CCHS Succeeding in Training Primary Care Doctors for Rural Areas

"A lot of people don’t realize we’re one of the most productive Family Practice residency programs in the country - in the top 10% in numbers of residents we have graduated," says Russell Anderson, M.D., Associate Dean for Academic Affairs at CCHS and associate professor of Family Medicine. Very few family practice residency programs have trained 179 family doctors, he said. "There are only 35 or 40 of the 385 family practice residency programs in the U.S. that are as large as we are." CCHS has 36 slots in its residency program, which was established in 1971. Anderson, who does consulting all over the country for family practice residency programs, is especially proud of the record of CCHS in preparing family doctors who establish practices in rural areas.

During the 1970’s and 1980’s the decline of the family farm, resulting demographic shifts, and rural economic problems all contributed to the shortage of doctors choosing to practice outside of metropolitan areas. State and national leaders were deluged with complaints from citizens in rural areas who were losing their hospitals and family doctors. The demand for family doctors nationwide is now greater than we can supply," he said.

"One of the difficulties for medical education in supplying rural areas is that demand in cities has also increased dramatically. There is a groundswell of support both inside and outside the medical school community to recruit students who are more likely to return to rural areas." He says a native of a rural area who married someone from a small town is more likely to set up a rural practice - either in his or her hometown or in a similar size town.

The Tuscaloosa program has a major mission the improvement of medical care in rural and undeserved areas of Alabama. Its academic programs emphasize primary medical care and medical care delivery but provide a well-balanced clinical curriculum for all medical students enrolled. Faculty physicians, residents, and medical students care for patients at DCH Regional Medical Center, the Tuscaloosa V.A. Hospital, CCHS preceptors’ offices, and Capstone Medical Center. (See related article on the Capstone, page 2). The major purpose of the CCHS program is to educate the "undifferentiated physician," one who is competent at the basic level in all the traditional clinical disciplines and whose specialty is chosen by just 12 percent of medical students and whose proportion has been shrinking.

State Grants Help CCHS Fund Rural Rotations for Residents

Thanks to grants from the Alabama Family Practice Rural Health Board, Family Practice residents in Tuscaloosa can participate in month-long rotations with rural family physicians. The program has scheduled such rotations in previous years, but in the past, the residency program has had to absorb all the cost of the residents' educational experience.

"In the past year the Rural Health Board reimbursed family practice programs in Alabama for CCHS resident salaries away from the program. This year the Board will be helping the Tuscaloosa program create educational modules for a rural rotation in Pickens, Bibb, and Fayette counties," said Alan Maxwell, M.D., who heads the Family Medicine Department at CCHS. "We will be working with the Rural Alabama Health Alliance (RAHA), an organization comprised of physicians, hospitals, and local citizens in the three counties, to create an excellent educational experience for our second year residents," adds Dr. Maxwell.

Dr. Bill Curry of Carrollton, Chairman of RAHA, said the program is one positive step toward RAHA's goal of impacting doctors' career choices during their educational process. "This gives communities and new doctors a chance to make a positive impression on each other."

During the practice experience, the resident works side by side with a practicing family physician. This affords the resident the opportunity to become acquainted with the realistic side of a medical practice, to see patients, and to better understand the importance of involvement in the community. Maxwell stresses the importance of this experience in preparing "family doctors" for future practice. "Residents spend a great deal of time in the hospital. That is important, but they need the balance of the small town practice setting," he said. The rural practice...
Capstone Medical Center Sees Growth in Patient Care

Between 1983 and 1991, the Capstone Medical Center has seen significant growth in the amount of patient care that it delivers. Physicians on the faculty of the School of Medicine here at the College of Community Health Sciences (CCHS) practice medicine at Capstone, and resident physicians and medical students see patients at Capstone as part of their training.

In 1983, 8,586 patients made 27,321 office visits. By 1991, the number of patients increased to 12,011 accounting for 44,795 office visits; this was a 29% increase in the number of patients and a 39% increase in the number of office visits. The charts at right show the number of patients seen at the Capstone Medical Center and the number of office visits by year.

The Capstone Medical Center (CMC) offers a comprehensive array of health care services. Since the CMC is home base for the family practice residency program, nearly 60% of all patient visits are made in the Department of Family Practice. The remaining visits occur in Obstetrics and Gynecology (14%), Pediatrics (13%), Internal Medicine (8%), Psychiatry (5%), Surgery (4%), and Occupational Medicine (1%).

The Capstone serves a wide range of patients. Patient characteristics remained relatively constant over this time. On the average, women made 64% of the visits; whites made 54% compared to 37% for blacks. Thirty-two percent were less than 20 years of age, 53% were between the ages of 20 and 54 years, and 15% were over 55 years. During the 9-year period, approximately 75% of the patients had insurance coverage; 47% had private insurance, 17% had Medicaid, and 11% had Medicare. Since 1983, there has been a 10% reduction in the proportion of patients who do not have insurance. Current estimates indicate that 10% of the patients have Medicare, 27% have Medicaid, 46% have private insurance, and 17% do not have insurance coverage. More than 80% of the patients seen at the Capstone Medical Center reside in Tuscaloosa County, but records show that CMC has treated patients from every county in the state at some time.

Chris Nagy

Rural Doctors (continued from page 1)

education is oriented toward primary care and community medicine. Anderson estimates that 60% of CCHS’ 170 residency graduates are practicing in small towns or cities. He points out that almost half of the residents trained at CCHS come from other states, but many remain in Alabama.

The record for the University of Alabama School of Medicine medical students who spend their last two years of medical school in the Tuscaloosa Program (CCHS) is also impressive. 39% have entered family practice, and many are at work in Alabama counties (see map).

State Grants (continued from page 1)

experience has been an elective in the past, and will continue to be an elective, said Maxwell, but a required rural rotation is being added to the residency training program.

“Family doctors outside urban areas have fewer specialists to depend on,” says Russell Anderson, M.D., an Associate Professor Family Medicine and Associate Dean for Academic Affairs at CCHS. “They have to know more about more things. This is good experience for all our residents no matter where they go.”

In addition to being an excellent real-world exposure to family practice, this rotation will provide a number of residents the opportunity to evaluate potential future partners and their rural lifestyle. In fact, this situation occurred this year when Carrolton recruited residents who had trained in Pickens County. Two former CCHS residents, Blane Schilling, M.D., and David Tuten, M.D., are opening an obstetrical practice in Carrollton and meeting a need for care unavailable for years.

Reid Kerr, M.D., a third year resident, from Huntsville, said he found his supervised practice experience (SPE) with Dr. Larry Skelton in Moundville extremely valuable in learning the mechanics and problems of a one-man, small-town practice. Dr. Kerr plans to practice in Andalusia, and he said he learned a lot about which lab equipment he needs to buy and how staff in a small office interacts. Both office politics and equipment are different from what he found in the offices of Tuscaloosa specialists he has worked with during his training. Resident Melissa Behringer, M.D., who worked with Dr. Bill Owings in Centreville during an August, 1992 rotation, said she chose family medicine because she enjoys taking care of patients herself and working through diagnostic testing and decision-making without routinely referring her patients to specialists. She likes to care for “the whole patient,” she said, “and you get to work through diagnoses and do a lot more procedures.”

Kathleen Shine, M.D., a third year resident from Saraland near Mobile, enjoyed her rural experience in Demopolis. She first went to Demopolis as a medical student, and it helped her decide that family practice was what she wanted to do. Her decision was reinforced, and she also chose Demopolis as her future practice site when she returned to Demopolis as a resident for a supervised practice experience with Dr. Maurice J. Fitzgerald and Dr. Norbert E. Perret, Jr. “I loved it,” she said, “and I think it’s important to have the rural rotation experience during medical training.”

The rural rotation program illustrates two of the Family Practice Rural Health Board’s major missions: 1) facilitating the training of more family physicians for Alabama’s rural areas, and 2) using the training itself as a recruiting tool to sell family practice residents on a career in more provincial areas. Established by the Legislature in 1990, the Board has funded numerous innovative programs like this one. Dr. Neil Christopher of Guntersville is chairman of the Board. Eight other family physicians and two legislators serve with him.

Editor’s Note: For more information about this project or the Board’s other enterprises, contact Ellen Stone, Executive Director, Alabama Family Practice Rural Health Board, P.O. Box 1900, 19 South Jackson Street, Montgomery, Alabama 36102-1900 or call 1-800-539-0272.

Kathleen Shine, M.D., (center) a third year resident, talks to Kelly Elmora, M.D., (left) and Jeff Parker, M.D., first year residents, about the value of the rural rotation they will experience during their family practice residency at CCHS.
Philp's Workshop in Scotland Will Draw on Their PBL and OSCE Experiences

Dr. James and Elizabeth Philp, CGHS faculty members, presented a workshop at the prestigious Fifth Ottawa International Conference on Assessment of Clinical Competence, held this year at the University of Dundee, Scotland the first week of September. The conference, which is held every two years, is a premier event on evaluation of clinical competence and is attended by medical educators from all over the world.

James Philp, M.D., said he first became interested in teaching evaluation when he found that doctors were not following the guidelines that had been put in place. He said that prior to 1945, only surgeons could "cure" a patient and that when doctors began using drug treatments, more patients lived than died, doctors became overly optimistic and stopped following their guidelines.

He noted in another study he did at the University of London that what his medical students reported they would do often differed from what they actually did when observed in the clinical setting. This discovery underpinned his philosophy as a medical educator. He is committed to student-centered learning and to a problem-based learning (PBL) curriculum and says that evaluation of an educational method should match the curricular objectives.

The workshop on Assessment of Clinical Competence, he said, was an opportunity to discuss the role of psychiatry in the curriculum. He is interested in evaluation in 1964 when he began using drug treatments and more patients reported they would do often different things than they had said they would do. He said that this is a common problem in medical education.

Philp, Elizabeth, M.D. says she is a strong proponent of problem-based learning and OSCE testing in medical education. "Students become more responsible for their own learning, understand material better, and retain it longer when they're not spoon fed," she said.

She said that finding this method brings teachers and students closer together and that students learn to apply their knowledge in the context of a patient disease. It is not just intellectual, abstract learning of facts. Simulated patients cannot replace real patients in a student's medical learning experience, she said, but learning to deal with a man with impotence is an example of when a well-trained simulator might be useful since a real patient is unlikely to talk easily about his problem. Standardized patients become "real" to the student during the encounter, she says, and it gives the student experience in relating to patients. "They often become demoralized by having to present lectures during their first two years in medical school, and they really enjoy learning in new context with "patients."

The workshop in Scotland by the Philps will demonstrate how to computer-score an entire OSCE exam. Their focus is on the design and scoring of OSCE questions of a variety of types, including multiple choice questions, short essay answers, and standardized patient stations where interpersonal or clinical skills are assessed by observers.

OnRounds • 3

PBL Curriculum Focuses on Student-Based Learning

On her way to pick up a dog for therapy (honestly!), Dr. Nancy Rubin talked about her role as clinical coordinator for the Problem Based Learning (PBL) grant project at CGHS. Dr. Rubin is CGHS Associate Professor of Psychiatry, in charge of administration of the project and training for new faculty in this learning method which shifts the emphasis from the teacher-based/lecture process to one in which students identify topics, research the information they need, and collaborate to solve problems.

She is also working with other faculty to develop more OSCE (Objective Structured Clinical Examination) cases to use in student evaluation at the end of each rotation. OSCE is a performance-based examination of students which gives students immediate feedback. It tests students' ability to think critically and apply their knowledge and skills (which they have gained through both PBL and traditional learning methods).

PBL is an exciting new learning method for medical clinical education, says project director Paul Tietze, M.D., but it is time-consuming for both faculty and students. Rubin says faculty need to "share a lot about what works and what doesn't work," and students require about six weeks of indepth (4 times a week/4 hours a day) practice in PBL study to become comfortable with it. The rewards are worth it, she feels, and she said it was fortunate that the Dean and discipline chiefs of CGHS have made a commitment to PBL in the curriculum.

Rubin says the most interesting aspect of the project for her is the chance to work with other faculty since she spends most of her time at Capstone doing therapy with private patients. The dog was not getting therapy, but was part of Rubin's afternoon counseling session to help a patient overcome a dog phobia.

Parker Joins Psychiatry Faculty

Pamela E. Parker, M.D., has been appointed assistant professor in the Department of Psychiatry at CGHS. Formerly, she is a strong proponent of problem-based learning and OSCE testing in medical education, and was named to Who's Who in American Colleges and Universities. During her time in Music percussion studies at the University of Rochester and at Huntington College in Montgomery, Alabama, and she earned her M.D. at the University of Alabama School of Medicine in 1982. She was chief resident in the Department of Psychiatry at UAB and served as a resident in the Department of Internal Medicine. She is a Fellow in the Academy of Psychiatric Medicine and a Diplomate, American Board of Psychiatry and Neurology.

Parker has studied gastroenterology with Professor Ian Bouchier in Dundee, Scotland, and with Dr. Arthur Freeman, Jr., at South Highlands Hospital in Birmingham. Some elective months in medical training were also spent with Professor Dame Sheila Sherlock of London, England in the study of liver disease. She is presently in private practice in Birmingham, and she is particularly interested in the psychiatric impact of serious disease and enjoys helping patients whose medical problems cause depression or anxiety.

She came to Tuscaloosa because she wanted to "work toward making psychiatry palatable to the general public" by serving a family practice setting. She finds Tuscaloosa to be a city with a strong family medicine program, and hopes to focus future research on the role of psychiatry in family medicine.

She commutes daily from Birmingham where she lives with her husband, Dr. Charles Ford, a member of the medical school faculty at UAB, and their three children, ages 5, 4, and 2. Before her children were born, she performed as an organist and harpsichordist and judged American Guild of Organists Competitions.

Dr. Pamela Parker
Reports of elder abuse and neglect have increased dramatically over the last decade in both Alabama and in the United States. At the present time, between a million to 1.5 million cases of moderate to severe elder abuse exist in the United States. In Alabama, from 12 cases reported in 1977, the Department of Human Resources now receives in excess of 9,000 reports of elder abuse each year. Why is there such an increase in victimization? The answer is partly demographic. The United States has experienced a dramatic increase in the percentage of the population that is over the age of 85. One out of 6 persons over 65 has a son or daughter also over the age of 65. In 1982, Americans over the age of 75 constituted only 5 percent of our population. By the year 2030, this old, old group will constitute 10 percent of our total population. It’s important to look at the 85+ group because this is the group most likely to be victimized. Since 1900, the 65+ population increased eight times in Alabama while the 85+ population increased 22 times. Secondly, there has been a decline in the number of adult offspring. Since 1800, there has been a steady decline in the number of children born per mother so that fewer number of adult children as potential caregivers are available at the same time we are experiencing increasing aging pyramids.

Elderly victims frequently deny that they have been subjected to some form of family violence. Why? Some possible reasons include fear of public exposure, shame at having a child that would abuse them, some unwarranted guilt, a feeling of breaking the family code of solidarity, or fear of retaliation by the abuser. Frequently, elderly female victims have been victimized as spouses and earlier as children. Abuse may also be hidden because of what the abuser is doing. Frequently, abusers justify their actions by arguing that the victims provoked the abuse and they merely got what they deserve. Abusers may be unaware they are abusive because of a long term pattern of badgering or slapping. Some elderly caregivers are demented, mentally ill, or has been designated as the primary caregiver, is a relative in 86% of all cases, and lives with the elderly victim in 75% of all cases. The caregiver has cared for the victim an average of 9.5 years with 10% caring for victims over 20 years. In addition, many abusers who are neglected or abused are victimized by aging caregivers themselves. Spouses of older people are old themselves. These are by no means only grandchildren that are abusing grandparents. Some 60 percent of adult perpetrators report that the elderly person is a significant source of stress, and physical trauma is indicated in half of all cases.

What are some types of abuse and neglect? While there is considerable confusion over specific types or categories, the following represents a middle ground or a mainstream approach to typologies. First, physical abuse, which includes sexual abuse, may be easiest to diagnose because of the indicators. It is not likely to occur first in the ordering of pathologies. Indicators include burns in unusual places, physical injury to face or head, spongy scalp, fractures, joint contractions, old and new bruises, and subdural hematomas. Neglect is generally viewed as being either active or passive. Neglect is the single most common form of abuse/neglect reported to authorities in the United States and one most often likely to be seen by primary care physicians and home health care nurses.

Passive neglect is the unintentional failure to fulfill a caregiving obligation, a situation where distress is inflicted without conscious or willful intent. Frequently, older people may neglect themselves. Active neglect is the intentional failure to fulfill caregiving obligations and may include abandonment, denial of food, moderation of personal hygiene. Older persons also may experience a failure to thrive syndrome characterized by dehydration, abuse, malnutrition, abnormal blood chemistry values, and decubitus ulcers.

The third type, psychological abuse, is likely to occur earlier than other forms of abuse and is the most difficult to measure. The deliberate infliction of mental anguish of badgering, yelling, threatening, or berating older people can have serious manifestations. The results of psychological or emotional abuse can be humiliation, aggression, self-isolation and self-destructive actions including suicide.

Finally, financial abuse is defined as illegally or unethically exploiting by using funds, property, or other assets of an older person for personal gain. Material exploitation is intentional or motivated behav­ior, primarily of greed, that is rarely reported because the perpetrator is likely to be a family member. For health care professionals, perhaps the best indicator is if medications, therapies, or regimens are not being followed because of caregiver claims that they are too expensive, even when there are sufficient funds coming into the home to allow for such expenditures. Denial of civil rights, lastly, includes the rights of freedom of movement, assembly, speech, freedom from forced labor, and the freedom not to be inappropriately tied or locked up or improperly restrained.

Are there explanations for why elder abuse exists? There are a number of potential explanations. The most common theory is that abusers are socialized to abuse elders through learning both pro­ductive and anti-aging attitudes. Certainly, ageism plays a part. If the perpetrator has cared for the victim an average of 9.5 years with some explanation being reported for more than 30 years.

Who are abusers? The abuser is typically a caregiver who has accepted or has been designated as the primary caregiver, is a relative in 86% of all cases, and lives with the elderly victim in 75% of all cases. The caregiver has cared for the victim an average of 9.5 years with 10% caring for victims over 20 years. In addition, many abusers who are neglected or abused are victimized by aging caregivers themselves. Spouses of older people are old themselves. These are by no means only grandchildren that are abusing grandparents. Some 60 percent of adult perpetrators report that the elderly person is a significant source of stress, and physical trauma is indicated in half of all cases.

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caregiving, what is unclear is what the specific stressors are. Some suggest that actions of older persons themselves frequently are the trigger. Others suggest competing tasks or insufficient time or money. Still others argue that the functional status of the elder contributes most greatly. Another factor is social isolation. The absence of social support contributes to elder abuse in a number of ways. Social isolation forces caregivers to cope with crises and stress by themselves, enhances the feeling that they are trapped by the caregiving situation, and that they are unappreciated in this burden. Lastly, a related, but not causal factor, is vulnerability. Unlike children, older people become more vulnerable with increasing age, and frequently they intentionally or unintentionally increase their dependence on others. By so doing, this decreases their ability to prevent or escape abuse.

There are community-based programs which can help address these factors. Respite care, day care, homemaker services and home health services can relieve the pressure on the caregiving situation. Clearly, the suddenness of need of care is a continuing factor in the potential for care giving situations to go awry. A hip fracture resulting in a sudden need for care is far different than seeing a gradual slow decline in the same person. Preparation time is significantly different.

In addressing the problems of elder abuse and neglect in our society, it is important to remember that old people can be relocated successfully, can learn, can adjust to new environments, and can improve in overall functioning in different situations. The ability for all of us to continue to adapt is somewhat remarkable, and adaptability is not solely the province of the young.

-Lois A. Unahower, Ph.D., Director Center for the Study of Aging Professor, Behavioral and Community Medicine

Editor’s Note: The Center for the Study of Aging at the University of Alabama was established in 1971 as an all-University Center with affiliated faculty from disciplines across the campus. Located within the College of Community Health Sciences, the Center serves as the focal point for multidisciplinary education, research, and service activities in gerontology.

SOME WARNING SIGNALS OF ABUSE

Physical Signs
- Recurring or unexplained injuries, such as bruises, cuts, or burns
- Combination of new and old injuries
- Injuries without underlying diseases
- Dehydration or malnutrition
- Injuries in areas usually covered by clothing

Social-Psychological Signs
- Depression or withdrawal
- Hesitation to talk openly
- Fearfulness of caregivers or helping professionals
- Confusing or contradictory statements by a competent elder
- Resignation or denial

Financial Signs
- Unjustified control of competent adult’s finances by another person
- Refusal of needed services
- Lack of knowledge about financial matters
- Refusal to make financial decisions or pay bills without consulting another

Signs of Denied Civil Rights
- Unwarranted social isolation
- Signs of physical restraint
- Inability to talk with older person in absence of caregiver
- Unwarranted schedule of imposed activities

Signs of Medical Neglect
- Nontreatment of medical problems
- Oversedation
- Presence of bedsores

Signs of Self-Neglect
- Changes in reasoning ability
- Abuse of alcohol or drugs
- Decline in cleanliness of self and/or home

Maxwell Appointed Chief of Family Medicine

Alan J. Maxwell, M.D., who has served as Acting Discipline Chief for Family Medicine at CCHS for the past year, was appointed to head the department on August 21. The search committee, chaired by Russell Anderson, M.D., concluded its work in mid-August.

Dr. Ficken announced the appointment following final interviews with officials at the University of Alabama School of Medicine’s UA Health Alliance (RAHA) to link practice sites and preceptors in Bibb, Fayette, and Pickens counties with CCHS in training for medical students and residents. (See related story, page 1) He said he especially appreciated the help he received from the RAHA Education Committee in developing the program. Chaired by Gary Maguirk, M.D., of Fayette, the committee includes John Brandon, M.D., of Gordo, and Bob Butler, M.D., of Centre. He said Dr. Bill Gorry of Carrollton, chairman of RAHA, has been particularly supportive in helping CCHS focus on training family doctors.

Dr. Maxwell is certified by the American Board of Family Practice and became certified in Geriatrics in 1988 when the joint certification was first offered by the Boards of Family Practice and Internal Medicine. An associate professor of clinical family medicine at CCHS and adjunct associate professor in the University of Alabama Department of Psychiatry, Dr. Maxwell is also Medical Director of Forest Manor Nursing Home and Chairman of the Family Medicine Department at DCH Regional Medical Center. He is a member of the Alabama Board of Examiners of Nursing Home Administrators. He earned his Medical Degree at the University of Alabama and received his medical degree at the University of Alabama of Aging at the University of Alabama was received from the RAHA Education Committee in developing the practice sites and preceptors in Bibb, Fayette, and Pickens counties.

Dr. Maxwell served as assistant professor of Family Medicine at CCHS 1977-80. He then joined the faculty at the Baylor College of Medicine in Waco, Texas and later the University of Oklahoma Health Sciences Center in Oklahoma City where he was director of the Graduate Division of the Department of Family Medicine, director of the Family Practice Residency program, co-director of the Family Medicine Inpatient Referral Service, and Chief of Family Medicine Service at O’Donoghue Rehabilitation Institute. As honor of which he is extremely proud is the establishment at the University of Oklahoma of the “Maxwell Award for Clinical Excellence in Family Medicine” presented annually to a graduating resident with the best academic performance.

Maxwell said his first experience at CCHS helped him decide on medical education as a career. He said “teaching family medicine is intellectually challenging, and the teacher learns more than the student.” He credits Dr. Bill deShazo, whom he calls his mentor, with being the most important influence in developing the CCHS practice residency program. He is proud to take over the leadership role in placing family doctors in small towns. He came back to Tuscaloosa as an experienced teacher and administrator. He spends the majority of his time now in teaching and patient care. He has the largest private practice in the Department of Family Medicine. He also chairs the Graduate Medical Programs Review Committee at CCHS and serves on the Resident Selection Committee.

His primary research interest is geriatrics, and he has made numerous presentations including the conference, “National Issues Forum-Moral Dilemmas, Moral Choices,” and the International Congress of Gerontology. He is presently working with Dr. Mary Ann Plant to publish research on “Sense of Control in the Frail Elderly at Home” and “Assessment of Sense of Control in Rehabilitation Nursing Staff and Patients.”

Dr. Maxwell and his wife, Belinda have three children ages 8-11.

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“Private support for excellent medical education is our goal,” says Lorin Baumhover, Ph.D., who has taken a leadership role for CCHS in the University of Alabama’s capital campaign, “the Campaign for Alabama.” As the College’s Development Officer, he will work closely with the campaign steering committee’s chair, Pete Snyder, M.D., and the volunteer committee members to raise funds to endow faculty chairs and professorships for the medical school in Tuscaloosa.

“The medical community, the business community, and the people of Alabama all have an investment to make in providing well-trained primary care doctors who choose to practice in rural areas,” added Baumhover. He clarified that the medical students who train here at CCHS during their last two years of the University of Alabama School of Medicine program are also prepared for and have gone on to residencies at prestigious institutions nationwide in all medical specialties and subspecialties. And what brings many medical students to CCHS, he says, is the one-on-one training and professional contact students have with faculty and practicing physicians here and in surrounding counties who serve as adjunct faculty and with whom medical students spend six to ten week rotations in the various medical specialties.

What Snyder, Baumhover, and committee members hope to do is to involve CCHS constituencies and supporters all over Alabama in joint efforts to endow permanent faculty positions for The University of Alabama’s College of Community Health Sciences (CCHS). Grayson Simmons, M.D., Menendez; Jim Sullivan, M.D., Dothan; Fran Snyder, Tuscaloosa; Dudley Terrell, M.D., Ozark; Dale Trammell, M.D., Decatur; and Robert Yoder, M.D., Florence, have recently joined the CCHS Steering Committee to help secure endowment funds.

Alumni, former and future patients of the CCHS Capestone Medical Center, organizations and communities with an interest in training doctors for rural practice are all target audiences for information. The Steering Committee will be contacting key people and hosting special events to share information about CCHS and its goals as part of the Campaign for Alabama.

“There are many ways to give to the University during the Campaign for Alabama,” said Larry O’Neal, UA Assistant Vice President and Director of Development. “Cash, securities, and appreciated property such as real estate, equipment, art, books, paintings, copyrights, patents, oil and gas interests, insurance, deferred gifts, and bequests can all be arranged to benefit the University and provide tax advantages to the donor.”

O’Neal and his staff are always available to help donors and their professional advisors with financial and estate planning.

O’Neal sees the CCHS campaign as critical because CCHS, like other divisions of UA, contributes to the diversity and complexity of the University’s education mission. The CCHS rural service goal ties in to the University’s work to improve economic development in the state and provide access to rural areas through the ‘Rural Health Alabama’ project, said O’Neal. He also stresses the prestige factor of this campaign for volunteers, alumni, and others affiliated with the University.

The campaign and the University will be highly publicized, he says, and “the University will reach the highest echelon of private support for a public institution.” Many leadership gifts have been accepted, and the pride of donors is evident. He quoted one donor, John Saxon, who has provided two presidential chairs and an endowed scholarship who said, “as people go through life, they never forget people and institutions that have helped them to accomplish worthwhile objectives and to have the courage to face what the future has in store for them...”

Finding Broad-Based Support is Goal of CCHS Steering Committee

Profile

OnRounds in this issue begins profiles of CCHS capital campaign steering committee members. These volunteers are working to raise $6 million to endow permanent chairs and professorships for medical school at CCHS. The CCHS campaign is part of “The Campaign for Alabama,” the most ambitious private fund-raising effort ever launched at The University of Alabama, one aimed at putting the University of Alabama in the top ranks of higher education.

Snyder Chairs Steering Committee

Arthur (Pete) Snyder, M.D., of Tuscaloosa combines a busy surgical practice with his part-time academic work at the College of Community Health Sciences where he serves as discipline chief for surgery. Once headed for a career as a clinical psychologist, he enjoys patient contact. He said he chose surgery as a medical specialty because of the opportunity to make decisions rapidly and see results immediately. “Generally, surgical patients get well,” he says.

Many of his medical students come to CCHS because of the depth one-on-one instruction they get from him and thirty-eight other surgeons who serve as part-time surgical faculty. Since many of the medical students here are preparing for primary care practice rather than a surgical specialty, he stresses the importance of recognizing and diagnosing conditions which require surgery, i.e., internal bleeding, appendicitis, gall bladder disease, etc. and points out that primary care physicians not only refer to surgeons but also perform many minor surgical procedures or attend in emergencies where surgical expertise may be needed.

Dr. Snyder was born in Atmore and grew up in Mobile. He graduated from The University of Alabama and from the University of Alabama School of Medicine.

He completed an internship at Carraway Methodist Hospital and a surgical residency at the Mayo Clinic. He practiced and taught at Geisinger Medical Center in Pennsylvania and moved to Palm Springs, California, before coming back to Alabama to raise his family. He practiced for ten years in Ozark, staying until his youngest child graduated from high school, before coming to Tuscaloosa and CCHS. The opportunity to teach again was a motivating factor. He says he really enjoys his students.

Snyder and his wife, Fran, a Mississippi native whom he met in college, have two children in graduate school and one who is still in college at The University of Alabama. “We have strong ties to the University,” said Mrs. Snyder, who commuted to Tuscaloosa from Ozark to complete graduate studies in social work, “because we both graduated here and educated our children here.” Dr. Snyder is active in the medical community, and he enjoys tennis, golf, travel, and snow skiing. But aside from surgery and teaching, “his real passion is gardening,” said his wife. “Our house is always filled with twigs and sick plants that Pete is nursing back to health. There are seedlings germinating in the refrigerator, and he has plants under grow lights in the basement. He has a special patch in the woods in front of our house.” He also enjoys a special fondness for dwarf evergreens, azaleas, and rhododendrons.

When asked about the importance of the campaign and why he decided to chair the Steering Committee, he says in his typically understated way, “I thought it was a good thing for the University of Alabama and the people of Alabama. This college is helping to provide health care for rural areas and train family doctors.”

“Pete has done our civic duty,” he says of his wife who has been active on the local health board, meals on wheels, and community soup bowl projects. “But this is an important contribution that I can make.” Mrs. Snyder encouraged him to take on the role. “He has always been so busy with his surgical practice that he couldn’t get involved in community service,” she said. “In Ozark he was the only surgeon and had no coverage. He could hardly keep his head above water,” she said, “but he feels - as many men do - that he has reached a point in his life when he can restructure his priorities and devote some time and energy to other things he deems important.”
 occupational medicine is short supply. In fact, most occupational medicine is performed by family physicians. So, how do family physicians prepare to provide services that may seem distant from their specialty? CCHS’s answer to this question is twofold: (1) develop a program for teaching occupational medicine to residents, and (2) provide occupational medicine services for the community.

Much of CCHS’s involvement in Occupational Medicine focuses around the Capstone Occupational and Preventive Medicine Unit. Drs. Russell Anderson, Jerry McNight, and John Wheat involve residents in the evaluations of employees from companies throughout the West Alabama region. Field trips for family practice residents and faculty are one of the high points of teaching Occupational Medicine. The coal mines of Walker and Cullman counties still exist, and the cotton fields of Tuscaloosa, aluminum plants in North Alabama, fiber-board processing in Sumter County, and area Methane gas fields offered a varied experience last year. These trips provide discussions with residents, employers, and employees about workplace hazards, safety, worker’s compensation, health promotion, and the like. After such trips residents and physicians in the community often use the resources of the Occupational and Preventive Medicine unit to answer their questions about caring for employees.

A special interest of the Occupational and Preventive Medicine group physicians is Agrimedicine which applies occupational and preventive medicine to the health problems of agricultural and forestry workers and families. Jointly with physicians in the Rural Alabama Health Alliance (RAHA), Drs. Anderson and colleagues developed a proposal to provide agrimedicine training in the community as much as possible in order to develop local expertise and to provide a favorable context for learning, analogous to learning critical care in an intensive care unit.

The program would be a significant step toward addressing Alabama’s need for rural physicians and agrimedicine services, according to Dr. Bill Curry of Barber, Chairman of the Rural Alabama Health Alliance (RAHA). He said he is hoping to receive word of funding for the project.
Bart Mitchell Bailey is from Gadsden, Alabama. He attended Gadsden State Community College, the University of Alabama, and received a B.S. degree from Birmingham Southern in 1987. Bart is the son of Edward Bailey and Sue W. Abercrombie.

Sandra Rose Balk is from Huntsville, Alabama. Sandy attended UAH, UAB, and received her B.S. degree in biology from Birmingham Southern in 1990. She is the daughter of Mr. & Mrs. Robert Balk.

Robert Christian Brunner is from Miami, Florida. He received a B.S. degree in microbiology from the University of Alabama in 1990. Bobby is the son of Mr. & Mrs. Robert Brunner.

John David Creasy is from Jackson, Tennessee. He attended Lambuth College and the University of Tennessee in Knoxvile where he received his B.S. degree in biochemistry in 1989. John is the son of Mr. & Mrs. Fred Creasy. He is married to Victoria.

John Wilson Crommett is from Ft. Walton Beach, Florida. He attended the University of West Florida and the University of Alabama where he received his B.S. degree in microbiology in 1990. John is the son of Wayne and Sue Crommett.

Andrew Martin DeWitt is from Midfield, Alabama. He received his B.S. degree in biology from the University of Alabama in 1988. Andy also completed Medical Technologist training in 1989 at the Baptist Medical Center School of Medical Technology. He is the son of Mr. & Mrs. James W. DeWitt, III. Mark and his wife Jann are the parents of Lauren Danielle who was born on July 22, 1992.

Jignesh Narendrakumar Gandhi was born in Bombay, India. He attended high school in Ozark, Alabama. Jignesh received his B.A. degree in history from the University of Alabama in 1990. Cody is the son of Mr. & Mrs. Ronald F. Henderson.

Robert Keith Hunt is from Snellville, Georgia. He received his B.S. degree in 1981 from Georgia Institute of Technology. Bob attended Emory University Dental School and received his D.D.S. from Baylor College of Dentistry in Dallas, Texas in 1985. He received a certificate in oral and maxillofacial surgery at the Medical College of Georgia. Bob is the son of Mr. & Mrs. James E. Hunt.

Richard Edwin Jones, III is from Mobile, Alabama. He transferred to the University of Alabama School of Medicine from the University of Alabama, and received a B.S. degree in biochemistry in 1989. John is the son of Mr. & Mrs. Robert Balk.

La'Quetta Nicol Morris is from Talladega, Alabama. She received her B.A. degree from Harvard University with a major in biochemistry in 1990. La'Quetta is the daughter of Levoid M. Lawler.

Regina Manacsa Nepomuceno is from Birmingham, Alabama. Sue received her B.S. degree in chemistry from the University of Alabama in 1990. Regina is married to Tracy.

Robert Gerard Swanton is from Metairie, Louisiana. He received his B.S. degree from LSU in Chemical Engineering in 1984. Robert has also done post-graduate work at the University of New Orleans and the University of Alabama. He is the son of Mrs. Estell S. Swanton.

Mark Samuel Eich is from Sheffiled, Alabama. He received his B.A. degree from Huntingdon College in 1988 and also attended the Naval School of Health Science in San Diego, California. Mark is the son of Dr. & Mrs. W. Foter Eich, III. Mark and his wife Jann are the parents of Lauren Danielle who was born on July 22, 1992.

Narong Kulvatunyou was born in Thailand. He attended high school in Fairhope, Alabama. Narong attended the University of South Alabama School of Medicine. Richard received his Ph.D. in April, 1992 from USA. Richard came to Tuscaloosa to be with his wife, Sherry. Christopher Gordon Kelley is from Oxford, Alabama. He received his B.S. degree from Jacksonville State University in 1989. Chris is the son of Mr. & Mrs. Gordon L. Kelley.

Kennedy Frank Kunz is from Hoover, Alabama. He received a B.S. degree from the University of Alabama in 1990. Kenny is the son of Mr. & Mrs. Lawrence F. Kunz.

La'Quetta Nicol Morris is from Talladega, Alabama. She received her B.A. degree from Harvard University with a major in biochemistry in 1990. La'Quetta is the daughter of Levoid M. Lawler.

Regina Manacsa Nepomuceno is from Birmingham, Alabama. She received her B.S. degree in 1989 from the University of Alabama in Birmingham. Regina is the daughter of Dr. & Mrs. Cecil S. Nepomuceno.

Wallace Burl Pardy, Jr. is from Anniston, Alabama. He received a B.S. degree from the University of Alabama in biology in 1991. Wally is the son of Mr. & Mrs. W. B. Pardy.

Dykes Taylor Rushing, Jr. is from Elba, Alabama. Taylor attended Enterprise State Junior College and Troy State University where he received a B.S. in German/Physical Science in 1990. He also was an exchange student at the University of Kaiserslautern in Germany. Taylor is the son of Mr. & Mrs. Dykes T. Rushing.

Robert Gerard Swanton is from Metairie, Louisiana. He received his B.S. degree from LSU in Chemical Engineering in 1984. Robert has also done post-graduate work at the University of New Orleans and the University of Alabama. He is the son of Mrs. Estell S. Swanton.

John Grant Wideman is from Birmingham, Alabama. He received his B.S. degree in biology from Birmingham Southern. John also did post-graduate work at UAB and Samford. John is the son of Dr. & Mrs. Gilder L. Wideman. John and his wife, Nancy, live in Alabaster.