On the Need for Critical Inquiry in Family Medicine

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A recent editorial was addressed to the entry of family practice as a specialty into a second stage of development, involving the further articulation of the academic discipline and development of a firm research base.[1] Although many have recognized the importance of this direction in recent years,[2-4] little attention has been given to the *attitudinal* requisites for this kind of effort.

Family practice has taken root from the background of general practice, and has more recently been involved in the definition and incorporation of important additional elements to this form of medical care. The teaching and clinical application of general practice has traditionally been of a derivative nature – its content has been derived as portions of all of the other clinical specialties. Medical graduates preparing for general practice in the past, as well as for family practice today, have found themselves confronted with the need to acquire a broad range of knowledge and skills. The immensity of this task, together with the relative lack of an active research base representing the experience of the family doctor, have tended to nurture an attitude which values what is "*practical.*" The pressure has been to acquire a practical approach to the diagnosis and management of a wide spectrum of clinical problems which can be readily applied in a busy practice. It is perhaps natural that a "mind set" has frequently been developed favoring the reduction of clinical knowledge and procedures to readily understandable and recallable dimensions. This "mind set" has sometimes seen "research" as of little importance or relevance. This attitude has often been reinforced by exposure, during one's medical education, to research activities in other disciplines, involving "esoteric" conditions and complex pathophysiologic mechanisms, not directly applicable to the work of the family doctor.

Today's circumstances are quite different. Family practice is now becoming an integral part of the formal system of undergraduate and graduate medical education. The necessary tools for research are being effectively implanted in many teaching and clinical settings, including the use of the problem-oriented medical record, chart audit, and data retrieval systems. It is suggested, however, that an additional and absolutely vital ingredient is required for family practice to develop and to apply its needed research base: a new "mind set" of *critical inquiry.*

As clinicians in family practice, we should regularly question the effectiveness of what we do, seek documentation for the value of current clinical approaches, and reject those which lack documented value. Through an attitude of critical inquiry, we should raise questions about the effectiveness of diagnostic and therapeutic approaches. We should learn *something* from every patient we see. Many related disciplines can be involved in the study of problems in family practice, but it is the family physician who must ask and follow-up on the questions needing study.

By dealing with the everyday problems of patients and their families, the family physician has several inherent advantages relating to research on a patient care level: (1) contact with all members of the family of all ages and both sexes; (2) direct experience with primary care of unselected patients; (3) opportunity for long-term follow-up of patients; (4) multidisciplinary approach to care; and (5) contact with patients in all stages of disease. The family physician, therefore, has a wider perspective of health and disease on the community level than anyone else in medicine. The study and articulation of the experience of family physicians on a cumulative basis is becoming a valuable contribution to medicine in general, and primary care in particular.

The ability to think critically must be stressed in all family practice residency and continuing medical education programs. An attitude of critical inquiry will pay big dividends to all involved in family practice. These benefits will be reflected by increased quality of teaching programs, development of the academic discipline of family medicine and of a body of knowledge which family physicians will teach, an ongoing stimulus for continuing medical education, increased practice satisfaction, and most importantly, improved health care for our patients and their families.

References

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Private Practice Management

Changes Contained in the Tax Reform Act of 1976 Which Affect Most Individual Tax Returns

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The 1976 Tax Reform Act, which was passed by Congress and signed by the President in October 1976, contains many items which will have a major impact upon physicians in their investment and tax planning. This article is the first of a series which will review the changes in the law and the impact of those changes on the physician. Not all of the information contained in these articles will have an effect upon all the physicians served by this journal because of the differences in economic level and differences in approach to tax matters.

The Tax Reform Act contains certain changes which affect all individuals that are required to file a tax return. The first of these is a permanent change in the "percentage standard deduction." This is the percentage of "adjusted gross income" that may be subtracted in addition to the personal exemptions, from "adjusted gross income" to arrive at taxable income. The "percentage standard deduction" is used by those taxpayers who do not itemize their personal deductions. The change now permits one to use a "percentage standard deduction" that is calculated by multiplying 16 percent times their "adjusted gross income" and subtracting the result from their "adjusted gross income" so long as the result is less than the maximums contained in the act. These maximums are $2,400 for a "single" individual or an individual filing under the "head of household" status, $2,800 for those individuals filing returns under "married filing jointly" or "surviving spouse" categories, or $1,400 for those individuals using the "married filing separately" category. These changes increase the amount that may be used in calculating taxable income if the taxpayer does not itemize his personal deductions. In general, this group would be those physicians who do not own their own residences, or who do not have large medical expenses.

The second of the changes contained in this section of the act probably does not apply to most physicians. This change is an increase in the amount known as the "low income allowance." This allowance is the minimum amount that an individual may use instead of the "percentage standard deduction" if the "percentage standard deduction" calculation results in a lesser amount. In other words, the "low income allowance" is a minimum amount that each taxpayer is guaranteed that will reduce their "adjusted gross income" regardless of its level. These amounts are: $1,700 for individuals using the filing status of "single" and "head of household", $2,100 for those individuals using the filing status of "married filing jointly" and "surviving spouse," and $1,050 for those individuals filing a return using the status of "married filing separately."

The changes in the "percentage standard deduction" and the increase in the "low income allowance" are permanent changes in the law which become effective for tax years ending after 1975.

The third change in the act relates to the "general tax credit" that was implemented in 1975. (This was the $30 for each personal exemption that was contained in the Tax Reduction Act of 1975.) However, the 1976 Tax Reform Act changes the calculations required in applying the credit somewhat. The new provisions of the act now permit the use of one of two alternatives. An individual may either

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