Well-rounded instruction in occupational medicine as part of family medicine residency training is feasible through a program that balances a longitudinal curriculum of monthly occupational and environmental medicine (OEM) lectures, community-based OEM patient care, and worksite assessment. Such training would help equip family medicine residents to integrate occupational medicine into their practices, which, in light of a shortage of board-certified practitioners in OEM, would help fill community needs.

The Intern-Resident Training Committee of Carson City Hospital in rural Michigan established both learner and institutional goals and objectives for such a program of instruction. A learner-needs assessment found appreciable interest among the residents for occupational medicine training. In addition, results of a survey of the occupational health community suggested there is inadequate coverage of OEM in medical schools and residencies. Furthermore, a focus group of occupational health managers revealed that clarity of communication and standardization of reporting were paramount concerns. Instruments for standardized OEM history and for OEM case management were developed for use within the residency continuity clinic.

The curriculum was implemented with a variety of teaching strategies, including worksite assessment. Practice-based, case-oriented instruction was subsequently phased into the program as residents assumed responsibility for managing cases under the supervision of family medicine preceptors knowledgeable in OEM. An occupational medicine rotation was developed that included focused clinical exposure to OEM patients and studies that would lead to eligibility for a certificate of additional qualification in occupational medicine.

Learner evaluations included chart reviews and patient satisfaction surveys. Program evaluations included interviews with occupational health managers. The residents were judged by their preceptors to have performed well. The responses of the health managers and the patients were positive. This program in occupational medicine was found to be educationally sound with demonstrated community benefit and patient satisfaction. Further, it is cost-effective, requiring no external funding.

(Key words: medical education, occupational and environmental medicine, primary care)

Dr Eckstein is the family medicine residency director at Carson City Hospital, Carson City, Mich.; Dr Teitelbaum is a professor in the Department of Internal Medicine and chairman of Section of Preventive Medicine at the Michigan State University College of Osteopathic Medicine, East Lansing, Mich. This faculty development project was supported by faculty development grant No. 5 D45-PE 50045 from the Division of Medicine, Bureau of Health Professions, Department of Health and Human Services.

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While it is widely agreed that board-certified specialists in occupational medicine are the preferred practitioners of the OEM specialty, there remains a need for specialty support among trained primary care physicians.

In August 1998, the number of certified specialists in the field was only 2218, according to data obtained through a telephone call to the American Board of Medical Specialties. Factors influencing the shortage of OEM training include lack of awareness on the part of medical school deans and advisors about the field and lack of curricular exposure in medical school and most residencies. Furthermore, there has been a failure of those within this field to market themselves effectively.

The influence of managed care organization on the healthcare professions has brought with it an emphasis on community-based medical practice. This emphasis on serving the healthcare needs of populations and industry has made the concept of nontraditional occupational medicine specialists (primary care physicians) a valid consideration. Training primary care physicians in the field of occupational medicine can help satisfy this broad societal need. This effort demands, however, that specific qualities and skills be acquired by such primary care physicians. The American College of Physicians has suggested that internists are best positioned to fill the gaps in occupational medicine coverage. Some have proposed that financial or grant-type incentives be used to encourage primary care physicians to practice in the OEM field. The physicians would be encouraged to achieve performance benchmarks in the field of occupational medicine, similar to what was done in the early days of preventive cardiology.
One interesting concept for integrating occupational health issues into an internal medicine clerkship uses problem-based case studies. This approach does not include a longitudinal curriculum, however. Another approach is a combined program in family medicine and occupational medicine, but this requires a platform that supports both residencies and necessitates recruitment of candidates who are willing to spend an additional year in training. Another strategy outlines the essential core content of continuing education courses for primary care physicians who choose to pursue a career in occupational medicine. This model, although it is endorsed by the American College of Physicians, does not address the issues of undergraduate or residency-level education and training.

Other strategies used in primary care residencies include those used in three programs implemented at Duke University Medical Center between 1984 and 1991. The first approach involved a 4-week rotation through the Department of Occupational and Environmental Medicine, but it lacked an ongoing core curriculum and lost its funding after 2 years. The second program called for an internal medicine OEM preceptorship with one-half day per week in an ambulatory setting under the supervision of an attending OEM, along with a series of three 1-hour lecture presentations. The third program combined monthly OEM lectures with attendance at back school in the department of physical therapy, 10 hours of work in the employee health clinic, and study of a standardized workbook containing pertinent occupational medicine literature.

Another curricular example is found at the Medical University of South Carolina. Despite having neither an accredited school of public health nor an OEM residency, the university obtained a Department of Energy grant that it used to develop a 3-year longitudinal curriculum. This curriculum consisted of five required and nine elective areas intended to enable graduates to practice OEM. This program was largely patient-centered self-study and provided limited opportunities for clinical exposure. It emphasized learner evaluation methods, including pre- and post-tests for lectures and chart audits for clinic experiences.

Purpose
This project developed and implemented a longitudinal curriculum of regularly scheduled OEM lectures, community-based OEM patient care, and worksite-assessment opportunities. The goal was to provide a well-rounded experience that would equip graduates of a family medicine residency to practice occupational medicine.

Carson City Hospital is a 100-bed community hospital in the central part of Michigan's Lower Peninsula. Carson City, a town of 1200 people, is located in a rural environment with some light industry, in a service area with a population of 65,000. The hospital sponsors one residency in family medicine. The total 1998-1999 enrollment was four residents when we initiated the OEM program in July 1998. Greenville Family Care Center, which serves both as a group family practice and as the resident continuity clinic, is located in Greenville, Michigan, approximately 20 miles west of Carson City. Greenville is a semi-rural community of 10,000 with a substantial mixture of commercial enterprise and light and heavy industry. Helathworks, Inc., is an occupational medicine services entity that contracts to provide services for numerous shops and industries in the Greenville-Carson City area. Its office is located at the Greenville Family Care Center. The hospital's Intern-Resident Training Committee recommended in April 1998 that any OEM didactic presentations be delivered at Carson City Hospital's morning lecture session, while implementation of OEM practice curriculum would occur at the Greenville Family Care Center.

The committee proposed the following learner goals to address the need for OEM training of its residents: (1) Facilitate the family medicine residents' acquisition of the fundamental cognitive skills in non-clinical subjects on which the practice of occupational and environmental medicine is based; and (2) ensure the residents' competency in the psychomotor skills required to treat most of the occupational health problems seen in a primary care practice.

Methods
A learner-needs assessment was conducted in August 1998. This assessment was based on a review of the literature, which included the core curricula in occupational and environmental medicine of both the American Academy of Family Physicians and the American Osteopathic College of Family Physicians, as well as standard OEM and physical medicine texts and experience in local practice. The assessment addressed respondents' familiarity with various OEM topic areas and their interest in further education in these subjects. The subjects included six clinical topic areas (biostatistics, epidemiology, industrial hygiene, worksite assessment, legal and regulatory issues, and OEM terminology) and six nonclinical topic areas (occupational health history, use of transcutaneous electrical nerve stimulation [TENS], therapeutic ultrasound, joint and trigger point injections, occupational dermatitis, osteopathic manipulative treatment, and exercise prescription).

For familiarity with OEM topic areas, respondents used a Likert scale with values of 1 through 5 (1 = thoroughly unfamiliar; 5 = very familiar). For interest in further education and training in the topic areas, the Likert scale also was used, again with values of 1 through 5 (1 = no interest for further education or training; 5 = definite need for further education and training). Respondents used the full range of the scale, and the results are shown in Table 1.

The results reflect appreciable interest in further education and training in occupational medicine. It is worth mentioning that respondents who showed a greater level of familiarity also indicated a greater level of interest in further education and training.

While the residents surveyed were supportive of this OEM initiative, the responses of the community industrial health managers to a survey about improving education in occupational medicine were even more compelling. Eighty-one percent of those responding to
Table 1
Learner Needs Assessment (N = 4)

<table>
<thead>
<tr>
<th>Familiarity with nonclinical topic areas</th>
<th>Familiarity with clinical topic areas</th>
<th>Interest in further training for nonclinical topic areas</th>
<th>Interest in further training for clinical topic areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>N = residents</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Median</td>
<td>2.94</td>
<td>3.13</td>
<td>3.40</td>
</tr>
</tbody>
</table>

In addition, a focus group was conducted in July 1998 with members of the West Michigan Occupational Health Initiative (WM OHI), which is a division of the Alliance for Health in Grand Rapids, Michigan. The Alliance for Health is a community health planning coalition dedicated to effective and efficient healthcare delivery, and the WM OHI addresses those issues specifically with respect to occupational and environmental medicine. The focus group discussion established two priorities with respect to occupational and environmental medicine: standardization of reporting for occupational illnesses and injuries, and clarity of communication between treating physicians and occupational health managers. This message was so convincing that it seemed addressing these two issues effectively would be key to making occupational medicine training a reality within the family medicine residency.

In response, two products were developed to address standardization of reporting and clarity of communication. The first is a form for OEM history (Figure 3). The second is a form for reporting of OEM illnesses and injuries (Figure 4). The emphasis of the second form was standardization in the following areas: (1) patient demographics; (2) medical information, which includes impairment; (3) case management, which includes patient education, prevention, self-management, and activity modifications (work restrictions); and (4) billing information. These forms were distributed to the OEM healthcare community for review and appraisal. OEM providers were asked to evaluate the forms based on five criteria:

- Are the forms understandable in terms of content?
- Are they organized in a useful way?
- Do they include the important elements of a worker’s compensation case?
- Are the forms appropriate in length?

- Does the format allow for accuracy?

Of the 67 individuals surveyed, 24 (36%) responded. A Likert scale provided a range of responses from 1 to 5 (1 = not at all; 5 = significantly) (Figure 5). The 24 respondents indicated that the forms for OEM history and OEM illness and injury were satisfactory for addressing both standardization and clarity in reporting OEM information. Most indicated that the products “significantly” achieved the criteria (Figure 5).

Objectives for OEM training in a family medicine residency were based on (1) the literature review; (2) the needs assessment of the family medicine residents; (3) surveys of the community’s OEM health professionals; (4) priorities as expressed by the focus group discussion, and (5) 10 years’ experience in treating OEM patients at the Greenville Family Care Center through Healthworks, Inc. Three primary objectives were proposed:

- The residents will be able to diagnose and treat the most common OEM disorders in a primary care clinic.
- The learners will demonstrate the ability to evaluate the OEM literature, perform case management, and perform worksite assessments for local industry.
- The learners will develop an interest in lifelong learning in OEM.

An institutional goal and an objective were also established in collaboration with the medical director of Carson City Hospital, the office manager of the Greenville Family Care Center, and the Intern-Resident Training Committee. The goal was for occupational health managers to perceive an improved level of OEM care in the community, while the...
objective was to permanently implement the curriculum at the training institution (Carson City Hospital). The topics in the curriculum agreed upon by the Intern-Resident Training Committee closely resembled those that were cited in the learner-needs assessment, with three exceptions. Osteopathic manipulative treatment and exercise prescription were both integrated into the clinic training experience with preceptor supervision because of the residents’ exceptionally high level of knowledge and competence in these areas. Two of the residents had completed OMT fellowships prior to participation in the residency program. Second, occupational dermatitis was taught on a case-based approach within the continuity clinic experience, as dermatology is well covered elsewhere in the curriculum through lectures and a popular dermatology elective rotation. Finally, an actual worksite evaluation exercise was scheduled through the cooperation of one of the local industrial facilities, which has developed model ergonomic work stations and stresses compliance with sound ergonomic principles. For this reason, a session on ergonomics was substituted for industrial hygiene. The schedule for 1998-1999 was as follows:

Injection Techniques: Sept 16 and 21; Oct 18
OEM History: Oct 23
Therapeutic Ultrasound: Nov 6
OEM Terminology: Dec 21
Use of TENS: Jan 27
Legal and Regulatory Issues: Feb 19
Ergonomics: March 14
Worksite Assessment: March 23
Epidemiology and Biostatistics: April 12 and 16
Final Self-Assessment: April 20

Each didactic session was facilitated by physicians and lay experts from the community who had experience in the respective fields.
Figure 3. Occupational/environmental history form.
**Environmental History:** *(Please explain all yes answers below.)*

12. Have you ever changed your residence or home because of a health problem? No Yes
13. Do you live next door to or very near to an industrial plant? No Yes
14. Do you have a hobby or craft which you do at home? No Yes
15. Does your spouse or any household member have contact with dusts or chemicals at work during leisure activities? No Yes
16. Do you use pesticides around your home or garden? No Yes

17. Which of the following do you have in your home? *(Please check those that apply.)*

- [ ] Air conditioner
- [ ] Humidifier
- [ ] Electric stove
- [ ] Central heating
- [ ] Air purifier
- [ ] Gas Stove
- [ ] Fireplace
- [ ] Oil heating

*Please number and explain all yes answers from the front and above on the following lines.*

---

**Figure 3.** *(Continued)*
### Figure 4. Occupational/environmental case report form.

<table>
<thead>
<tr>
<th>Date:__________________________</th>
<th>Name:__________________________</th>
<th>SSN:__________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Company: ________________________</td>
<td>Job Title: ______________________</td>
<td>Supervisor: ____________________</td>
</tr>
<tr>
<td>Date of Onset: __________________</td>
<td>Report: Initial □ Follow-up □</td>
<td></td>
</tr>
</tbody>
</table>

**MEDICAL REPORT**

**Symptoms:**

Initial Event: □ Recurrence: □ Previous Dates: __________________________
Onset: □ Sudden □ Gradual

**Diagnostic Studies**

**X-Rays:**

**Laboratory:**

**Diagnosis:**
1. __________________________
2. __________________________
3. __________________________
4. __________________________

**Contributory Factors:**
1. __________________________
2. __________________________
3. __________________________

**Work related:** □ Yes □ No □ Probable □ Possible

**Comorbidities:**
1. __________________________
2. __________________________

**Complications:**
1. __________________________

**Treatment:**

**Medications:**
1. __________________________
2. __________________________
3. __________________________

**Therapy:**

**Procedures:**

**Devices:**

**Medical Impairment (Case Specific):**

**Time to Recovery:**

**Referrals:**

**Consultant:**
Date: ________________________ Time: ________________________

**Therapy:**
Date: ________________________ Time: ________________________

**Employer Notified:** □ Yes □ No □ Follow-up appointment: □ Yes Date: ______ Time: ______ □ No

**Comments:**

**Disposition (check all that apply):**

□ Improved □ Not Improved □ Resolved □ Maximal Improvement □ Discharged From Care

**Physician Name (Print):** __________________________
**Signature:** __________________________
**Date:** ________________ **Time Arrived:** ________________ **Time Departed:** ________________

---

Page 1
CASE MANAGEMENT

SELF-MANAGEMENT:

PREVENTION:

EDUCATION:

ACTIVITY: No Modifications □ Modifications applied until:
Complete rest: □ Modified schedule: __________________ hours/day __________________ days/week
No Driving □ No Working Near Machinery □ No Working at Heights □
Standing (maximum): ___ 0 hrs ___ 0-2 hrs ___ 2-4 hrs ___ 4-6 hrs ___ 6-8 hrs
Sitting (maximum): ___ 0 hrs ___ 0-2 hrs ___ 2-4 hrs ___ 4-6 hrs ___ 6-8 hrs
Walking (maximum): ___ 0 hrs ___ 0-2 hrs ___ 2-4 hrs ___ 4-6 hrs ___ 6-8 hrs
Comments: __________________________

Lifting: (Weight & Range)

Lifting Frequency (reps/minutes): ___ 0 ___ 1/5 min ___ 1-4/5 min ___ 5/5 min ___ other

Not at all Occasional (1-33%) Frequent (34-66%) Continuous (67-100%)

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<tr>
<th>Lifting</th>
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<th>FEE</th>
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<tbody>
<tr>
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</tbody>
</table>

Twisting Trunk

Bending at Waist

Push/Pull

Squatting

Climbing

Grasp (R / L)

Grip (R / L)

Reach Out (R / L)

Overhead (R / L)

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<tr>
<th></th>
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</table>

Figure 4. (Continued)
tive fields of study. For each session, participants received sections of a reference workbook that contained readings and the appropriate cases for discussion and study. Among the tools used to implement the curriculum were slide projections during lecture presentations, videos on such issues as the Americans with Disabilities Act, and scripted sessions on audiotape to assist with role identification within the worker’s compensation system. Problem-based case studies were employed to provide instruction and determine competence in various procedures, such as injection techniques, use of TENS, and therapeutic ultrasound. An interactive video presentation served as the format for the ergonomics presentation.

Group discussions were organized routinely for problem-solving sessions during studies of terminology, legal and regulatory issues, and epidemiology and biostatistics. Worksite assessment, as noted earlier, consisted of visiting a local industry where ergonomic applications at workstations had been studied. A journal club was used to support the curriculum, with emphasis placed on population-based studies that one would encounter in the OEM literature.

Practice-based, case-oriented instruction was phased into the family medicine residents’ continuity clinic for half-day-long periods three to four times per week, under the tutelage of family medicine preceptors experienced in OEM. An elective OEM rotation provided an additional opportunity for self-directed learning and included supplemental readings selected from the American College of Occupational and Environmental Medicine Practice Guidelines. One of the requirements of this rotation was that participants become familiar with local employee assistance programs, which provide confidential counseling for workers affected by behavioral and stress-related issues. Study of this area was supplemented by videotapes available from the National Alcohol and Drug Abuse Clearinghouse. Because of a fortuitous scheduling opportunity, this 1-month elective rotation included attendance at the Mid-Year Educational Conference of the American Osteopathic College of Occupational and Environmental Medicine, which was held in Kansas City in April 1999. During this conference, the resident who selected the optional rotation participated in Part I of the college’s three-part basic course of instruction that leads to a certificate of additional qualification in occupational medicine. During this elective month, the participating resident also received the benefit of a focused clinical experience with OEM patients through preferential scheduling and one day of instruction in back school in the Department of Physical Therapy.

Results
Numerous evaluations were conducted both of the learners and the program. Residents evaluated the lecture presentations using a Likert scale that assessed lecture content, organization, materials, usefulness, and level of interest in the topic. Open-ended questions allowed the residents to elaborate on these issues. This form of evaluation revealed a number of interesting and important findings. Residents responded positively to the use of small group learning techniques, and they generally preferred procedural training with direct clinical applications to didactic sessions about the nonclinical issues. Eighty-five percent of the respondents indicated that the learners either agreed or strongly agreed that the presentations were valuable.

Learner formative evaluations were based on attainment of performance benchmarks in the procedures and case studies, as set by the preceptors. Also, minutes were taken by the journal club moderator to document satisfactory assessment of literature by the residents. The journal club endeavor and the case study activities also provided evidence of attainment of the cognitive and the psychomotor skills initially outlined in the learner goals. Performance skills in procedures were acquired easily, and the use of these skills to treat patients under preceptor supervision was both useful and effective. Patient satisfaction surveys were distributed either by mailing or by distributing them directly to patients (N = 50). Only one survey contained equivocal negative comments about the experience, whereas many others indicated that the patients would recommend the care they received to others.

Learner summative evaluations included a chart review of 50 patients’ records for OEM cases seen by the residents from January 1999 through March 1999. The residents were able to consistently provide the required elements of information in a standardized manner. Four preceptors interviewed in a semistructural format felt comfortable with the level of OEM expertise displayed by the residents in case management. Table 2 displays the results of the final self-assessment for the four residents who completed the program. This self-assessment used essentially the same Likert rating scale as in the needs assessment. The median for familiarity with nonclinical subjects increased from 2.94 in the needs assessment to 3.83 in the final self-assessment, while familiarity with the clinical subjects increased from 3.13 to 4.11. Interest in using OEM skills was emphasized in the final self-assessment rather than interest in further OEM education and training, which was emphasized in the earlier needs assessment. For the nonclinical subjects, the median for interest in use was 3.39—nearly identical to the 3.40 in the needs assessment. However, the median for the clinical subjects increased substantially, from 3.53 to 4.28. While the number of subjects in the final self-assessment is too few to offer statistical significance, the assessment does support the clinical significance established by other methods of evaluation.

Program formative evaluations consisted of satisfaction surveys that were mailed to community occupational health managers (N = 8). Of five respondents, all indicated that they had received exceptionally effective communication, case management, and service. The medical director of Carson City Hospital and the office manager at the Greenville clinic were interviewed in a semistructured format numerous times during the implementation phase of the curriculum, which began in August 1998, and also during the practice-based clinic instruction, which
began in January 1999. In each interview, their responses demonstrated overall approval with the progress and performance of the residents.

The program summative assessment consisted of interviews with occupational health managers (N = 8) in a structured format. These interviews reaffirmed the findings of the formative survey conducted with the health managers regarding the performance of the residents.

**Comments**

The development and implementation of this OEM curriculum was conducted as a project in faculty development during a 1-year clinical educator fellowship. This fellowship was sponsored by the Division of Family and Community Medicine in the Statewide Campus System of the Consortium of Osteopathic Graduate Medical Education and Training. Mentoring was provided by a member of the Department of Preventive Medicine of the Michigan State University College of Osteopathic Medicine. The mentoring experience provided considerable opportunities for refining curriculum development and implementation. It also served as an opportunity to explore innovative methods of performing community surveys, conducting evaluations, and organizing presentations.

The feedback from residents regarding small group learning activities suggests that more of this style of learning experience would enhance the curriculum, especially for the less-popular nonclinical topic areas. This is consistent with adult learning principles, which are emphasized in the faculty development fellowships through the Statewide Campus System.

We advise those considering similar projects to incorporate OEM into a family medicine curriculum to coordinate their activities as early as possible with the office manager. This should help avert the numerous pitfalls inherent in performing chart reviews, which can be a deceptively complex task. In addition, it might be wise to network with others who share similar interests through professional organizations or colleges, such as the American Osteopathic College of Occupational and Preventive Medicine. This would likely prevent “reinventing the wheel,” because many useful strategies may already be available from such organizations.

---

**Table 2**

**Final Self-Assessment (N = 4)**

<table>
<thead>
<tr>
<th></th>
<th>Familiarity with nonclinical topic areas</th>
<th>Familiarity with clinical topic areas</th>
<th>Interest in utilizing nonclinical topic areas in practice</th>
<th>Interest in utilizing clinical topic areas in practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>N = residents</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Median</td>
<td>3.83</td>
<td>4.11</td>
<td>3.39</td>
<td>4.28</td>
</tr>
</tbody>
</table>
The evaluations helped to document the important issues of patient satisfaction, acceptance by the occupational healthcare community, and acceptance of the people supervising the program. Based on responses to these evaluations, it seems logical that this program of OEM instruction and practice within the resident continuity clinic would be permanently implemented with little alteration in content. Slight modifications in the teaching strategies, as previously described, would be feasible.

The curriculum in occupational and environmental medicine for family medicine residents at Carson City Hospital includes both a didactic portion, which is longitudinal, and a practice-based phase of instruction. Implementation of this program occurred over 1 year. It is shown to be educationally sound, cost-effective, and independent of external funding, and it was favorably evaluated by patients as well as corporate clients. It is strongly encouraged that this program be adapted to other settings.

Acknowledgment
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References


15. Recommended Core Educational Guidelines for Family Practice Residents, AAFP Reprint No. 226, October 1990.


