

# The Importance of Graduate Medical Education for Permanente Physicians, Kaiser Permanente, and American Medicine

By Scott Rasgon, MD, Senior Editor

## Introduction

In this tribute, the voices of Kaiser Permanente (KP) Graduate Medical Education (GME) leaders highlight the rich history of resident education in KP, its importance to Permanente physicians and the organization, and its current and future impact on American medicine. Managed care organizations have often been criticized for not participating in GME—financially and with scholars.<sup>1</sup> Most of these organizations are not vertically integrated medical care systems like KP, and their competitive bargaining with hospitals has had an unfortunate negative effect on GME. However, KP has a six-decade experience of independent residency training programs. In an interview, Benjamin Chu, MD, KP Southern California Regional President, shares a comparative view of American medicine and KP on the basis of his years of work with GME at New York University School of Medicine; program leaders Bruce Blumberg, MD, and Marc Klau, MD, review GME in Northern and Southern California, respectively; program

leaders Thomas Tom, MD, and Peter Chee, MD, outline the UCLA-KP connection; Jimmy Hara, MD, with Sandra May Gonzales, PhD, delineates the required competencies for residents; and, with Walter Coppenrath, MD, describes a Community Service Program. Twenty-year perspectives are shared by two physicians who were residents in the KP system: one, Barry Rasgon, MD, who trained at the Oakland Medical Center and stayed on to become the Director of Research at the Oakland Medical Center Head and Neck Residents Training Program; and another, Richard Schwartz, MD, who left the KP system to become the Medical Director of the North Shore Medical Group and Associate Professor of Clinical Medicine at Stony Brook University Hospital, where he has also served as Chief of General Medicine. Albert Palitz, MD, reminisces about the teachers who helped him to find the direction of his life. Finally, Barry Rasgon, MD, and Janell Rasgon, RT, share a story of a third world residency experience in Guatemala.

## An Interview with Benjamin Chu, MD From an External Perspective: A New President's View of Kaiser Permanente Graduate Medical Education

Prior to joining Kaiser Permanente (KP) Southern California (KPSC) two years ago, Dr Chu was Associate Dean for Clinical Affairs at the New York University (NYU) School of Medicine and NYU Medical Center where he developed a Graduate Medical Education (GME) consortium among affiliate hospitals—Bellevue, New York Veterans Affairs Medical Center, Lenox Hill, Gouverneur, and NYU Downtown. He then became Senior Associate Dean at Columbia University College of Physicians and Surgeons for the Harlem Hospital Affiliation, and also served as a 12-year member of the

New York State Council for GME.

*What were your principle contributions to GME?*

In New York until recently, “residents” who lived in the hospital would work as many as 100 hours of the 168 hours in a week. Some would work every other night; some every third night. In the early 1980s, I thought residents were required to work too many hours, without enough time for their personal lives, for rest, or for medical education. When I joined the Bell Commission of the New York State Department of Health, I supported a strong focus on resident hours and supervision. Our

recommendations—considered bold and controversial in 1986—were to limit residents’ hospital schedules to 80 hours a week with adequate time for rest between assignments, and to mandate proper attending supervision. It wasn’t until 1989 that New York State adopted and implemented those rules; other states followed voluntarily, but the Accreditation Council for Graduate Medical Education (ACGME) did not officially adopt the 80-hour rules until 2001. It is hard to believe that controversy continued until then. I am proud of those recommendations.



Benjamin Chu, MD

**I am a strong proponent of residents spending more clinical time in outpatient settings. And that's what KP offers physician residents ...**

*What is your opinion of the direction of GME?*

I am disappointed with the lack of balance between primary care and specialty training. Specialty training is definitely needed because American medicine is still 70% specialty oriented; however, I hope we can shore up primary care training in the near future. Furthermore, I am a strong proponent of residents spending more clinical time in outpatient settings. And that's what KP offers physician residents, because both settings are integral to our system. This is our greatest value to GME.

*Now that you have been with KPSC for two years, what differences have you observed or experienced?*

In Southern California we have the "Permanente Online Interactive Network Tool" (POINT)—a Web-enabled and data-driven suite of products that support organizational goals and objectives. This allows residents to understand the larger context of their patient panels. This continuity of patient care involves a longer-term commitment to keep people healthy, different from many resident specialists who only treat people for an episode of care.

Another major difference at KPSC is the financing for GME. In California, there is no real financial incentive for the program. In New York, a huge proportion of the hospitals' revenue base is tied to GME—the more residents you have, the more add-ons to your Diagnostic-Related Group. In KP we subsidize our GME costs through our Community Benefit Program. Resident education is a commitment to education and physician development, and not an economically driven mission.

*Can you explain how KP's database capabilities enhance GME?*

KPSC has a clinical database on 3.2 million members—no other health care provider has data for that

many people. A typical American physician, in an average year, might have 2000 people under his or her care. They recommend a course of therapy and, if they are committed to continuity, might follow-up on patients for a week or two. However, only seeing someone three or four times a year, physicians don't usually know how many of those patients have had mammograms, Pap smears, or colonoscopies. You can't consider patients' long-term health without tracking their primary preventive services, along with management of their chronic diseases. With our systems, we not only provide primary and preventive services, we also have the ability to track our patients. Having access to such a large population database is an important tool in determining the ultimate benefit of an intervention.

If, for example, a resident were to practice in a modular outpatient setting with 15,000 patients and seven to ten physicians, the resident can accurately see how many diabetics there are, how many have had HbA<sub>1c</sub> measurements, how well their diabetes and blood pressure is controlled. From that database, because our technology integrates database information and a team redirects system resources, residents learn new approaches to achieving better health outcomes for our patients. KP can offer a wonderful setting to learn, shape, and practice evidence-based, outcome-oriented 21st-century medical practice.

*How specifically does KP's technology system advance the practice of evidence-based medicine for residents?*

The KP system, called HealthConnect, not only gives residents a broad perspective, they can be more analytic about delivering the highest level of health to a certain population. Without this advanced-technology

tool, the American GME curriculum is highly dependent on which patients come in for medical care, who is hospitalized, and what the attendings know. In each case they must determine the evidence and recommendations, and neither resident nor attending has time to search the world literature for each patient. Having KP HealthConnect readily accessible, residents have a powerful tool—with much of the evidence embedded in the system, coupled with decision support and Web-based search tools. KP experts take clinical evidence, roll it into standardized protocols, and constantly update the system with the latest knowledge. Conducting population-based research improves clinical practice. A good example of this was the KP experience with VIOXX (Merck and Co, Whitehouse Station, New Jersey). Because we tracked patients, we observed a higher rate of cardiovascular events in patients on VIOXX, which led to important findings that helped recall this drug. These electronic tools allow inpatient-based residents to easily track their patients' clinical course after discharge, exchange information with other physicians and specialists, and maintain contact with patients.

*How does research fit into GME training?*

By tracking millions of people over time, it is possible for physicians to observe the differential effects of their interventions, for example, ethnic variations in response to therapies, or differences related to gender. Much of the early heart disease research was conducted on men. Physicians and investigators did not fully understand the natural course of the disease in women, how women presented with the illness, and their responses to therapies. With our population databases, answers to these questions can be obtained through carefully designed

research studies. Residents should be actively engaged in population-based health-services research to best improve their clinical practice.

*Would you like to say something in conclusion?*

KP should become more involved in GME. Training residents in our standards for medical practice, we can play a major role in transforming health care in America. As important, bringing young doctors with energy and openness to new ideas into our system for their GME forces KP to remain at the cutting edge of health care delivery. There are wonderful benefits all around. ❖

### Six ACGME Competencies

The six ACGME competencies are:

1. *Patient care* that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health

2. *Medical knowledge* about established and evolving biomedical, clinical, and cognate (eg, epidemiologic and social-behavioral) sciences and the application of this knowledge to patient care

3. *Interpersonal communication skills* that result in effective information exchange and that team with patients, their families, and other health professionals

4. *Professionalism*, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population

5. *Practice-based learning and improvement* that involves investigation and evaluation of patient care and appraisal; assimilation of scientific evidence; and improvements in patient care

6. *Systems-based practice*, as manifested by actions that demonstrate awareness of and responsiveness to the larger context and system of health care and the ability to effectively call upon system resources to provide care that is of optimal value.

## The Programs

### Required Residency Competencies

By Jimmy H Hara, MD, FAAFP; Sandra May Gonzales, PhD

*Why is GME at KP important to American medicine and resident training?*

ACGME requires all residents in all programs nationwide to demonstrate six competencies upon completion of training (see Sidebar: Six ACGME Competencies). All of the KP residency programs are accredited by the ACGME.

KP residents have a unique opportunity to learn these competencies in a vertically integrated health care system, in particular because of five major KP capabilities, several elucidated by Dr Chu:

- The Member Appraisal of Physician/Provider Service (MAPPS)
- Population care management (PCM) and chronic disease management (CDM) programs, tracking systems, and data
- The Kaiser Immunization Tracking System (KITS)
- HealthConnect—electronic health and medical record
- Permanente Online Interactive Network Tool
- Regional Clinical Guidelines

Most programs across the nation have difficulty providing and measuring one particular competency—“Practice-based learning and improvement”—which is achievable in KP through: PCM, CDM and KITS. In addition, evidence of improvement in MAPPS satisfies “Interpersonal communication skills” and “Professionalism,” and also qualifies as evidence of “Practice-based learning and improvement.” The competency of “Systems-based practice” is satisfied through the informatics and population tracking systems available through the PCM, CDM, MAPPS, and HealthConnect and POINT.

This is a great contribution we can offer American medicine.

### Two California Programs

GME leaders and program directors, Bruce Blumberg, MD, Northern California and Marc Klau, MD, Southern California, review the Northern and Southern California GME programs describing their history, current state, community outreach, impact on American medicine—specifically in California—and future directions.

### The Permanente Medical Group in Northern California

By Bruce Blumberg, MD

Sidney Garfield, MD, the founding physician of the Permanente Medical Groups, made this statement in 1952: “... a medical plan worthy of perpetuation, in addition to being economically sound, must provide teaching and training to stimulate high quality of care and research to contribute to medicine of the future.”<sup>2</sup>

Always the visionary, he may have had a more practical motive in his stated support for GME programs. In an era when the relentless attacks of organized medicine hampered The Permanente Medical Group (TPMG) in recruiting and retaining physicians, the KP residency programs served as a lifeline of much-needed staff physicians.

As our reputation flourished and recruitment successes blossomed, graduates of KP residencies have made an important contribution to our staff ranks. The grounding of trainees in the fundamentals of Permanente Medicine virtually ensures a cultural fit, and those who graduate to a Permanente staff position usually spend their entire careers in our program.

Our GME mission—articulated in the Northern California KP policy and procedure manual—is: “Kaiser Permanente, a leader in the delivery of quality medical care, has been committed to GME for over 55 years. Our goal is to provide organized educational programs in a

**... resident training  
... a community  
benefit that gives  
back to local  
communities  
through care to the  
underserved ...**

scholarly and supportive, integrated, managed-care environment, facilitating the ethical, professional and personal development of the resident, while ensuring safe and appropriate care for patients.”<sup>3</sup> Two milestones of success occurred in 2006—the Oakland Medical Center’s internal medicine residency celebrated its 60th anniversary and the San Francisco Medical Center’s internal medicine program marked its 50th anniversary. Two additional landmarks occurred in Spring

2007—the Oakland obstetrics/gynecology (Ob/Gyn) and pediatric residencies respectively reached 60 and 50 years old.

Northern California funds 200 residency positions per year. Another 150 positions are funded in affiliated programs, primarily at academic partner institutions: Stanford University, University of California (UC), San Francisco, and UC Davis. These rotating positions ensure that 800 to 1000 physician trainees spend time in a Northern California KP facility in any given year. The sponsored programs include internal medicine and Ob/Gyn at Oakland, San Francisco and Santa Clara facilities; pediatric, and head and neck surgery, at Oakland; and two consortium programs—emergency medicine (EM) (cosponsored with Stanford University) at Santa Clara, and podiatry at Santa Clara, Hayward/Fremont, Oakland/San Francisco/Walnut Creek, and Vallejo/Santa Rosa/San Rafael.

KP Northern California physician trainees account for 5% of all resident physicians in the state, with the most prominent impact in EM and Ob/Gyn, 10% and 13.5% respectively.

Thirty percent of KP residents make a career in TPMG after graduation and 15% of TPMG staff physicians received some part of their residency training in a KP-sponsored residency. An even larger group of TPMG

physicians rotated through a KP facility as a resident, in an affiliated program. Of all TPMG physicians practicing in the Sacramento Valley, 30 to 50% rotated through a KP facility during residency at UC Davis. Familiarity with residents allows the medical group to identify and select the best-performing graduates, who in turn have become 250 of the current TPMG physician leaders—25 occupy senior leadership positions, including directors of the TPMG Board, and Associate Executive Directors.

Beyond contributions to the medical workforce, residency programs provide other major benefits to KP: the opportunity to teach is a source of great professional satisfaction for faculty—600 TPMG physicians hold faculty appointments at one of the three Northern California medical schools. To the extent that “the best way to learn is to teach,” faculty assert that teaching responsibilities keep them at the cutting edge of their specialty practice. A significant number of staff physicians at our major teaching hospitals were attracted to TPMG careers by the opportunity to teach in a setting that did not require a “publish or perish” mentality. Increasingly, residency programs have incorporated opportunities for student research. Residents have presented their work at regional and national professional meetings, and in peer-reviewed publications, bringing recognition and credit to KP GME programs and the organization.

With residency programs an important element of Community Benefit activities, KP improves the community’s health. Specifically, our residencies have fostered long-term professional relationships with safety-net providers, including school health clinics, women’s health clinics, and providers of care to minorities and other underserved populations.

An educational setting within a superb, health care delivery system is one distinct advantage of the KP GME programs, and, along with the availability of a large population of patients followed longitudinally through all aspects of the continuum of care, distinguishes KP from virtually all academic settings. This exposure to population management, evidence-based care, and team-based chronic care constitutes the cornerstones of Permanente Medicine, preparing leaders of 21st-century medicine.

KP’s depth of physician leadership and influence in public health policy ensure that KP will continue to play an important role in directing American medicine’s GME.

## Southern California Permanente Medical Group

By Marc Klau, MD

Why does GME still matter? A surgeon walks into the operating room and learns a resident will operate with him/her today and knows that the difficult case will take one or two hours longer, and there will be 50% more “heartburn” because of the complexity of the case. Over in family medicine, the attending for the day supervises four residents, plus add-on patients, and the time for a breather at lunch disappears. So, why do we want to, or need to, train residents—the doctors of tomorrow? Why not let the university take responsibility? In challenging financial times, do our resources meet our core needs, with extra for residents?

More than 50 years after revolutionary physicians founded Southern California Permanente Medical Group (SCPMG), physicians still practice their founders’ way of providing better quality medical care. Recent graduates of residencies, the founders recruited other young, visionary physicians. Once KP established a strong foundation, it was natural to develop residency and fellowship programs—the first at Los Angeles Medical Center (LAMC) in internal medicine, family medicine, pediatrics, general surgery, Ob/Gyn and urology.

Since then additional surgical and medical residencies and fellowships were added, including residencies in family medicine at Fontana, Woodland Hills, Orange County and Riverside. Currently, 264 residents participate in our independent programs, and 60 residents from affiliated programs. With the support of KP’s Community Service Program, and federal reimbursement for the cost of providing residencies and fellowships, the residency program makes financial sense.

To ultimately address the question of relevance, we have enlarged and refocused our prioritized purpose for resident training: 1) a community benefit that trains the doctors of tomorrow; 2) a community benefit that gives back to local communities through care to the underserved; 3) a source of physicians for SCPMG, especially in difficult to recruit specialties; and 4) an enhancement of the KP image as a teaching center. To serve this fourfold purpose, we recruit the best medical students by offering competitive salaries, improve work-life in the context of an 80-hour work week, improve training for personal development, and renew a focus on caring for the underserved. And, we offer the best of Permanente Medicine—evidence-based medicine with integration of services across the continuum in a caring environment. By clarifying our purpose and improving

the overall experience for residents and attendings, we remain true to the vision of our founders, so that all attendings know that by working a little harder they are developing the next generation of physicians.

“In the end, it’s not the years in your life that count. It’s the life in your years.” (Abraham Lincoln.)

## Program Affiliation

In December 1990, the Department of Internal Medicine at KP Los Angeles (KPLA) signed an affiliation agreement with the UC Los Angeles (UCLA) School of Medicine.

## UCLA—KP Connection

By Thomas Tom, MD; Peter Chee, MD

Why would UCLA affiliate with KP? According to Jan Tillisch, MD, UCLA’s Education Vice Chair of Medicine, KP’s strength is in primary care medicine. This affiliation enables 72 third-year UCLA medical students (half of the third-year class) to rotate within the Internal Medicine Department at KPLA. UCLA medical students, mentored by enthusiastic role models, have exceptional learning opportunities from a large and diverse population of patients and experience KP’s comprehensive care delivered within well-functioning medical practices.

The success of this affiliation can be measured by various academic standards. KP offers fellowships in cardiology, gastroenterology, nephrology, interventional cardiology, and electrophysiology. Currently, there are 39 internal medicine house officers and 24 fellows. Since 2001, 100% of KP graduates have passed their board examinations, which places the internal medicine training program among the elite in the nation. These outstanding internal medicine residents and subspecialty fellows actively teach UCLA medical students. The ACGME has awarded KP fellowships and general internal medicine training programs a five-year accreditation, bestowed on only the best. One hundred and five internal medicine faculty members hold UCLA academic appointments, a hallmark of teaching and clinical excellence. KP attendings participate in UCLA’s faculty development programs on quality, the patient care experience, and the latest advances in internal medicine.

According to Dr Tillisch, “For 16 years, UCLA students have favorably viewed your medicine clerkship rotations, which is more patient-centered and pragmatic care.” The UCLA affiliation is a distinguished milestone for KP physicians teaching the next generation of doctors.

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## Community Benefit

In recognition of decades of community service provided by the KPLA family medicine residency program under his direction, Jimmy Hara, MD, Residency Program Director, was awarded the National KP David M Lawrence, MD, Community Service Award.<sup>4</sup> As a result of this award, Dr Hara expanded the residency community service experience from the Los Angeles Free Clinic and Venice Family Clinic, to additional venues of the UCLA Salvation Army Homeless Shelters, the Asian Pacific Health Care Venture, and the UCLA Mobile Clinic.

## GME Programs and Community Service

By Jimmy H Hara, MD, FFAFP; Walter G Coppenrath, MD

The UCLA Mobile Clinic provides medical services to the homeless in West Hollywood. This volunteer service was begun by two UCLA medical students in 2000, Patricia Koh, MD, and Walter Coppenrath, MD, who matched into the KPLA Family Medicine Residency Program.

Under the direction of Raymond Baxter, PhD, Vice President for Community Benefit, and Winston F Wong, MD, Medical Director of Community Benefit, the KP National Program Office has a legacy of commitment to community service. The Community Benefit budget contributes funds to GME in support of four major focus areas: professional education (GME), vulnerable populations (Medi-Cal, community clinics and public hospitals), evidence-based medicine and research, and public advocacy.<sup>5</sup> The Southern California KP GME programs qualify for funding in the professional education and service to vulnerable populations areas because of services provided at the Hollywood Sunset Free Clinic, the Asian Pacific Health Care Venture, the Los Angeles Free Clinic, and the Skid Row Collaborative Clinics.

## Twenty-Year Perspectives

An important aspect of GME is the impact the training program has on the resident's decision about where to continue the practice of medicine. Here are two views: a resident that stayed in the system in which he trained and a resident who left and integrated his learnings into another system.

## Train and Stay

By Barry Rasgon, MD

In my last year of medical school at the University of Southern California (USC) in 1985, I strolled down a beautiful white sandy beach in Malibu, contemplating one of the biggest decisions of my life: where to do my

Otolaryngology-Head and Neck Surgery (OHNS) residency training? Preparing to interview at six programs, mentally sorting the pros and cons, I pondered which one would best shape my clinical and surgical skills.

On the interview trail, many residents were content, though many were unhappy. I had heard about the OHNS program at KP Oakland Medical Center from two USC students—accepted there for the following year—who suggested I do a one-month externship, during which I was offered a position that I gratefully accepted.

The big question asked by many—why would I want to attend a program that is not university-based?—was answered by several revealing facts: the residents there were the happiest I had met anywhere; staff interaction was amicable; and the staff's office doors were always open for residents with questions, or problems, or for a chat. Elsewhere, hierarchy was a barrier. Most important, during the first two years residents in the clinic and operating room at KP were exposed to all the complex and interesting surgical cases one would see at the university.

Training at KP Oakland was unique: the first two years were like an apprenticeship—residents were assigned to a different staff surgeon each month. When the staff surgeon was in clinic, the resident was in clinic; when the staff surgeon was in the operating room (OR), the resident was in the OR. This essentially set up a one-on-one learning situation engendering a strong foundation for both clinical and surgical skills. As residents developed, they were given more autonomy and responsibility, running their own clinics as Senior and Chief Residents, with more freedom in the OR. Staff surgeons were always available for questions or help.

Exposure, through rotations, to the diverse faculty at five different KP medical centers was, and remains today, a valuable feature of training at KP. Residents work one-on-one with 20 head-and-neck surgeons, trained at many university training programs across the country. The residents experience surgical techniques and "pearls" that faculty members have acquired. There are many ways to skin a cat, as you've heard, some ways better than others.

Clinical research, another strength of KP Oakland training, was integrated into the residency program by a required four-month period of protected research time, with the expectation to complete a research project every year during training, and to present at the Bay Area Residence Research Symposium—a competition between UC San Francisco, UC Davis, KP Oakland Medical Center, Stanford, and other West Coast Head and Neck Surgery Training Programs. Each

... the expectation to complete a research project every year during training ...

resident is assigned a staff supervisor to guide his/her research. Additional support through the Departments of Research, Medical Editing, and Audio Visual is also available—all located in Oakland. Since 1993, residents and staff of the OHNS program have given 128 presentations at regional, national, and international meetings—an average of 9 presentations per year—and published 66 articles in peer-review journals, and 10 book chapters—an average of 5 publications per year. Since 1999, residents have won 34 research awards at regional and national meetings.

When I graduated from residency at KP Oakland Medical Center, I was asked to continue as Director of Research for the Training Program where I continue as I write this tribute 21 years later.

### Train and Leave

By Richard Schwarz, MD

I came to KP in the summer of 1981, to complete my final year of residency in internal medicine. The first two years had been spent at a university medical center, where the experience had been intense but the hands-on teaching sparse. On my first day at KP I made rounds, one-on-one, with an attending physician, a “real doctor” who actually practiced while—and what—he preached. That experience was repeated many times during the year, and I wound up staying two more years in KP’s nephrology fellowship program, during which I was schooled in an admirable approach to patient care.

I had wished to be taught by experienced, dedicated clinicians, professionals doing that which I planned to do with my life, rather than by professors for whom practice was a part-time sideline. At KP I found what had been lacking during medical school and during my first two years of residency, both of which took place at respected major medical centers. In my mentors at KP I encountered not only knowledgeable men and women, but true role models after whom I could fashion my own professional approach. These were physicians who made indelible marks on my development as a physician and as a person, for which I feel continued gratitude, especially Hock Yeoh, MD, who was and continues to be an advisor and guiding light for me. The qualities of the nursing and ancillary staffs remain unsurpassed in my experience.

It has been over 20 years since I left KP to return to the east as a busy internist and nephrologist, but the lessons I learned there have stood the test of time.

Many of the clinical and teaching skills that I have relied upon, and that have served me well in my career,

were learned at KP; many of the principles currently sweeping the country, related to preventive medicine as well as early disease detection and management, have been tenets of Permanente Medicine for decades, and I have made them central to my practice too.

It gives me great pleasure to offer this heartfelt testimonial: the philosophy of the KP Health System, as well as the care and education available there, are models that the rest of the country would do well to emulate.

### Influencing the Future

Most physicians in training find experienced physicians whom they admire, choose to emulate, and in particular who have a career-long guiding influence, often unknown to the mentor—like a teacher who is visited by a student 20 or 30 years later to learn that they have been the singular reason for the student’s life’s work!

### Remembering Mentors

By Albert M Palitz, MD

On July 1, 1981, as a first-year medicine resident, I transferred from the Los Angeles County-USC Medical Center to KP’s LAMC, beginning a 25-year career practicing Permanente Medicine. At LAMC I observed a culture of collegiality, collaboration, and intellectual honesty that benefited patients, physicians, staff and the organization.

From my earliest days, I learned an important lesson: health care is a human relations business, and people are our most important resource. I first rotated on the Infectious Disease Service with Joel Ruskin, MD, and Sam Wilson, MD. They brought academic rigor and discipline to their consultations, setting a high standard for trainees and colleagues. I next rotated to the intensive care unit. I recall Tony Oppenheimer, MD, a pulmonologist/intensivist, sitting at the bedside, holding the hand of a dying patient, explaining to the family with extraordinary calm and sensitivity that death, though unavoidable, could come with comfort and dignity. On a later rotation, at the end of a long day, I recall discussing a pulmonary case with his colleague, Jim White, MD, whose waiting room was always filled with add-on patients. Jim was committed to seeing every patient who wanted to see him, no matter how many or how late.

Ed Butts, MD, surveyed dialysis units across the country for the National Institutes of Health, before joining SCPMG. He then built the best dialysis unit in the country at LAMC. His colleague, Hoch Yeoh, MD, taught us to consume the medical literature “like

... many of the principles currently sweeping the country, related to preventive medicine ... have been tenets of Permanente Medicine for decades ...

a whale, which must take in thousands of gallons of seawater, to find a little algae." We nicknamed him "Yoda" after the *Star Wars*' Jedi master. I recall presenting a puzzling case of abdominal pain to Henry Carleton, MD, a nephrologist, who stopped me during my presentation and said, "Let's go see that patient." With his gentle guidance I diagnosed my first case of abdominal epilepsy.

To see endocrine consultations with Walter Lusk, MD, was to return to the days of William Osler, MD. Walter called his own patients from the waiting room. Before they entered the exam room, he was assessing their physical dimensions, attitude, energy, gait, and tone of voice, and checking their skin texture and grip strength

with a handshake. With a few open-ended questions, and others of great specificity, and a focused physical exam, he arrived with uncanny accuracy, at a working diagnosis usually confirmed with a few lab tests or a scan. His colleague, Irv Ackerman, MD, the Chief of Medicine, left an academic career in Boston to join SCPMG, and the Housestaff revered him, as much for his warmth and good humor as his remarkable intellect.

There were internists—Herb Sklar, MD, Al Luck, MD, Mario Milch, MD, Ellen Masse, MD—who cared for enormous panels of devoted patients over long careers. They taught me that there are no substitutes for commitment, compassion, availability, consistency and dogged advocacy for your patients. I recall reviewing hematology

### Third World Residency Experience

For an attending physician to bring a resident-in-training to another country of the world is the epitome of leaving the familiar for a learning adventure in the unfamiliar—together the physicians have a profound experience.

#### Resident Service in Guatemala

By Barry Rasgon, MD; Janell Rasgon, RT

Excitement stirs the air—today we embark on a memorable journey. Not a luxury vacation to the Bahamas or Hawaii, the group is taking the red eye to Guatemala. Several days before, many Guatemalans began a parallel journey on foot, often without shoes, and with children in hand to the same destination—Nuevo Progreso in the city of San Marcos. The US group consists of surgeons, anesthesiologists, nurses, surgical technologists, many from KP, volunteering time at Hospital de la Familia to provide medical care and surgery for the indigenous people.

On arrival, 50 boxes of donated medical supplies must be unloaded and checked in. Many medical team families also donated small stuffed animals to brighten the children's postoperative course. After settling into our rooms, we head to the hospital to unpack boxes, check the inventory, and prepare for next day's surgeries. Hospital de la Familia includes three buildings: the first houses all the clinics on the bottom floor—the Eye, Surgery, Plastic Surgery, Ear, Nose, and Throat, and Ob/Gyn; the second and third floors are the living quarters for the visiting medical team (second floor) and the nuns (third floor). This area resembles a small inn. In the second building are the living quarters—kitchen, dining, and laundry—of the Guatemalan doctors and dentists. The third building consists of the OR—all three operating tables in same room—a small three-bed recovery room and a small inpatient area divided into three rooms—one each for children, men, and women. All inpatient beds are lined up along the walls to maximize space to house as many patients as possible.

Staff surgeons and residents rotate between the medical clinics—where they see 40 patients a day per service—and the OR—where they operate on six to ten patients per day per service. The exception was the ophthalmology team who saw 75 patients a day and operated on 25, performing 250 surgeries in a 10-day period. Twenty-five patients wearing sunglasses lined up outside after cataract surgery is a sight to behold. In the hospital pediatric ward parents sit and sleep on the floor, night after night, caring for their children. Some parents have little money and depend on the hospital for food. All survive on little or no sleep, in heat and humidity, without a change of clothes, making no complaints, only thankfulness. Each patient, even the children, enters the OR with a smile. I didn't realize how brave, cooperative, and trusting a child could be when facing unfamiliar people.

KP's Head and Neck surgical residents routinely journey to Guatemala each year with one staff surgeon, providing an excellent opportunity to experience third world medicine, and to treat patients, often with advanced disease. The residents speak about it as an invaluable experience, and often participate again in the future. Several general surgery and Ob/Gyn residents from KP have made the trip as well.

The reward for this hard work was not monetary, but friendships, teamwork, and knowing you may have changed an unfortunate someone's life forever and feeling the heartfelt appreciation of the people of Nuevo Progreso.

slides with the brilliant Akimi Ching, MD, and thinking, "I'm not smart enough for this field." Later, my wife and I named our second child in honor of Akimi. Her colleague, Jack Braunwald, MD, the Chief of the residency program, taught us to be thorough and patient and, most importantly, always be kind to patients and one another.

Three years later, in 1984, I joined the gastroenterology fellowship. My chief and mentor, Harold Frankl, MD, among the first Board-certified gastroenterologists in the country, was highly respected throughout the nation. His fellows, whenever confronted with a difficult clinical decision, would think, "What would Harold do?" Harold's wife, Gloria Frankl, MD, a radiologist with an international reputation in mammography, taught my wife important lessons about balancing career and family. Fred Simmons, MD, made avid hepatologists out of us all.

Like trainees everywhere, I acquired knowledge, technical skill, and experience that helped me develop into a physician. But what I cherish most and remember most about my residency and fellowship at LAMC were the wonderful people—physicians and staff—and the collegial culture they created, which inspires me in my work to this day.

## Conclusion

KP has had a long and distinguished commitment to GME. The changing face of GME in America has evolved so that much of what is expected of Perman-

ente physicians is now reflected in the ACGME Core Values. KP continues to have the opportunity to make a significant positive contribution to American medicine through its GME programs because of its information technology programs, including the clinical database—a powerful tool for residents to use to view and assess the continuum of care—and HealthConnect, offering residents a broader perspective for analytic consideration; the unique opportunity to accomplish the ACGME competencies in a vertically integrated system; exposure to population care management, evidence-based care, and team-based chronic care in an integrated system; and the values of KP that are reflected in a community benefit program that offers residents the opportunity to learn as they serve their communities. ❖

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## Learning

One cannot teach a man anything.

One can only enable him to learn from within himself.

— Galileo Galilei, 1564-1642, Italian physicist, mathematician, astronomer, and philosopher