution.

Residents in most programs will tell you that they feel competent in adult medicine. Pediatrics and obstetrics tend to vary more. Be sure to get residents' opinions on each component of the training. It is also helpful to have some idea of what you want your career to look like after residency. This will help you to prioritize your clinical training goals.

There are a few 4-year residency programs nationally, most of which began as part of the AAFP's Future of Family Medicine project. Many of these programs prepare graduates to receive a fellowship at the end of their residency and/or include more advanced skills in things like leadership and practice management.

Internal medicine - You will find a range of approaches to inpatient medicine, ranging from an entire hospital dedicated to the family medicine residency (e.g. Santa Rosa in CA), to a geographically separate 'family medicine medicine' ward within a hospital that also has an internal medicine program (e.g. BU/BMC), to sharing hospital floors but having a separate 'family medicine' team (e.g. the Swedish and Group Health/Kaiser programs in Seattle), to being a family medicine resident incorporated into an internal medicine team. Thus, the complexity of patients on the service differs (how many zebras, how much bread and butter, and whether you follow the patients if they are transferred to the ICU). Other questions to consider (and ask at your interviews if you don’t find the answers elsewhere!):

- Does the FM service include children and pregnant women, or only adults?
- What’s the size of the average patient list? You want to consistently see numbers adequate to keep you busy and learning, but not be overwhelmed and too busy to learn well and provide quality care.

- Is there a cap? The ideal is for the inpatient service to have an on-off valve of some sort so that there is a cap when too much walks in the door, and a place from which to draw more patients when the FM service is slow.
- How many patients does each resident usually carry?
- Is there a night float team?
- In the case of opposed or partially opposed programs, is night float from FM or IM, and how well does this work?
- How much teaching is built in to the inpatient service (e.g. on rounds, morning report, noon conference)?
- Are you taught by FM or IM attendings? If IM attendings, do they tend to favor their own residents, or do they treat everyone equally?
- How much of the teaching is based on reviewing original studies and examining the evidence? We take evidence-based medicine for granted at the Harvard hospitals, but some places don't even have Internet access in the clinic or on hospital floors, so looking up those articles isn't going to happen easily.

Pediatrics - Adequate inpatient pediatrics training can be difficult to obtain outside of a children's hospital setting. Yet, in the children's hospital setting there are highly complex patients whereas family physicians in-training need to see bread and butter cases. Even in programs that are mostly unopposed, the inpatient pediatrics months often consist of being integrated into a pediatrics team at a large children's hospital. This is a reflection of a national trend: the number of pediatric beds in community hospitals is declining, as children are hospitalized less often, so the volume for you as a resident is in the children's hospital. It is important to find out how this works: when you rotate, are you replacing a Pedi intern, or are you an 'extra' intern? How much responsibility are the FP interns given (are they treated the same as Pedi interns)? Are you included in the teaching that Pedi residents receive, or are you expected to stay on the floor and do scut? It can also be challenging for a program to provide an adequate quantity of outpatient pediatric visits. Pediatric ER and pediatric ambulatory clinics may be in the curriculum to remedy this. Some programs have a required newborn nursery rotation. Also consider whether the program has PALS training (Pediatric Advanced Life Support) and NRP (Neonatal Resuscitation Program) training.

Obstetrics - The AAFP previously required a minimum of 40 deliveries, of which 10 had to be from your clinic patients, however this requirement was removed in 2016. If you plan to practice OB, you will most likely want to perform at least 100 deliveries, either by attending a program which routinely exceeds these numbers, by taking electives (you could, for example, take an away rotation at a very high-volume center), by being proactive about picking up pregnant patients, or by doing a fellowship after residency. The number of deliveries varies a lot between programs, roughly in proportion to the time in the curriculum devoted to OB. All residencies have at least 2 months; some may have as many as 5. Some programs struggle to fulfill the minimum requirements, while others routinely do over 100.

If you plan to practice OB, you should ask what is the average number of deliveries for a resident; what were the most deliveries anyone got (to see if those with a special interest in OB have gone before you

and done well); and how many of the graduating residents are practicing OB. You can ask how hard (or easy) it would be to get c-section certified within the three years (possible and even advertised in some programs, whereas others will tell you that requires a fellowship). The clinical educators in OB may be FM doctors, obstetricians, and/or midwives. How much teaching done by FM doctors is determined mainly by how many FM doctors with advanced OB training are on staff (someone able to do Cesareans needs to always be present). In some programs, the FM doctors do almost exclusively low-risk obstetrics and co-manage complicated clinic patients with an obstetrician. In others, the FM doctors do an enormous amount of high-risk obstetrics.

Think beforehand about what level of OB training you will want. Are you happy with low-risk; are you willing to settle for low-risk if there are good electives with which you can supplement that training; do you absolutely want experience in high-risk; or do you plan to not do OB at all, so it doesn't matter?

OB training is generally thought to be the most difficult specialty for having an 'opposed' service. This is because the obstetrics residents are under pressure to reach certain numbers of deliveries, and conflict may ensue. So when interviewing at a program with opposed OB training, make sure to ask about how the residents get along, as well as how the FM residents are treated by the OB attendings. Also find out if you will be replacing an OB intern or if you will be an extra intern during your rotation – this will directly affect the number of deliveries. Another point about OB is that labor and delivery practices differ greatly among different hospitals as to how high-intervention it is (IVs for everyone, continuous fetal monitoring) or how holistic (birth balls and jacuzzis), as well as how pro-breastfeeding the hospital is. Finally, if you plan to do a lot of OB, and you plan to stay in the same geographical area after training, you might ask about how easy or hard it is for FM doctors to get hospital privileges in that area.

Family medicine residencies allow the unique opportunity of managing the deliveries of your continuity patients. Depending on the model, you may be delivering your continuity patients during any rotation of residency, or only during a few dedicated months. A few programs have "Mom-baby" rotations where you deliver continuity patients and care for the babies as well.

Other clinical experiences

Other rotations - Each program will have several shorter rotations. The surgery month varies quite a bit between programs, from ambulatory clinics only, to being first-assist in many surgeries, to (at the extreme) learning to perform some surgeries. The time spent in ER and ICU rotations also differs between programs. There are a bunch of sub-specialty rotations in each program (derm, urology, psych, etc.), ranging from 2-4 weeks each. Some programs have made these types of rotations longitudinal. The number of electives is extremely variable, from 1-2 months in the final year in some programs, to 3-4 months in second year and more than 7 months in the final year in other programs.

Procedural curriculum - Every residency will make an effort to teach you certain procedures.

Colposcopy, IUDs, nexplanons, and mole removals are common examples. Some programs teach flexible sigmoidoscopies although these are being phased out of most practices. At programs with a rural focus

especially, you may be able to learn and get certified in doing your own colonoscopies. If you have a particular interest in a certain procedure, you can probably arrange an elective, or proactively pursue opportunities (for example, first-assisting in Cesarean sections during your OB rotation in a program where this is not routine). There is considerable variation in how many procedures you get to do during the ICU rotations - ask about this if it is important to you. Some programs may provide medical and/or surgical abortion training as an elective, but in others you may need to take a month away elective if you want to learn the procedures. If this is of interest to you, do ask about it.

Lecture/didactics curriculum - Ask who teaches it (FM doctors, specialists), and try to get a sense of the quality of the lecturers. Programs will let you sit in on conferences if you so wish, and if you have the time. Lectures may be given back-to-back one whole afternoon each week (which if "protected" offers a nice break for the weary intern!), or at lunchtime daily (also a nice break but only if "protected", i.e. someone takes your pages). One big advantage that FM training has over IM primary care tracks is that the lecture curriculum is targeted to the generalist.

Psychosocial curriculum - This is an integral and required part of FM residencies, and all programs have a "behavioral scientist" on faculty. Some residencies have a psychiatrist on faculty and a robust mental health curriculum, and others have a social worker or psychologist, who do not practice the pharmaceutical side of mental health management. Most residencies have a Balint group or a variation thereof (where residents discuss their difficult patient relationships in order to gain insight and improve their doctoring). Each program will have a faculty member in charge of psychosocial learning, and often a psychologist will precept your more 'challenging' patients with you to help you learn. You should examine the psychosocial part of the residency for quality and usefulness, as you would any other. You might also want to ask about the availability of social workers, especially if the clinics are in underserved areas, and behavioral health integration in the clinics.

International/ away electives - If you are interested in electives abroad (or in other parts of the US), make sure the program allows it. The maximum time away from your clinic is 1 month in 2nd year and 1 month in 3rd year (due to AAFP regulations which aim to ensure that your clinic patients have access to you during most of the year). Keep this in mind when you look at curricula – having to go to another state to do extra OB, or any other elective, means that you will not be able to go abroad in that year. If your program only has electives in third year, you may have to choose an international experience over an elective in another part of the United States. Some programs provide funding or stipends for international work or away electives, and some have special tracks in their curricula for residents interested in international medicine. Others have established relationships with hospitals in other countries, sometimes even with faculty teaching and working both domestically and abroad. A few programs offer Spanish language training.

Resources:

- Information about the national requirements for family medicine programs: https://www.acgme.org/Specialties/Program-Requirements-and-FAQs-and-Applications/pfcatid/8/Family%20Medicine

- Board pass rates for every FM residency program (2020 data):
- https://www.theabfm.org/sites/default/files/PDF/ResidencyPerformance_Online.pdf
- National listing of patient centered medical homes and specifics about each clinic: http://bphc.hrsa.gov/uds/datacenter.aspx?q=d&state=WA#glist

5. Other differences between programs

As with any residency, the vast majority of your time will be spent in clinical training, however, family medicine is also a perfect gateway to working in community and/or public health, through research, administration, or public policy. Many programs have a strong social mission. Perhaps most importantly, your fellow residents are likely to be interested in the interface between society and medicine. So, although you will be busy in the hospital and the clinic, the non-clinical opportunities that a program provides may also be important to you. Once again, it is worth taking some time now to think about your career goals, to determine how important this aspect of residency programs is to you. On your interview visit you will get a feel for the "personality", or flavor, of the residency and the residents; do they call themselves family-friendly (home call, less intense call schedules, life balance), 'work hard play hard', tough, broad spectrum, urban underserved, rural focus, academic, research, etc. The size of programs varies widely, from less than 3 residents per year to 14 or more. The hospital size varies, too, with some being in <200 bed community hospitals and others in huge academic hospitals--in which did you thrive during medical school?

Patient population – What patient populations do you WANT to work with? Many family physicians are eager to work with underserved populations. How much of the residency population is underserved? You can assess this by asking the percentage of patients who are uninsured or on medicaid. Is the population diverse (ethnically and socioeconomically)? What languages are spoken (and what translator services are available)? Is there a single well-defined patient community, or do patients come from a variety of neighborhoods and backgrounds? How sick is this population? Are there lots of young people here? How much social disintegration is there? Does the program work together with community-based organizations (schools, NGOs, churches), and if so, what projects have they done this way? Some programs specifically state their mission as working with the medically underserved, and therefore attract faculty and residents with that goal.

How old is the program? - Family medicine was established as a specialty in the late '60's, so the oldest programs are 40 years old. There are also a lot of newer programs that have sprung up in the past decade. Benefits of young programs include: they can be especially dynamic because the faculty is dedicated to establishing FM in that setting; residents are often central to determining the future of the curriculum; and you may be helping to increase the amount of health care to populations which a short while ago had less. Benefits of older programs include they are well-established in their hospitals and clinics; they have gotten the 'kinks' out of the curriculum; and the faculty may be more experienced in that area and practice setting. Commonly, the newer programs are staffed with graduates from older programs in the same region!

Community projects - Sometimes community work is built into the curriculum, i.e. home visits or a final-year project in community medicine. Sometimes residents take the initiative. Many programs will have activities that were founded by previous residents – e.g. school clinics or health care for the homeless. Look at the quality of what has been produced and get a feeling for the level of enthusiasm of current residents. Is there help with grant writing? Has any resident successfully applied for a grant during their training? Many programs require a community project, but that does not necessarily mean that the residents put effort and enthusiasm into it. Ask about past projects and assess current residents' interest to get a real feel for this aspect of the program.

Research – Do the residents do research projects? Are they small independent projects, or are they collaborations with faculty on large ongoing studies? Is the residency program linked with an academic department? If there is a department, ask how many residents have actually worked with the research faculty, and try to get a sense of how accessible such collaboration would be. Is there an epidemiologist or statistician on staff? Is the program connected with a medical school and/or public health school that offers its own set of resources?

Teaching opportunities - do medical students rotate through the hospital? The clinic?

Other residencies in the hospital - Do they treat family medicine doctors with respect? Of what quality are the other residency programs in the hospital? Some programs boast that they work alongside top residency programs in pediatrics or medicine. Other programs boast that they are known as the best residents in the hospital, which they see as a source of extra respect.

Fellowships - How many graduating residents go on to fellowships, and what kind of fellowships? Which fellowships, if any, does this institution offer? FM fellowship programs often draw heavily from the residencies with which they are associated.

Commitment to the underserved - What happens to a patient who arrives at the clinic with absolutely no insurance? (Many programs in fact refer them elsewhere, but sometimes you have to dig to get to this true answer). How do you help your indigent patients get medications? What sorts of support services are present in clinics with a large underserved population? How many of your graduates end up working with underserved populations?

Ethics – Does the program accept pharmaceutical company gifts/lunches/samples?

Resident diversity - What types of jobs have the graduates gone into after graduation? Think about whether you want to be in a program where the graduates go into a variety of practice settings, from private practice to community clinics, or whether you want a more united mission, for example the majority working with the underserved. Also think about the diversity of the residents as people – are they diverse ethnically, do they speak different languages, are all (or none) married with kids, are they older, are they mainly female or male, etc. Also think about what kinds of things they do in their spare

time – do residents have some of the same interests you do? Do they tend to spend time together outside of the hospital/clinic?

A note on geography: although this is only a generalization, places with a lower cost of living tend to attract more married residents or those with children. Residents often buy a home regardless of being partnered, but if you are single keep in mind that residencies in smaller cities where it is cheaper to live may be almost all partnered.

Cost of living. Think about it! Resident salaries are quite similar across the US however CoL can vary significantly. Income taxes also vary. Given that many residents end up practicing where they train, this can have a long-term impact on your quality of life.

Relationship between faculty and residents, and residents and residents - Are they admiring of their residents, and think of the residency program as a driving force of the department? Do they seem to work closely? Or does the faculty seem more interested in their own research and clinical work than in the residents? At some programs I thought the faculty was great, but the residents were much more lackadaisical. Did the residents seem to enjoy hanging out with each other at the dinner event the night before your interview? Do they talk about doing things together? Does it seem like a supportive peer environment?

Vacation Time - 3-4 weeks usually. Scheduling varies, as does your ability to split up the weeks (e.g. some programs require you take 1 or 2 weeks at a time, while others will let you divvy up the weeks to allow for multiple 3 or 4-day weekends). Maternity leave policies can also vary -- some programs have "parenting" electives to allow residents to extend maternity leave beyond the standard 12-weeks. This is a sensitive topic to ask about since some programs might worry that you will be away during your residency.

EMR - Most programs have transitioned to electronic medical records in both hospital and clinic settings, but some computer systems work better than others. Be aware of whether clinic and hospital systems are the same, and also for multiple EMRs within one hospital (there is a program out there with 6 different EMRs!).

Locations - Ask how many hospitals and clinics are used for rotations and check out the commute between. Some programs have their clinic across the street; others require a 20-minute to 40-minute drive from the hospital! Some programs have you at various hospitals and others use just one for all rotations. The interview day always includes hospital and clinic tours.

Patient Centered Medical Home: Many programs will tout that they are PCMH's or striving for same. If this is important to you, ask about their efforts and successes!

Resources:

Cost of living calculator: http://money.cnn.com/calculator/pf/cost-of-living/

6. General recommendations

Know both the pros and cons of the programs you end up ranking highly. You are more likely to be happy in a program if you are aware of both the good and bad before you begin. The 'perfect residency' isn't one that has no faults; it's one whose faults you can live with, work around, or overcome, because you are enthusiastic and inspired by the program as a whole. In other words, there is rarely a *perfect* program. Make sure you interview at enough programs so that you can rank five or six of them. If you are couples matching, you may need to rank more programs, depending on the competitiveness of your couple's program.

When on the interview trail, here are some questions you can ask residents to try to get the real scoop on the program:

- What changes would you like to see in the future to improve this residency?
- What are the residency's weaknesses?
- Why did you choose this residency over others?
- What is unique about, or what are the strongest aspects of this residency?
- How has your experience been different than you expected?
- What type of applicant would fit best here, in terms of personality and career Interests?

7. Where can I learn more about family medicine programs?

Your most helpful resource will likely be HMS graduates who went into family medicine (see table below). They will be happy to hear from you!

As highlighted in the sections above, these sites are also helpful (here are the links again):

- The American Academy of Family Physicians guide to residencies. Make sure to download *Strolling through the Match*, the AAFP's guide to applying into FM!
  http://www.aafp.org/residencies
- the Doximity residency site
  https://www.doximity.com/residency/programs?specialtyKey=4fdbd5be-62fb-4757-99d2-edf76b72d4c9-family-medicine&sortByKey=reputation&trainingEnvironmentKey=&intendedFellowshipKey=

- AMA standardized info on residency programs http://www.ama-assn.org/ama/pub/education-careers/graduate-medical-education/freida-online.page (note that if you click on a residency's page, there might be multiple tabs that have quite a lot of information embedded within them)
- Information about the national requirements for family medicine programs: https://www.acgme.org/Specialties/Program-Requirements-and-FAQs-and-Applications/pfcatid/8/Family%20Medicine
- **AAFP Annual Conference (July) for Medical Students and Residents** http://www.aafp.org/events/national-conference.html
    - Funding and scholarships are available! Every year, several HMS students are awarded scholarships to travel to the conference. More information can be found at the link above

8. Application timeline

Feb/March of year 4:

- If you have been active in FM and leadership at HMS, apply for the Pisacano Scholars Leadership Program, due March 1st http://www.pisacano.org/
- Deadlines for some of the more competitive away electives. You usually apply via VSAS (the registrar will give you code to register) but a lot of programs will have away elective info on their websites, and you'll need to contact their administrators directly. You can do this before the VSAS process. You DON'T need to do an away elective to get an interview--they are technically for your benefit to help you evaluate programs but can be tricky because they are essentially a month-long interview.
- Schedule your Step 2 CS and CK dates. The only month to really avoid is your sub-i month. By the time the registrar contacts you about this, some dates might be filled up--do it in advance.
- Request your medicine sub-i, to complete before September when you submit your residency application
- Schedule an FM elective before September as well. It is a good idea to complete one HMS based FM elective (the CHA elective or the Advanced Clinical Elective in Family Medicine, these are preferred over the rural FM elective as you will not be precepted by HMS faculty, so getting a well written letter might be more difficult). Other options include an away elective (could be local, with UMass, BU/BMC, or Greater Lawrence Family Health Center. Also consider Brown FM residency. Also consider the HMS Shiprock elective (in New Mexico) and the HMS rural FM elective as a second option!
-

June/July/August

- Keep an eye out for the Match Mentoring Series at the Center for Primary Care – meet with your fellow applicants in Primary Care to get some additional support with preparing an application specific to your specialty choice! For more info contact Megan Lenneman or Kathe Miller.
- Request your letters of recommendation!! Most programs require 3 letters, a few require 4. ESPECIALLY coming from HMS, one letter should be from a family physician with whom you have worked. Remember that your letter writers might be writing letters for multiple students -- ask early (by the end of July at the very latest).
- Work on your ERAS application. The personal statement is most time-consuming. The CV doesn't have to be perfectly formatted -- you input the info and ERAS formats it.
- Go to the website of every program you are applying to for specific application instructions (some request that you specifically address certain questions in your personal statement and will discard your application if you don't answer them)
- You will need to upload a photo to ERAS. While this is a pain to arrange, it is the first impression you will make to the program and it's important. Dress should be business professional. BU media services will take your photo and make it the right size (more challenging than you might expect) for $20. Call (617) 638-4370 for an appointment. You can find more info here: http://www.bumc.bu.edu/bumc-emc/services/creative-and-technical-servi ces/

September

- ERAS is due. Submit it on the first day since a lot of programs will download applications immediately.
- You might get interview invitations within the first few days of submitting ERAS. FM programs invite EARLY. See table below for invite timing in the 2015-2016 cycle. Respond within 24-48 hours to invitations to schedule interviews. It is rude to wait longer, and you might not be able to get a convenient interview time if you wait. The beauty of this process is that it is perfectly acceptable to cancel interviews as long as you inform programs at least 2 weeks in advance. It is therefore in your advantage to schedule all interviews that are offered to you, and then to cancel as you progress through the interview season. Some programs post their interview dates on their websites, which makes it easier to "hold" dates for programs that you are interested in.
- Do yourself a favor and don't schedule more than 3 interviews in a 7-day period. You will not be able to retain the information you receive, or to put your best foot forward.

-

Name of program	**When invited for interview (more or less -- eg mid-Sept)**
Lawrence	mid Sept
Tufts CHA	mid Sept
BU/BMC	late Sept
UCSF	early Oct
Maine Medical	late Sept
Swedish First Hill	mid Oct

Swedish Cherry Hill	mid Oct
U Washington	mid Oct
Group Health	late Sept
Santa Rosa (Sutter)	mid Oct
UPenn	mid Sept
Jefferson	early Oct
UMich	mid-late Sept
UWisconsin (Madison)	mid Oct
Kaiser Napa	mid Sept
Brown	mid Sept
UCLA	early Oct
UCLA Harbor	early Oct
Montefiore	early Oct
Mount Sinai/Beth Israel	early Oct
USC/California Hospital	late Sept
White Memorial	late Sept
Kaiser Los Angeles	late Sept
UConn	late Sept
UMass	late Sept

-

October - January

- Interviews and post-interview communication. If your co-applicants in FM are open to it, it can be helpful to check in about interview invitations. That way you'll have a better sense of whether a top program you are interested in has sent out interview invites; if you haven't heard from them, you might want to figure out a way to reach out to them, either yourself or with the help of an HMS advisor.
- Despite being less formal a field in general, most FM applicants still wear the standard black/dark color suit to interviews. As one program director advised, you want to make an impression, but not because of what you're wearing.
- Dinners the night before are mostly at residents' homes in FM. They are great opportunities to decide whether you click with residents and to get the inside scoop. I always felt I knew a lot more about the program if I'd attended the dinner the night before. While programs say it doesn't matter if you attend the dinner, the residents are often involved in the ranking process.
- FM is one of the specialties that likes a lot of communication after the interview (e.g. sending thank you emails or cards and asking residents questions). One PD specifically said that he only has veto power when it comes to the rank list and that it is therefore important to connect with

residents and follow up if you are interested in the program (this is a little extreme). I got several thank you notes *from* residency programs after I interviewed, so it would have felt especially strange not doing the same.

- Budget time in January to make your rank list decisions. You'll likely want to reach out to residents and program directors to ask follow up questions, and might even want to do a "second look" at some programs (some places will arrange formal "second look" events, whereas others will do so only if you request it).

- **January - February**
- Residencies tend to make their rank lists the first and second week of February. It is therefore to your advantage to know your top 1-3 choices by this time so that you can send a "love letter" to your top choice program. While HMS might tell you this is not necessary, recent grads who are now involved in the ranking process at FM residencies have encouraged HMS students to declare their top choice to program directors, especially if the program is not local. No matter how earnest you are about your desire to go into family medicine, coming from Harvard raises doubts about whether you will rank family medicine or another specialty first, whether you will want to be at a community program, etc. Of course if you tell a program they are #1, you had better rank them #1!! Your professional reputation is on the line.
- Rank list tips:
    - Rank *your* top choice first, not the program you think will rank you first--the match works in the favor of applicants.
    - Take everything programs say with a grain of salt - they might tell you that you're their first choice, that you'll definitely match, etc. Experience proves that these statements don't always come true.
- Don't rank any program that you don't want to attend. There are options if you don't match that are better than being miserable for 3 years (however as long as you rank at least 6 programs you will be fine!).
- Despite all of the differences listed above, the curriculum of FM programs has to be very similar due to the ACGME requirements. The differences that might end up mattering more are the people in the program, the location of the program, and the places residents go after graduation.
- February is the perfect time to update this guide and offer advice to future generations of FM applicants while the process is still fresh in your mind :)

Mid-March

- Celebrate!!! You are going to be a family physician!

F9. HMS Graduates Who Matched into Family Medicine Residencies

please update email addresses and positions as you discover them!

HMS year	Name	Residency Program (state)	Position (last updated 2021 - please update!)
1954	Hugh Piesen Hermann	BU transitional internship 54-55 Brigham surgery residency 57-58 (pre ABFM)	Physician in Woodstock, VT
1976	Gregory Augustine "Greg" Bazylewicz		Chief Network Development Officer and Population Health Officer at Lahey Health first president of Northeast Physician Hospital Organization Practiced in Manchester By The Sea
1977	Rachel Wheeler	HST at HMS then residency UMass (MA)	Retired; former Family Physician at CHA
1977	Carlos A. Moreno	U Texas HSC residencySan Antonio Academic Family Medicine Faculty Development Fellowship at the University of Missouri-Columbia	Former STFM president, Chair, McGovern Medical School At UTHealth C. Frank Webber Chair of Family Medicine, & Community Medicine, University of Texas, Houston
1978	J. Lloyd Michener	FM residency at Duke University	Professor Emeritus, FM and Community Health 1994-2017 Chairman, Dept of Community and Family Medicine at Duke University Medical Center experienced researcher in Population Health
1978	Kathleen E. Toomey	MPH at HSPH Residency University of Washington Health Policy Research Fellow at UC San Francisco	2019 commissioner of the Georgia Department of Public Health 1993, Dr. Toomey became the State Epidemiologist and Director of the Epidemiology and Prevention Branch of the Division of Public Health in the Georgia Department of Human Resources where she managed three major health programs Director, CDC Botswana Director, Fulton County Department of Health https://www.astho.org/Directory/Member-Bios/Georgia/
1981	Peter A. Selwyn	Residency Montefiore NYC MPH Columbia U (epidemiology)	Professor and Chairman of Department of Family and Social Medicine at Montefiore Medical Center Director, Palliative Care Program at Monte HIV care
1982	Gwen Wagstrom Halaas	U of Minnesota residency MBA Healthcare Univ St Thomas in Minnesota	vice chancellor of academic affairs at WSU Health Sciences Spokane. previously Senior Associate Dean at University of North Dakota

		https://provost.wsu.edu/gwenhalaas/	
1983	Carolyn J. Sanders	Case Western Reserve, FM residency	Family physician in Lafayette and Boulder, CO
1983	Nicholas L. "Nick" Gideonse	Oregon Health and Sciences University FM residency	2021 practicing family doc, previous Medical Director/Associate Residency Director at OHSU Family Medicine at Richmond OUD treatment, maternity care, end of life care.
1983	Mary C. Hoagland-Scher	Group Health, Seattle (2020 certified in Lifestyle Medicine)	Former Medical Director of the Vashon Health Center, Chief of Group Health Tacoma Urgent Care. Current Medical Director of Rotacare Tacoma, a volunteer-run free clinic for uninsured patients Qliance Medical Management Tacoma
1984	Suzanne Johannet	Duke University Hospital FM residency	45 WARWICK RD, Belmont, MA 02478 FM practice
1984	Lawton Shaw Cooper	U Rochester Highland Hospital, residency MPH HSPH	Medical Officer at NIH National Heart Lung & Blood Institute - clinical cardiovascular research
1984	Ronald Epstein	Highland Hospital, Rochester (Family Medicine) Fellowship in FM/Psych/HIV at Highland Hospital	Professor of Family Medicine, Psychiatry, Oncology and Medicine (Palliative Care) American Cancer Society Clinical Research Professor University of Rochester School of Medicine and Dentistry 1381 South Avenue, Rochester, NY 14620 USA +1.585.506.9484 | Author “Attending” (read it!)
1985	Jeffrey Alan Benson	Albert Einstein Montefiore, NY	Martin’s Point in ME, and ME VA medical center
1988	Rob Saper	UCSF (CA) FM residency Integrative Medicine Research Fellowship with MPH (Harvard)	2021 Director of Wellness and Preventive Medicine, Cleveland Clinic. Full Professor and Director of Integrative Medicine, BU
1991	Dana Kent	Natividad Medical Center (CA)	Natividad Medical Center Faculty ? practicing Seaside CA
1991	Katherine Gish	Mountain Area Health Education Center Family Practice (NC)	Whitesburg KY family physician, previously Appalachia, VA

1992	Joan Fleischman	Albert Einstein/Yeshiva (NY)	early abortion care https://earlyabortionoptions.com/dr-joan-fleischman-md/

1992	John Chaffee	Spokane Family Medicine (WA)	Family Medicine Federal Way, WA
1994	Connie Casillas	Lawrence FMR (MA) Fellowship, Social Mission of Medicine, Kaiser Permanente and George Washington University	Kaiser Permanente Pasadena Chief Information Officer for Alliance in Mentorship. Instructor Kaiser Permanente Tyson School of Medicine and David Geffen School of Medicine at UCLA. past co-chair for LAMC's Equity, Inclusion & Diversity Committee, California Health Care Foundation Fellow for Cohort 19. previously practiced with Pomona Valley Health Center's newly established Family Practice Residency Program as its Obstetrical Coordinator and Core Faculty between 1997-2000.
1994	Carl Morris	Providence (now Swedish-Cherry Hill) (WA) MPH University of Washington	Kaiser Permanente Washington FM Residency Program Director
1994	Caroline Richardson	Family Practice Intern, St. Margaret Memorial Hospital, Pittsburgh, Penn., 1995 Family Practice Residency, Hunterdon Medical Center, Flemington, N.J., 1996 Family Practice Residency, Thomas Jefferson University Hospital, Philadelphia, Penn., 1998	Michigan - Associate Chair for Research Programs The Dr. Max and Buena Lichter Research Professor of Family Medicine Editor-in-Chief, the Annals of Family Medicine
1994	Naomi Wortis	UCSF (CA) Fellowship UCSD Addressing Health Needs of Underserved	Director of Community Programs, UCSF Dept of Family and Community Medicine Endowed chair in family medicine
1993	Daphne Miller	Natividad (CA) (or UCSF) NIH primary care research fellowship	https://www.drdaphne.com/dmmd Agriculture and health author
1993	Sharon Hausman-Cohen	Austin Medical Education Program, Seton health residency Integrative Medicine	Co-founder and medical director, Resilient Health https://resilienthealthaustin.com/clinicians/ integrative medical practice
1995	Christina Antenucci	Swedish Hospital/Providence Medical Ctr, WA	Asst Prof, Case Western Reserve
1995	Steven Bromer	UCSF (CA)	CMO for Quality, West County Health Centers, CA Special interest HIV medicine

1995	Peter Hatcher	OHSU (OR)	Rockwood Community Health Center 2020 SE 182nd Ave Portland, OR 97233 503.988.5558
1995	Nancy Morden	St Luke's, Duluth (MN)	Vice President of Clinical Innovation & Population Health UnitedHealthcare Dartmouth College Assoc Prof Health Services Researcher, Pharmacoepidemiologist, Health Policy Researcher
1995	Felix Nunez	Harbor UCLA (CA) MPH UCLA	Inland Empire Medical Director for Molina Healthcare in California - Riverside and San Bernardino counties CMO Family Health Care Centers of Greater Los Angeles Previous Vice President of Clinical Services for the Community Clinic Association of Los Angeles County, Medical Director of The South Central Family Health Center, Assistant Medical Director with the Los Angeles County Department of Health Service
1995	Elizabeth Twardon	St. Paul/Ramsey (MN)	Direct Primary CAre in Asheville NC http://www.twardonfamilycare.com/about
1996	Starie Seay	Maine-Dartmouth (ME)	Practicing family doc Ellsworth, ME
1996	James MacDonald	Maine-Dartmouth (ME) Sports Med Fellowship at Boston Children's	Nationwide Children's Sports Medicine and an Associate Professor in the Department of Pediatrics and Family Medicine at The Ohio State University College of Medicine Associate Editor, Clinical Journal of Sports Medicine
1997	Alison Lux	St. Lukes Med Center (WI)	Family Doc at Quadmed in Sussex, WI (on site health care for employers) previous chief of family medicine at Martin Luther King Heritage Health Ctr in Milwaukee
1998	Sarah Young-Xu	UMass (MA)	Medical Director and family doc (with ob) Ammonoosuc Community Health Services Woodsville NH Asst Prof FM Dartmouth FM
1998	Christopher Thiessen	Duluth FMR (MN)	Family Med with OB in MN
1998	Moya Sommerville	U of Maryland (MD)	Family Physician Kennesaw/Acworth GA
1998	Victoria Smith	LSU Health Sciences Center (LA)	Associate Medical Director and VP of Medical Affairs Ochsner Health LA
1998	Eric Knight	Tufts FMR (MA)	Founding Board Member, Jacob A Neufeld Foundation (dedicated to addressing physician burnout, depression and suicide) previously Family Physician in NH, left in 2017
1998	Ilene Klein	Brown FMR (RI)	Chief Population Health Office, Healthstat Inc, founder and CEO Krysalis Consulting, management consulting company

1998	Ambur Economou	Cox Med Center (MO)	in practice, Monett, MO
1998	Carlin Chi	UCSF (CA) UCSF faculty development fellowship	assoc medical director and family doctor, petaluma health center CA
1998	Clara Chang	Lancaster General Hospital (PA)	family doc in Rochester, NY
1999	Rebecca Small	Santa Rosa (CA) Advanced training in Medical Aesthetics	Leads Venture Care Aesthetics, https://www.mchalecreative.com/VentureCare/index.html Director for the UCSF Medical Aesthetic Training Program also family doctor
1999	Sarah-Anne Schumann	BU/BMC (MA) Masters Health Care Management, Columbia U	Telemedicine provider with Amwell Medical Group around Tulsa (?) previous CMO United Health Care OK and E Tx
1999	Maisha Draves	UCSF (CA) MPH	medical director for Pharmacy in Northern California for The Permanente Medical Group and Family Doctor https://lowninstitute.org/deprescribing-champions-maisha-draves/
1999	Jennifer DeVoe	OHSU (OR) Doctor of Philosophy, Oxford	Chair of the Department of Family Medicine leads the DeVoe Lab, which runs federally-funded grants that study access to health care, disparities in care, social determinants of health, and the impact of practice and policy interventions on vulnerable populations. Elected to IOM 2014
1999	Susanna Chou	Scripps Memorial Hospital (CA)	private practice since 2003 previously Associate Medical Director at the Scripps Otay Family Health Center
2000	Raul Trejo	Scripps Memorial Hospital (CA)	Family doc and residency faculty, Chula Vista CA - award won for advocacy for Latinx populations, including highschool outreach, border health
2000	Nerissa Koehn	Tacoma FMR (WA) MPH Hopkins	Family physician in Montana
2000	Beverly (Aist-Mejia) Zavaleta	Christus Santa Rosa (TX)	Physician Advisor in Brownsville TX, and adult hospitalist. Previously had own FM practice
2001	Esiquio Casillas	White Memorial Med Center (LA) Health Policy Fellowship at White Memorial	Medical Director of senior care services/PACE at AltaMed Health Services.
2001	Stephen Buttenwieser	Lawrence FMR (MA)	Family doctor in Lawrence, MA
2001	Lia Bruner	BU/BMC (MA)	Asst Professor, University of Georgia practices in lexington VA or Athens, GA

2001	Murat Akalin	UC San Diego (CA) combined FM/psych residency	private practice in California
2002	Tara Scott	Santa Rosa (CA)	Program Director, Santa Rosa FMR

2002	Steve Martin	BU/BMC (MA)	BU/BMC and UMass FMR Faculty, rural practice in Barre, MA. special interests in SUD and prison medicine
2002	Laura Gottlieb	U of Washington Harborview (WA) (residency and MPH	Professor of FM at USCF, research director. https://profiles.ucsf.edu/laura.gottlieb
2002	Ellen Chen	UCSF (CA)	Family doctor in SF also Primary Care Director of Quality Improvement, San Francisco Health Network, San Francisco Department of Public Health Medical Director, Silver Avenue Family Health Center, San Francisco, CA
2002	Debra Stulberg	West Suburban (IL)	Chair of FM and Associate Professor, University of Chicago
2003	Laura Nell Hodo	U of Utah (UT)	had full spectrum FM practice in UT then transitioned to pediatric hospitalist, in 2017 moved to Mt Sinai in NY in hospital medicine https://www.mountsinai.org/profiles/laura-hodo
2003	Anna Flattau	Columbia-Presbyterian (NY) Master's in health promotion London School of Hygiene and Tropical Medicine Master's in clinical research methodology from Albert Einstein College of Medicine. Executive education program at Harvard Business School in managing health care.	Family PHysician Assistant Professor Vice Chair for Clinical Services and Director of Strategic Development
2004	Anje Von Berkelaer	Harbor UCLA (CA) Masters in Health Policy Research	co-founded private practice in Arlington, VT previously worked with Drs without Borders
2004	Aya Kuribayashi	Swedish-First Hill (WA)	The Everett Clinic in Everett, WA
2005	Christiana Nwofor (jones)	Jamaica Medical Center (NY)	Urgent Care
2005	Erin Lunde	Santa Rosa (CA) MPH UNM Albequerque 2 year surgical OB fellowship	Family Doc and Associate Program Director for Maternity Services, Santa Rosa Fam Med residency
2005	Catherine Livingston	OHSU (OR) Family Med AND Preventive Med	family doc associate prof of Fam Med OHSU

2005	Frances Baxley	UCSF (CA)	Instructor, Northwestern Lake Forest
2006	Jonathan Glazer Shaw	OHSU (OR)	Director of Community Partnership, Division of Primary Care, Stanford Associate Professor
2006	Tarayn Grizzard	Middlesex (CT) for 1 year then switched to Pediatrics at Baystate	https://hms.harvard.edu/news/re-match-day-leads-new-specialty
2007	Elizabeth Ferrenz	UCSF (CA)	BU Family Medicine Faculty (Asst Professor)
2007	Michael Monge	Ventura (CA)	Hospitalist, Mission Viejo Also hospice/palliative care
2007	Alisha Kithcart (Kidane)	Tufts FMR (MA) Maternal CHild Health fellowship, Chicago	Family doctor, Sugar Land, TX
2008	Elizabeth Schaefer	Santa Rosa (CA) FM internship transferred to med peds at Brigham	
2008	Kimberly Collins	U of Washington (WA)	Assistant Prof, Dept of Fam Med, U Washington
2008	Elise Cheng (Torres)	O'Connor (CA) OB fellowship Santa Clara Valley Medical Center	Family doc, Stanford
2009	Caroline Pahk	Lawrence FMR (MA)	DotHouse Health (Dorchester House FQHC) Boston
2009	Mark Shaffer	Palmetto (SC) Global Health Fellowship, USC (CA)	Asst Professor and family doc, U So Carolina
2009	Colleen Harrison	Santa Rosa (CA)	Family Physician in Montreal, Canada
2009	Clea Lopez	OHSA (OR)	Family physician in OR
2009	Claudia Diaz (Mooney)	UCSF (CA) Faculty Development Fellowship, UCSF	Associate Program Director, SFGH-UCSF Family and Community Medicine Residency Family doctor, SF
2010	Cathryn Christensen	Santa Rosa (CA) MPH Johns Hopkins	Burundi Clinical Programs Director of Village Health Works https://www.villagehealthworks.org/
2010	Ben Smith	Fort Collins Fam Med Residency	full spectrum faculty member in the community hospital where I completed residency in Fort Collins, CO.
2010	Judah Slavkovsky	Ventura (CA) then Gen Surgery Case 2012, Swedish 2013	General Surgeon

2010	Venis Wilder	Columbia-Presbyterian (NY)	Family doctor in Miami and social activist/hip hop-R&B artist
2011	Samuel Zager	Maine Medical Center (ME)	Family Physician at Martin's Point ME State Representative dis 41
2011	Anjana Sharma	Tufts FMR (MA)	Family Physician in San Francisco, Asst Prof Fam Comm Med UCSF. Special interest in patient engagement
2011	Stephen Pomedli	U of Toronto (Ontario, Canada)	Family physician in Toronto, Chief Medical Director League INC powered by Cleveland Clinic
2011	Kristin Nierenberg	Swedish-First Hill (WA)	Spent time as rural physician in Kodiak, AK then joined Kaiser in Seattle
2011	Tina Marie George	Geisinger (PA) MPH Yale	Family doc in Avoca, PA
2011	Alexandra Clifton (Oxnard)	Tufts FMR (MA)	Family doc and yoga instructor, authored a book on the early postpartum/postnatal period, special interest in mindfulness CHA in Somerville, MA
2011	Akochi Agunwamba	Mayo (MN)	Hospital Medicine, New Prague, MN
2012	Jonathan Takahashi	U of Wisconsin (WI) MPH HSPH	Family Physician at U Wisconsin, Integrative medicine
2012	Craig Szela	Albert Einstein (NY)	Family Doctor at Neighborcare Health in Seattle
2012	Vanessa Redditt	U of Toronto (Ontario, Canada) Fellowship Global Health and Vulnerable Populations, Toronto	Family Physician and Lecturer, Dalla Lana School of PUblic Health, U of Toronto
2012	Chinyere Obimba	Swedish-Cherry Hill (WA)	Family medicine with OB at Swedish-Cherry Hill
2012	Marianna Kong	UCSF	Physician Practice Transformation Specialist at the Center for Excellence in Primary Care, faculty UCSF
2012	Sheila Abdallah	BU/BMC (MA)	Family Doc, U Mass Worcester/ Southbridge MA
2013	Caty Reyes	Tufts FMR (MA)	Family Doc at Lynn Community Health Center, Lynn MA
2013	Jessie O'Brien	U of Wisconsin (WI)	Family Physician, Aurora Health Care in Milwaukee Aurora Family Medicine 5818 W Capitol Dr Milwaukee, WI 53216

2013	Michael Matergia	Exempla (CO)	Family doctor, Denver Sister Joanna Bruner Family Medicine Center

		Global Health Fellowship, U CO	960 North Ogden Street, Suite 460 enver, CO 80218 Founder Broadleaf Health and Education Alliance in the Himalayas https://www.broadleaf.org/
2013	Kelsey Leonard Smith	United Hospital (MN)	Family doc, St. Paul, MN special interest maternity care and transgender care
2013	Kat Barnes (Wakeham)	Group Health (WA)	Family Physician with Kaiser in Burien, WA
2013	Kirsten Austed	BU/BMC (MA)	Associate Professor of Family Medicine at Boston University School of Medicine, and is an Attending Physician at Boston Medical Center (BMC) and Research Fellow at Brigham and Women's Hospital
2013	Danielle Alkov	UCSF (CA)	Family doc, Women's Health https://www.womenshealthspecialists.org/about/ LGBDQIA+ care https://dimensionsclinic.com/#top
2014	Roberta Dennison	Tufts FMR (MA) Boston Children's sports med fellowship	Tufts CHA residency faculty
2015	Nicole Jackson	BU/BMC (MA)	Directory of Diversity Programs BMC, clinical family medicine in CT
2015	Ariel Wagner	Contra Costa (CA)	Director of Primary Health for Partners in Health, Malawi. ? practicing in Seattle
2015	Juliana Morris	UCSF (CA)	Working at MGH as of 2021 in family medicine and advocacy
2016	Kate (Majzoub) Perez	Swedish Medical Center-First Hill (WA)	Transferred to IM residency
2016	Diana Wohler	Brown University (RI)	Fill spectrum FM in Wilmington, DE
2016	Jon Watson	UCLA Harbor (CA) UCLA Addiction Medicine Fellowship	Orange County Correctional Facility post fellowship
2016	Alex Harsha	Contra Costa (CA)	Family medicine in Staples, MN
2017	Daniela Delgado	Harbor UCLA (CA)	Practicing in LA, UCLA instructor, focus on LGBT+ health
2017	Alexandra Gast	Boston University (MA)	? working at BMC
2017	Sara Martin	Santa Rosa (CA)	Faculty Ukiah Valley FM residency
2017	Viet Nguyen	University of Washington, Harborview (WA)	Neighborcare Health in Seattle, WA

2017	Anne Marie Williams	Swedish Medical Center--First Hill;, downtown campus (WA)	Family physician in Gallup, NM, IHS and HEAL fellow
2017	Deborah Orosz	Kaiser Napa-Solano in Vallejo, CA	Fam Doc at Kaiser, Oakland CA
2018	Deyang Nyandak	CHA Malden, MA	Completed a repro health fellowship, and staying in Malden as an attending
2018	Adeola On-Orisan	UCSF	Resident
2018	Jillian Moore	University of New Mexico	Resident
2019	Megan Townsend	University of Colorado Denver	resident
2020	Andrew Foley	Lancaster General Hospital, Lancaster PA	Resident
2020	Rebecca Hofer	UCSF	Resident
2021	Jacob Paul Anderson	UCSF	Resident
2021	Nikolai Renedo	Maine Medical Center, Portland ME	Resident
2021	Tiantian White	OHSU, Portland OR	Resident
2021	Katherine McDaniels	BMC, Boston, MA	Resident
2021	Alma Onate Munoz	Lawrence (GLFHR), MA	Resident
2021	(name removed per student request)	Pomona Valley, CA	
2022	Maahika Srinvasanan	Penn	
2022	Mara Farcasanu	Tufts/CHA, Malden MA	

Number per year:

2022 - 2
2021 - 6
2020 - 2
2019 - 1
2018 - 3
2017 - 5
2016 - 4
2015 - 4
2014 - 1
2013 - 7
2012 - 6
2011 - 8

Total # of HMS Graduates in Family Medicine as of end of 2016: 120+

10. History of Family Medicine at HMS

A Rich History of Family Medicine at Harvard

Kathe Miller MD, Family Medicine Advisor, HMS

Part I- The Early Days of Family Medicine

In October 2010, Harvard Medical School (HMS) announced the launch of the Center for Primary Care, a powerful and transformative initiative, but not an entirely new idea. The first time Harvard concentrated on primary care had been nearly 60 years before.

Family medicine is not the specialty one thinks of at HMS, and only recently has primary care surged in the list of visible themes. However, Harvard was once a leader in primary care. In fact, it was home to one of the first family medicine residences in the United States and one of the most innovative primary care training programs.
In the 1950s, HMS developed a series of programs around primary care and prevention. It led the academic community, as primary care was just coming into existence.

The term “primary care” was not even widely used until the 1960s. A definition by J. Millis in 1966 said primary care physicians needed to focus “not upon individual organs and systems but upon the whole man… (and) serve as the primary medical resource and counselor to an individual or a family.” This was a new and even controversial statement, as medical education had gone from preparing generalist physicians to specialists, since the 1780s when HMS was founded.

In 1953, Massachusetts General Hospital (MGH) designed a five-year experiment of the Family Health Program to evaluate if third and fourth year students could benefit from caring for an entire family. Because there were no family physicians at MGH, the families were cared for by a student who

coordinated with pediatricians, internists, and obstetricians. The success of this program led to a second program, the Family Health Care Program (FHCP), in 1954.

FHCP was founded on the Longwood campus with support from Dean George P. Berry and Physician in Chief of the Children's Hospital, Charles Janeway. It was located in a three-story converted house on the corner of Francis and Binney streets. FHCP's first director was Robert J. Haggarty, who completed a two-year general practice internship and pediatric residency. The FHCP was a living experiment and a forum for primary care physicians to try out ideas on care delivery and research.

The center was a setting for pediatric house officers to learn outpatient practice and to work with multidisciplinary teams to provide medical services to local needy families. The teams would care for families, who mostly lived within 3 miles of the campus, in outpatient, inpatient, and in-home setting. Teams included pediatric residents, nurses and social workers. Psychiatrists from Massachusetts Mental Health Center met weekly with the residents to mentor them on mental health in the primary care setting.

Many of FHCP's concepts were important in the development in the Patient Centered Medical Home, which went beyond the original ideas to add advanced technologies, such as patient registries and electronic medical records. The program for pediatric resident training was successful and shortly after its creation, residents assumed responsibilities for families over one or two years of their training.

The affiliated medical student program, which drew experience from the MGH experiment, was a consistently oversubscribed elective and an ideological precursor to the noteworthy Cambridge Integrated Clerkship.

The program then expanded from pediatrics to family medicine. While the children continued to receive inpatient care at Children's Hospital, adults were admitted to the Peter
Bent Brigham Hospital, and peripartum care was at the Boston Lying In Hospitals.
Massachusetts Mental Health Center met psychiatric needs for the program's patients.

In 1960, the program expanded with the creation of a U.S. Children's Bureau sponsored fellowship, for "training and investigation in family medical practice." Among these fellows were a number of experienced general practitioners who later became boarded in Family Medicine, such as John Jainchill, who became director of the Family Health and Primary
Care Department at Boston City Hospital, and Evan Charney, who became the Director of
Primary Care Education at the University of Rochester School of Medicine and Dentistry.

The final expansion was the creation of a family medicine and primary care residency-training program in 1965. The Theodore Schulz Foundation contributed $1 million to promote the education of HMS students, pediatric residents, and fellows in primary care. Joel Alpert, a pediatrician, was the first program director. He was also a visionary in primary care published many articles on his findings at the

center, and founded the Society of Teachers of Family medicine, which is still one of the most important groups promoting family medicine.

Family medicine at Harvard grew rapidly in the 1950s and 1960, but events of the 1970s suddenly and surprisingly ended many advances.

Part II – 40 Years in the Desert

The Family Health Care Program (FHCP) at Harvard Medical School (HMS) was an intense and rapidly evolving experiment in primary care and education, which ended suddenly in the 1970s. The specific training for pediatric residents was phased out as in-hospital clinical demands increased and residents found it difficult to make it to outpatient sessions. The time in the outpatient arena was no longer seen as a core educational component, despite assertions from participants.

In 1968, the newly established American Board of Family Medicine and the Department of Health, Education, and Welfare, which funded the residency, objected to FHCP training because of its lack of surgical training and only low risk OB training. The two government departments felt the FHCP provided insufficient training in inpatient medicine, surgery, and intrapartum care. The program was deemed inadequate and the funding withdrawn. In 1971, the residency was placed on probation for these concerns.

There was not academic or hospital department of family medicine in the HMS system.
FHCP was still based primary at Children's Hospital, the Peter Bent Brigham, and Boston Lying In hospitals. When the government funding was withdrawn, the chiefs of the hospitals declined to extend institutional support for the program.
The final decision to close the residency program came from, then Dean, Robert Ebert, and was met by resistance from the Student-Faculty Council. A petition was circulated, but the decision was not reversed. In 1976, the FHCP and the residency program folded. Funding from the Schultz Foundation, originally given to the FHCP, was used to support an ongoing student educational experience, but later the funding was reallocated, ending that program as well. The medical student elective at Massachusetts General Hospital (MGH) did not end along with FHCP, but it was offered at a new clinical home by two FHCP physicians, Richard Feinbloom and Stanley Sagov, at the Cambridge Health Alliance (CHA). However, this was only a medical student program and did not include training for residents. At the time, CHA did not have a department of Family Medicine, but Chief of Medicine Robert Lawrence welcomed family doctors.

Eventually, Sagov moved to Mount Auburn Hospital and became Chief of Family Medicine. At one point consideration for a CHA family medicine residency was made, but in order to obtain grant funding, CHA would have to guarantee to financially support the program should government funding be lost. CHA was unable to offer such a guarantee and the plan was abandoned.

Alan Drabkin MD, another family physician, arrived at CHA in 1986 to provide inpatient and outpatient care (he did not provide care on the labor floor). He accepted charge of the Family Medicine elective for HMS and became director for Health Care for the Homeless. More recently, Mt. Auburn had plans to host a family medicine residency under the guidance of Jim McGuire, Chief of Medicine. However, he died suddenly in 1997 and so did the residency plans.

Within Harvard, Family Medicine remained small. Tom Inui, chair of the department of Ambulatory Care and Prevention, brought in family medicine physicians under his
department. At the time, there was a division for Primary Care, but no academic department. Without a department, promotion was difficult other than based on years of service, as is still the case. A formal role was created for family medicine advising at HMS and filled initially by Mark Mengel, and later Drabkin.

Later, the department of Ambulatory Care and Prevention was replaced by the Population Medicine and in 2009 the Division of Primary Care was defunded. After outcry, Dean Jeffrey Flier appointed a committee to evaluate the issue. The Primary Care Advisory Group originally had no family medicine representation, but Drabkin serendipitously learned of the group and was able to join. Russ Phillips and Andrew Bates also joined to support the Family Medicine cause. Many of the committee's findings came to life in the founding of the Center for Primary Care.

Part III- The present and future of primary care at HMS

After four decades since the end of Harvard's family medicine and primary care programs, interest has surged again in family medicine, largely powered by Harvard Medical School (HMS) students. The last two years have graduated 15 students into Family Medicine residencies, and in the last five years, there has been a steady increase in students requesting a fourth-year family medicine elective.

Students have been working to build a community of physicians to promote family medicine education and act as mentors. Family medicine has a significantly greater presence at HMS due to the Center for Primary Care.
The formerly "title only" for a family medicine advisor is now a funded position.
The Tufts/CHA Family Medicine residency program, which joined CHA in (2002? Need to check date) is now sending residents to Beth Israel Deaconess for training in Labor and Delivery.

HMS currently has a wide but poorly united community of family physicians, none of which has a clinical site on the Longwood campus. Other affiliated practices include more than 60 family physicians working for Cambridge Health Alliance as well as the Family Medicine Residency. There are more than 200 family physicians employed in other Harvard affiliated practices.

Currently, students can gain exposure to family medicine thought the first and second year if they are paired with Family Physician for the Patient Doctor 1 and 2 courses. Student organized events and

workshops also promote family medicine, but none are required and therefore do not guarantee exposure to family medicine.
In the future, the Center for Primary Care will bring important change to the academic community at HMS. It has hired two family physicians to organize and promote primary care research, family medicine activities, mentorship, and develop more training sites.

Perhaps one of the most poignant reconnections can be found in the Sagov Center for Family Medicine, which was awarded a grant as part of the Academic Innovations Collaborative. This practice, founded by one of the originators of Family Medicine at HMS, now will join a Harvard based community of clinical experts and innovators to promote a community of primary care leaders.

If history is any proof, we will soon be in another explosion of primary care innovation. In contrast to FHCP, this new burst of activity will be sustainable, supported, and have wide influence in the innovation and education.
The rich history of family medicine those decades ago is a fascinating chapter, but the intervening years prevented HMS from staying on the cutting edge of Family Medicine. There is a lot of work to do, in order to HMS to regain a presence at a national level. However, with the current resources, not only financial but also in the dedication and enthusiasm of the primary care doctors working through the Center for Primary Care, HMS can once again become an important contributor to the field of academic family medicine.

Acknowledgements:
Thank you to Dr. Joel Alpert, Dr. Richard Feinbloom, and Dr. Stanley Sagov for generously making time to speak with me about this amazing history. Also to Kelsey Leonard-Smith, Kathleen Barnes, Diane Wohler, and the rest of the visionary, strong, and brilliant student leaders of the HMS Family Medicine Interest Group, for their enthusiastic participation.

The original Primary Care residency at Harvard, as described in the 1977 Harvard Med Alumni Bulletin

(https://archive.org/stream/harvardmedicalal52harv/harvardmedicalal52harv_djvu.txt)

Residencies multiply at Harvard hospitals
Over the past three years, training in primary care has assumed a steadily expanding role at Harvard hospitals. Forty residents in primary care are now in training at the Beth Israel, Massachusetts General, Peter Bent Brigham, Cambridge, Mt. Auburn and Children's hospitals; twenty-seven have already completed a three year program, and a total of fifty-three will be involved by July 1979. This commitment and continued growth in the number of primary care residencies has been made possible by grants from the Robert Wood Johnson Foundation.

How does a residency in primary care differ from one in internal medicine? Robert Lawrence '64, head of the Division of Primary Care and Family Medicine at HMS, explains that the primary care programs place greater emphasis on the effects of family, environment and other psychological and social factors on the

health of an individual. The clinical experience is geared to the common problems encountered in primary care practice. In
addition to medical training on the hospital ward, "each of the trainees devotes six months of the year to ambulatory rotations," and then receives "additional training in specialties such as office gynecology, common ear-nose-and-throat and ophthalmology, minor orthopedics, dermatology and psychiatry."

The emphasis on psychosocial factors in health is supported by data showing that from twenty to seventy per cent of all patients seeking care from first-contact physicians have complaints closely related to psychological and social disruptions in their lives. "In spite of this," asserts Dr. Lawrence, "medical education at both undergraduate and graduate levels has so neglected this aspect of training that most physicians enter medical practice with little or no education in the most elementary aspects of behavior, psychiatry, and personality development as they relate to all illness."

For the outpatient aspect of training, says Dr. Lawrence, "a rich and diverse experience is provided by having ambulatory care facilities in hospitals, neighborhood health centers, prepaid group practice plans, a student health service, and, recently added, rural practice in Vermont and Massachusetts where residents can rotate on an elective basis." Nine local sites are involved in the programs: the Beth Israel Ambulatory Care Program, the Bunker Hill and Chelsea neighborhood health centers of the MGH, the Children's Hospital Primary Care Unit, Dimock Health Center, the MGH, the Pearl Clinic at the Peter Bent Brigham Hospital,
Harvard University Health Service, and Harvard Community Health Plan. Since 1975, training in pediatric primary care as well as in internal medicine primary care has been available; a family practice residency program is in the planning stage.

An important spin-off of the development of primary care at the postgraduate level has been the growth of opportunities for primary care experience for HMS undergraduates. Clinical electives for medical students are now offered at three of the ambulatory care sites, and with the help of this year's grant from the Johnson Foundation, more will soon be made available.