

The Future of Family Practice in Our Medical Schools

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I cherish the honor of being invited to present the first Annual John Walsh Memorial Lecture. I first met John Walsh in 1947, shortly after World War II. We were the youngest members of a group of California practitioners who saw the need for the organization of constructive efforts to improve the role of the general practitioner. As a result, when the California Academy of General Practice was organized in 1948, John and I were elected to the Founding Board of Directors. In later years, I came to admire the strengths of positive purpose and idealism that characterized his subsequent career. These traits ultimately led to his election as President of the American Academy of General Practice and as the first President of the American Board of Family Practice. Thus, we can identify the persistent pursuit of ideals and the promotion of the family physician on the basis of quality education, training and high standards as the key to the success of not only Dr. Walsh, but that of family medicine as a recognized academic discipline. The precepts of John Walsh remain the key to the future of family medicine in our medical schools.

Five years ago, "The Future of Family Practice in Our Medical Schools" would have been presented in the form of a question. Today it can be presented as a statement. I must concede, however, that an exact description of that future remains to be determined by the attitudes, forces and circumstances that continue to impinge upon and influence

a still emerging renaissance. I might add that it would be equally difficult to precisely describe the medical school of the future.

In 1968, I observed that the problem was not so much that scientifically oriented academic medicine is incompatible with socially responsible family medicine, but that the ardent advocates of each frequently are. Although the degree of polarization has softened, it would be less than candid to suggest that an overwhelming number of today's medical school faculty are enthusiastic about family medicine. This reality should cause neither surprise nor resentment. Pellegrino has observed that "The majority of academic clinicians in health sciences centers are not suited by training, temperament, or motivation to teaching new roles required for an adequate health care system. Their education and interests do not suit them for teaching the missing dimensions of care."¹ These statements carry the sting of truth, but truth also demands that all should acknowledge that from the scientific, technological and academic standpoint, the medical school of today is far superior to that of the past.

We must never lose sight of the fact that medical education is a legitimate university function. It therefore carries very real academic responsibilities of fundamental importance — a responsibility that must be preserved if we are to maintain the excellence that was so long in coming. It was in 1910 that Flexner recommended that our medical schools work toward the development of a valid scientific basis for the practice of medicine. To accomplish this, he observed that medical schools should become identified with universities. He further proposed that the university medical schools become centers for the training of academicians for clinical investigation and optimal instruments for treating the ten to fifteen percent of problems of human illness that require highly specialized care. In essence, the medical school of today is now subjected to public criticism as a re-

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sult of its successful response to a mandate presented to them sixty years ago. I will be among the first to defend the importance of that success, but we must recognize that it represents an academic success with social consequences.

Those of us who must appeal to state and federal governments for funds required to operate a school of medicine have found it abundantly clear that our legislators and congressmen are now convinced that the modern medical school has not given sufficient attention to the need for a proper balance in the kinds of physicians we produce. Legislative attitudes usually reflect those of the general public, and the average man on the street views the justification for a medical school's existence as primarily for the purpose of producing the kinds of physicians the public wants and in the quantities they need. This reaction grossly oversimplifies the problem, but clearly articulates the challenge we face.

One of the things that will never change is the fact that in the long run it is society that will decide what we do and society is beginning to decide. There is going to be an emphasis on family medicine in medical education. The exact nature of the family physician of the future and the exact way in which we will produce them may be open to speculation, but in the final analysis this too will ultimately be decided by the public.

To my respected and admired academic colleagues, I would say "be not dismayed." In the past two decades we have seen that our society is perfectly willing to permit and to finance the most esoteric of academic research pursuits as long as (but only as long as) the needs of society are being met. The logical conclusion is clear — let us with enthusiastic vigor develop family medicine and other programs that relate to societal needs and by so doing insure the prerogatives of legitimate academic pursuits.

To my practicing colleagues, I would observe that the faculty of a university medical school would be derelict if they were not concerned with academic excellence and the pursuit of new knowledge. You must be supportive of their proper concerns for the protection of academic excellence. In so doing you will enhance and expedite the development of appropriate medical education and training programs in family medicine, which in turn will lead to a more balanced production of the kinds of physicians required to meet the needs, demands and expectations of the people that own our institutions.

As we look to the future and the development of family medicine as an academic discipline it is important that those who are developing these programs pay attention to those areas that justify the pursuit of family medicine as a unique discipline. I still see a dominant emphasis on episodic illness. This is understandable but a cause for concern. The basic science of family medicine must be found in the family itself — the ecology, the life styles, and the behavioral patterns of the family group and their relationships to health and illness. Here is a huge field of unexplored potential. The history of mankind suggests that as long as there are families they will need and want to identify with someone in the role of the family doctor. The core unit of society is the family. There are more families in our nation today than ever

before and there will be more tomorrow. Families are made up of babies, children, adolescents, mothers, fathers — and sometimes uncles, aunts, and grandparents. It is within this family milieu that we find the genesis of most physical illness, infectious disease, mental illness, genetically related disorders, social pathology, behavior problems, dietary and other habits that may lead to chronic disabilities as well as many common social ills.

Medical researchers have persistently concerned themselves with the causes and the treatment of disease. The time has come for us to begin the search for the causes of health — something that is more than an absence of disease, and this too leads directly into the family. We have witnessed the development of psychiatry, internal medicine, mental health, preventive medicine, prenatal care, pediatric care, adolescent care, obstetrics, and geriatric care as individual specialties and these in turn have become further fragmented into sub-specialties. Each of these has been concerned with "end pathology," the genesis of which will almost invariably relate back to the family in some manner if you just look far enough. It is not possible to separate physical, mental and emotional disorders — nor even poverty and ignorance from the pathology of the family. In the future the family will become a target for major research and teaching in our medical schools. The logical base for such studies will be found in departments of family medicine.

The foregoing comments have alluded to significant reasons that support a conclusion that family medicine will become a major discipline in the medical school of the future, particularly in the publically supported school. We now turn to a consideration of some developments that I feel will be essential to excellence in the medical education and training of students who elect to become family physicians. These may require revision of curricula in many medical schools.

When a medical school accepts the responsibility of developing academic programs in family medicine it should examine Pelligrino's premise that the education, training and motivation of most academic clinicians do not suit them for the primary responsibility of teaching family medicine. Furthermore, we must recognize that our faculties are occupied with their own responsibilities even if they were motivated toward family medicine. These observations lead to the conclusion that any good department of family medicine will develop its own core faculty. At the clinical level of training, family medicine will follow the old adage that "common things occur commonly." Family Medicine programs will therefore need clinical resources outside the university hospital where they can emphasize the care of common illnesses — emergency care, trauma, normal obstetrics, maintenance care of "wellness" care and to participate in all of the procedures and arts common to the practice of family medicine in the real world.

Medical schools of the future will develop more flexibility, patterned along the lines of a university, in that students

will have a choice from the beginning of taking courses that will fulfill curriculum requirements designated for those who wish to take a "major" in family medicine or in the field of their choice. A student may complete medical school in three years or in seven years; the important factor being a demonstrated level of competence rather than a term of years. Just as in college, if he decides to shift to another "major" he may expect the possible need for more time in school. Such a system would get us out of our hide-bound lock step traditions and would accommodate to the characteristics of the "slow" student as well as the rapid achiever. It would provide opportunities for both horizontal and vertical movements in medical education and would permit the man who enters medical school committed to a career in family medicine to immediately identify with his career choice.

Students in family medicine in the future will necessarily gain much, if not all, of their clinical educational experience in community hospitals that might be designated affiliate "clinical campuses," and with selected private practices, group practices or community clinics. Students will, as an observer and patient advocate, follow their own patients into the university hospital when special procedures are indicated that require the special kind of care available in a university hospital. In the family medicine clinics, trainees will identify with assigned families in the role of family physician. If they encounter need for a specialty consultation, they will make the appointment and go with the patient to learn that which can be gleaned from the consulting specialists. If one of their patients is admitted to a hospital service, they will go with them, learn of the admissions process, the feel of the waiting room, and assume gradually increasing responsibilities for patients in relation to their training, experience, and to the severity and nature of the illness to the patient.

The "clinical campus" off campus circumvents dilution of university specialty clinics — an important factor in minimizing faculty resistance. I have always felt that you could not adequately teach family medicine in the specialty clinic environment. The specialty clinics should be used for specialty purposes, e.g., consultation and special procedures. If one accepts this thesis, our concerns turn to assurance that the quality of the "clinical campus" is commensurate with university standards. Quality of family medicine programs can be controlled by the careful selection of clinical faculty, followed by the development of an evaluation and review process. If we will do this, the full time specialty faculty will recognize that there is a factor of excellence to be pursued in family medicine and that the faculty in family medicine is pursuing that excellence, including the unlimited opportunity to pioneer in the research of family patterns, their relationships to health and disease and improved systems in health care delivery.

I have thus far avoided the still controversial issue of the extent of experiences to be offered family medicine students and residents in the surgical disciplines. I will only say

that those who feel that we should revert to the "jack of all trades" 1930 style general practitioner who does anything and everything he wants to do — and those at the other extreme who would limit the family physician to a role of triage are both quite wrong. Anyone who has been a family physician in a medium to small community knows that sooner or later anything can and will come in through the office door. The family doctor can expect to encounter pathology and emergencies of every description. He must be able to handle prompt decisions, emergency trauma, simple fractures, normal deliveries and the principles of common surgical procedures — but he should be fully responsible to refer that which should and can be referred.

I would be out of character if I did not mention that departments of family medicine must consciously place more emphasis on child care and geriatrics. I find these two extremes in the life spectrum represent neglected aspects of most programs. By definition the word "family" implies children, parents and grandparents. Much of every day family medicine will involve advice, care and preventive care for children and the aged. Anyone who calls himself a specialist in family medicine should expect to have expertise in these areas. One may also predict that the new breed of students in family medicine will in the future be exposed to all aspects of a well-managed practice — including those of partnerships, clinics and groups. Computer technology applied to systems management will become a routine part of medical practice training but computer technology will never replace the need for compassionate human understanding. The successful family medicine departments of the future will be those that create environments in which responsiveness to human fears, guilt, aspirations, frustrations, ignorance and pain represent a way of life. We will return to the credo of the great Oliver Wendell Holmes, "To cure sometimes — to relieve often and to comfort always."

In summary, medical schools are owned by their society. The basic unit of society is the family. This history of mankind suggests that as long as there are families there will be a demand for family doctors. In the future our medical schools will produce family doctors in a planned relationship to needs. Public support for medical schools will reflect the adequacy, or inadequacy, of response to needs.

In conclusion, although it is not likely to have been appropriately recognized in his home community, the man we honor here today, Dr. John Walsh, made a notable, singular and lasting contribution to the American public, American medicine and family physicians of the future. His enlightened pursuit of the establishment of family medicine at the highest level of competence has provided a model for achievement that is an inspiration to all who are concerned with the future. The only reward he would want would be a continued pursuit of his own goals and standards, and this is our challenge and our responsibility.

Reference

1. Pellegrino, E. D. The regionalization of academic medicine: the metamorphosis of a concept. *The Journal of Medical Education*. 48:2:119-133, 1973.

