Family Medicine Approaches Maturity

George E. Burket, Jr, MD
Kansas City, Kansas

During the past eight years, since its inception in 1969, the specialty of Family Medicine has gradually been developing toward maturity. With the specialty now firmly based in biomedical science, behavioral science, and patient management, it is prepared to accept a place of full responsibility in the spectrum of health care. This article explores the scope of family practice relating to the needs of a changing society and advocates a broad application of the skills and knowledge involved.

Since the advent of Family Practice as a specialty in the delivery of health care, there has been considerable misunderstanding by the medical profession, organized medicine, and potential patients, often described as health-care consumers, concerning the specialty. The general feeling has been, in some areas, that it is merely another name for general practice and, indeed, the terms are used interchangeably at times. This is truly a misconception, even though family practice does have its heritage in general practice as do all specialties of medicine and surgery. The difference lies in the fact that family practice is only eight years of age while surgery, for instance, is 40 years old. During those 40 years fairly clear concepts have developed, although not distinctly recorded in black and white, concerning what does and does not constitute surgery, what constitutes internal medicine, pediatrics, etc. Recently developing "invasive" techniques in diagnosis and treatment cloud the picture a bit but still the concepts stand, fairly well understood by the profession and the lay public.

Now after eight years the concept of family practice is beginning to take a more definitive shape and is finding a more secure niche in medical education and health-care delivery. It is the purpose of this paper to describe in some detail one person's observation as to what is developing as family practice and its place in medical education and clinical practice. Background for these observations comes from years in clinical practice and academic medicine, and an intimate relationship with the foundation of family practice as a specialty.

Requests for reprints should be addressed to Dr. George E. Burket, Jr., Department of Family Practice, University of Kansas Medical Center, Rainbow Boulevard at 39th Street, Kansas City, KS 66103

Patient Management in Family Practice

The terms "comprehensiveness and continuity" have been freely and properly used in relation to the family physician from the beginning. They indicate a unique service, provided to the patient and his/her family, which is of prime importance in good total health care. The terms have been interpreted in many ways by various medical specialties who contest family medicine's sole proprietorship of their use. In addition, the majority of health-care consumers have difficulty understanding such complexities when used in definitions. Only when Stephens[1] in 1975 carefully delineated patient management as the "intellectual and academic basis of family practice" did the terms come to have real down-to-earth meaning that everyone, including patients and potential patients, could understand.

Without expounding on Stephen's thesis and his excellent defense thereof, it seems adequate for the purpose of this paper to quote his conclusions. "This [patient management] then, is the intellectual and academic basis for family practice. This is our field for inventiveness and discovery. This is our agenda for research. To be sure, the family physician may borrow a great deal of information and knowledge from other disciplines. Such borrowings constitute a variable and will not be the same in all areas of the country or in all settings. *But the constant is the skill of patient management.* One cannot be a family physician without highly developing this skill. One's bag of technical tricks will change from time to time. One may or may not deliver babies or perform surgery. Whether one does or not depends largely on personal preference and local conditions, but the sine qua non is the knowledge and skill that allows a physician to confront relatively large numbers of unselected patients with unselected conditions and to carry on therapeutic relationships with patients over time. This is what we should be teaching and learning and practicing. Everything else is secondary."[1]

One could not improve on this basic thesis and the intention here is to build on this base in advocating both an academic curriculum for family practice and a pattern for clinical practice. As one examines what the really successful general practitioner did in the past that made him stand out among his peers, one finds that it was successful, outstanding patient management. He gave to his patients

quality health care to the best of his ability, recognized his sphere of competence and, when necessary, provided for his patients quality consultation and referral. Referral did not mean that his responsibilities for the health care of that patient ceased. He still felt the responsibility for the successful completion of that care – and this required the utmost confidence and communication between the family physician and his consultants.

In his book, "The Walking Patient," Oakes[2] quotes Bagby and Wolfe commenting on the importance of the general practitioner in Great Britain: "No health service, private or public, can succeed unless careful attention is paid to the doctor who provides primary care in the community. All other decisions depend on what he decides when the patient is first seen."

These same skills in management must be extended into the training of the family physician today. It should not be left to chance but should be taught by intent. Furthermore, it must be stressed that any physician putting up his shingle as a family physician should be willing to accept or assume the unwritten contract for the responsibility of medical care and health care for anyone who enters his office. The assumption of this responsibility should occur whether the patient is an adult or a child, a male or a female, whether the problem involves disease or is psychosomatic, or whether the therapeutics involve medicine or surgery. That responsibility for total care exists whether the family physician actually uses his/her own skills or those of a consultant. It follows then that there should and must be certain flexibility in the family physician's training. As an example of this flexibility, one family practice resident may learn to perform liver biopsies and another may not. This is really inconsequential as long as the one physician learns to do the biopsy skillfully and is as competent in doing it as anyone immediately available and as long as the second physician selects a competent individual to perform the procedure for his patient when indicated. This example could be duplicated a thousand times in the practice of a family physician.

Patient management and responsibility for total patient care, then, is the core of family practice and is that which really makes it a specialty – one so very needed when it is exceedingly important that other specialties concentrate on special cognitive and technical skills. This is the common denominator of family practice. This is what should be at the core of family practice training and practice. This is the reason that the use of the patient management problem received its primary and maximum stimulation through the certifying examination by the American Board of Family Practice. And finally, this is the reason that the American Board of Family Practice statistics reveal that experienced family physicians (the practice-eligible candidates) have done better in the Patient Management Problems than in any other part of the certifying examination.

Other Elements of Family Practice

With the foregoing observations clearly in mind it is now possible to turn to other basics of family practice.

One could not continue this discussion further without looking first at the basic (the biomedical and the behavioral) sciences, upon which all medical teaching and practice are built, and then giving some consideration to their relationship to family practice. For the sake of clarity and order in this discussion these two areas will be considered the next building blocks for family practice, although one could certainly maintain that they are the real foundations and that patient management is superimposed. This will not be argued here, but rather saved for another day. Certainly, family medicine could not be a solid specialty without all three. There are those who contend that family medicine cannot be a specialty without its own area of basic science. Many do not agree with this contention but perhaps the term "science of patient management" might satisfy skeptics.

The biomedical or natural sciences came rapidly to the foreground at the turn of the 20th century when medical education became university oriented and the biomedical sciences became basic to all medical education. This stimulation, with demonstrated application of the biomedical sciences in clinical medicine, gave impetus to the development of scientific medicine as it is known today, creating the real necessity for the fragmentation of medicine into specialties and subspecialties in the provision of tertiary care. But it should be pointed out here that tertiary care has no sole proprietorship on the basic sciences nor is it necessary or even advisable for the same fragmentation to extend into primary care. Family practice also must, and does, have its base in the biomedical sciences and this, if for no other reason, is why primary care cannot be given over to less educated individuals. While other individuals may be assigned specific tasks for which they are well trained, the skills necessary in all the parameters of family practice require a good foundation in the biomedical sciences. Specific skills will be discussed later.

During the past 20 years a new basic science has found its way into medical education. Known as behavioral science, it is described by those who have studied it longest and know it best as originating in anthropology, sociology, and psychology. It came into being primarily because of a realization that there was something lacking in scientific medicine based strictly on the biomedical sciences. Some called it a lack of "humanism," others termed it a "lack of recognition of normal human behavior," many have called it "the lost art of medicine." Whatever the term, this void in health care could not be properly filled by academic medicine without the answer having its roots in a basic science where basic research could help it flower into clinical medicine. This basic science is now known as the behavioral sciences. There are now behavioral science departments in a few medical schools, but many academicians still do not accept it as a basic science. It is, however, now included in Part I of the National Board Examination for medical students.

It was not by mere accident that the behavioral sciences began to flourish and take root with the advent of family medicine. Although there were a few behavioral scientists working diligently from coast to coast, the parameters of the science were vague and the only outlet for their product into clinical medicine seemed in the

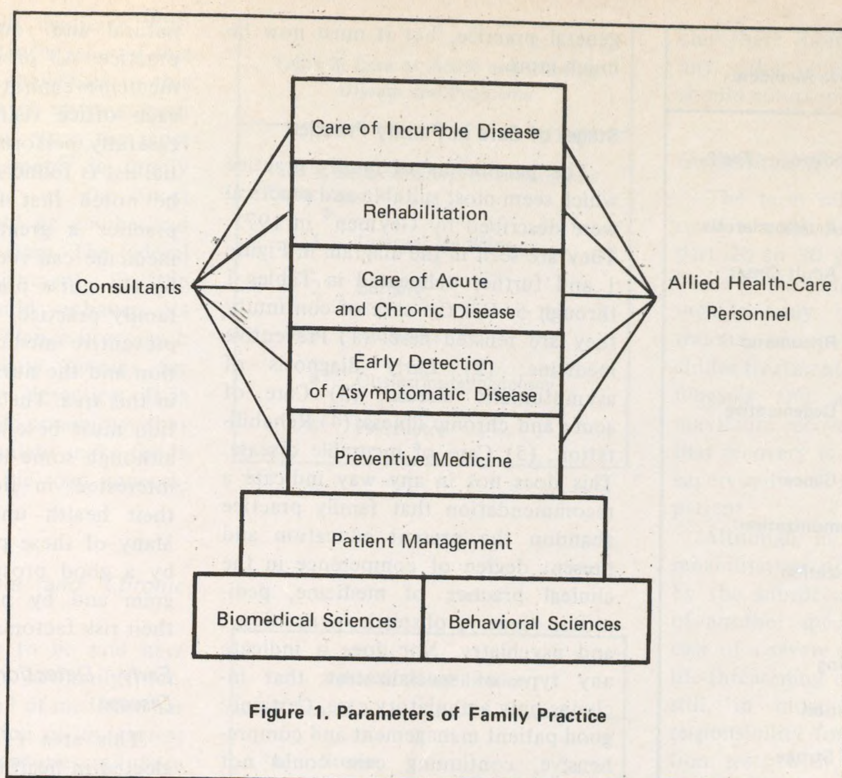

Figure 1. Parameters of Family Practice

1950s to be psychiatry.[3] When family practice had its beginning as a new specialty in 1969, emphasizing comprehensive, continuing medical care, family dynamics, ambulatory medicine, etc, it was quickly recognized that many of the problems confronted had nothing to do with organ ailments and the invasion of a human host by germs. Rather they had their etiology in abnormalities of human behavior, unfavorable environments, cultural differences, and a whole host of problems that could be understood, helped, or cured with the assistance of information filtering into clinical medicine from the behavioral sciences. Family practice now utilizes this new knowledge more than any specialty does, chiefly because the nature of the practice requires its use more often and in greater depth than most others. This does not mean, in any sense of the word, that the use of the behavioral sciences are the exclusive property of family medicine. Indeed they are used now to a certain extent by other specialties and as this knowledge is used in clinical medicine it adds further stimulation and maturity to the science itself as one basic to medicine.

With the roots of family medicine growing in the basic sciences one may now examine the parameters of the specialty in clinical medicine, which are diagrammed in Figure 1. Family medicine is a specialty of the future and is just now approaching maturity with the establishment of its base in the basic sciences. It had its beginning in sweeping social changes and because of a void in health care. Science can no longer be isolated from society, but must become a part of it. As it develops then, if it is to fullfill its destiny, family medicine must meet the challenges presented by the factors responsible for its origin. It cannot be a mere combination of internal medicine, pediatrics, surgery, obstetrics-gynecology, psychiatry, and community medicine. It must be more and different and its objectives must be tailored to meet the demands of the present while preparing for the future. It should never deny its heritage from

Table 1. Preventive Medicine	
*a.	Prospective Medicine — Risk Factor
*b.	Prevention of Arteriosclerosis
*c.	Prevention of Adult Onset Diabetes
*d.	Prevention of Rheumatic Heart Disease
*e.	Prevention of Degenerative Arthritis
*f.	Prevention of Cancer
*g.	Childhood Immunization
*h.	Adult Immunization
i.	Epidemiology
*j.	Family Planning
*k.	Patient Education
*l.	Prevention of Stroke
m.	Prevention of Birth Defects
n.	Prevention of Adverse Drug Interaction

Table 2. Early Detection of Asymptomatic Disease	
a.	Annual Check-up (Adults and Children)
b.	Annual Pap, Pelvic, and Breast Examinations
c.	Tuberculin testing
d.	Methods of Interpreting Casually Mentioned Problems
e.	Listening to Patient
f.	Alert Observation of Changes in Patient Behavior, Appearance, Speech, Gait, Color

general practice, but it must now be much more.

Stages of Care in Family Practice

The parameters of family practice which seem most suitable and practical were described by Geyman[4] in 1975. They are seen in the diagram in Figure 1 and further delineated in Tables 1 through 5. For the sake of continuity they are relisted here: (1) Preventive medicine; (2) Early diagnosis of asymptomatic disease; (3) Care of acute and chronic illness; (4) Rehabilitation; (5) Care of incurable disease. This does not in any way indicate a recommendation that family practice abandon the present education and present degree of competence in the clinical practice of medicine, pediatrics, surgery, obstetrics-gynecology, and psychiatry. Nor does it indicate any type of specialization that includes only ambulatory care. Certainly good patient management and comprehensive, continuing care could not exist if it stopped at the hospital door. What is suggested is an adjusted emphasis of curriculum and clinical practice to meet the needs of patients and to provide a major contribution to total health care. Such a realignment of emphasis will make it much easier to understand and to encourage the proper use of allied health-care personnel in family medicine. This will be covered in more detail a little further on in this discussion.

Preventive Medicine

For several years those who have been concerned about health-care costs have been advocating keeping people well. Certainly prevention does have economic considerations but economics is not within the purview of this paper. Here the concern is to look at the place of preventive medicine in family practice. It should be pointed out that a great deal of preventive medicine can be and is performed in family practice as a natural consequence of many office visits. Knowledge of the patient's heredity, his or her home and working environment, life-style, and temperament together with casual questions and advice performed at each visit can, over a period of time, constitute a great deal of preventive medicine. The physician, however, should be trained in this area of medicine and should make it a natural and routine part of his/her practice. All procedures in preventive medicine cannot be a casual part of each office visit and some must be carefully performed by intent. A partial list is found in Table 1, and it may be noted that in the well-organized practice a great deal of preventive medicine can very effectively be done by the nurse practitioner as a part of family practice. A sizeable portion of preventive medicine is patient education and the nurse is exceedingly good in this area. The importance of prevention must be emphasized to patients, although some individuals will not be interested in doing anything about their health until they become ill. Many of these people can be reached by a good prospective medicine program and by pointing out to them their risk factors.

Early Detection of Asymptomatic Disease

This area (Table 2) is much neglected in health care. The neglect has come about not by intent on the part of the practicing physician but through a multiplicity of factors. These include busy physicians who are thoroughly involved in delivering quality health care in their area of specialization not having the time to keep up with rapid social and scientific changes for which they are in part responsible. A very sophisticated group of aides in diagnosis of symptomatic disease are now available, many of which are procedures and techniques unheard of a decade ago. Still, there has been very little real activity or thought directed toward using certain of these sophisticated procedures in diagnosing asymptomatic disease. Here is a very fertile field of research for family practice. For instance the annual physical examination has been much maligned as a useless, expensive exercise in futility, but none of the critics have brought forth any better method of early detection of asymptomatic disease based on good scientific data. At this time, until there is more positive knowledge concerning etiology and prevention, early detection offers the only definite hope for increasing the percentage of cures in cancer. If for no other reason (and there are many more), emphasis on education and application in this one area lends humanistic, scientific, and economic reason for the existence of

the specialty of family medicine. With the erradication of cancer, should this occur, many other challenges in this area exist. Suffice it to say that even though, at this point, it is the most poorly defined parameter in family practice, it is one of the most important and should be emphasized in every training program. The federal health-care establishment in the United States should enhance its reputation for benevolence in research by providing adequate monies for investigation in early detection. It is within the realm of possibility that success in this area might make funds spent further down the road unnecessary.

The Care of Acute and Chronic Disease

Very little needs to be said here about this parameter of family practice (Table 3). Here all of medicine has spent the major portion of its interest and its energies for centuries and there is very little likelihood that there will be a sudden or complete change of direction. Most people seem accustomed to demanding or seeking the services of the physician only when they are ill, not realizing that the major etiological forces responsible for their miseries are to be found in their environment, diet, life-styles, and a total ignorance of or unconcern about what constitutes good health. Genetic factors have intentionally been omitted from the above because one really has no choice in selecting his grandparents.

Consequently this parameter will continue to occupy a major portion of the family practice academic curriculum and clinical practice. However, if family practice is to meet its real potential, fulfill its obligations to society, and avoid head-on conflict with other specialties (in which only the profession would be the loser), then family medicine should begin to place more emphasis on its other parameters. Good patient management makes it mandatory, however, that the family physician remain active in this parameter within certain spheres of competence. The degree of competence which each trainee develops depends upon his interest, ability, and site of future practice. Combined with the skills in patient management and the other parameters of family medicine there should be no conflict with any other specialty but rather all should complement one another.

Table 3. Care of Acute and Chronic Disease and Problems

Illness, Behavioral and Environmental Difficulties
1. Internal Medicine
2. Surgery
3. Pediatrics
4. Obstetrics-Gynecology
5. Psychiatry

Table 4. Rehabilitation

*a.	Stroke
*b.	Myocardial Infarction
*c.	Post-operative
*d.	Post-traumatic
*e.	Arthritis
*f.	Diabetic Complications
*g.	Debilitation from Neurologic Ailments
*h.	Congenital Deformities

Table 5. Care of Incurable Disease and the Dying

*a.	Cancer
*b.	Far Advanced Chronic Obstructive Pulmonary Disease
*c.	Certain Neurologic Diseases
*d.	Congenital Diseases
*e.	Incomplete Recovery from Stroke
*f.	"The Cardiac Patient"

Rehabilitation

The term rehabilitation has developed a much broader meaning in the past 20 to 30 years as exemplified in Table 4. No longer does rehabilitation include only therapy after stroke, trauma, or operation, but rather includes treatment after a multiplicity of illnesses and ailments from which maximum recovery can be expected if that recovery is carefully and properly supervised with the cooperation of the patient.

Although in many instances the rehabilitation process may be started by the subspecialists or practitioners of another specialty, such as in the case of a severe stroke or an extensive, life-threatening myocardial infarction, still, in most instances, the final responsibility for maximum rehabilitation rests with the patient and the family physician. One could describe many instances where rehabilitation to a more useful and productive life could have been accomplished had someone interested and adept at that skill been conveniently available to the patient.

This in no way is meant to minimize the importance of the specialist in physical medicine, orthopedic surgery, cardiology, rheumatology, etc, but the majority of patients do not have these experts available in their home environment where rehabilitation must really occur. Therefore in any health-care system, rehabilitation must be included as a parameter of family medicine and should represent a cooperative endeavor involving the consultant, the family physician, the physical therapist, the occupational therapist, the speech therapist, and the nurse practitioner. In most of the smaller communities the physical therapist must perform double duty in occupational therapy, and very often the school speech therapist works with the family physician in rehabilitation. In many instances the social service worker is an important adjunct to the team.

Care of the Patient with Incurable Disease

Incurable disease (Table 5) means many things but most think of cancer

first of all and the numerous decisions that must be made along the road to getting well or leading to an untimely death. These decisions are made more difficult and complicated by the fact that there are so many uncertainties relating to response and there is frequent disagreement even among those who are experts in the field of cancer therapy. Surgery, irradiation, or chemotherapy – the family physician, who is the health-care provider closest to the patient, must be prepared to participate intellectually, professionally, ethically, and morally in decisions that must be made. And if all treatment fails then the family physician must be prepared to help his patient through pain, fear, and uncertainty without becoming too emotionally involved himself.

Incurable disease must also include certain neurologic diseases which are slowly progressive and which require special kinds of encouragement and care.

The patient on renal dialysis or the individual left crippled by a stroke are only two more examples of this parameter of family practice. One could mention many more, but let it be said at this point that, for the young physician to perform properly in this area, he/she needs special training and experience.

Allied Health-Care Personnel

Using the patient management base for family practice and the parameters listed in Tables 1 to 5 it is much easier to visualize the roles various allied health-care personnel can play in clinical family practice and consequently in a training program.

One of the difficulties which has been encountered in the past is the tendency to think of family practice as internal medicine, pediatrics, surgery, obstetrics-gynecology, and psychiatry being applied to the family in a continuing and comprehensive fashion. In this context it is difficult to decide how to use allied health-care personnel in one's practice, where they would fit, and how much they legally should be allowed or encouraged to do.

When one thinks of family practice in terms of the parameters, it becomes quite easy to assign allied health-care personnel to various areas in a logical fashion. In Tables 1, 4, and 5, asterisks have been placed before many of the components which could be assigned to allied health-care personnel. This constitutes only a partial list and does not include any assignments from parameter 3, from which several procedures and skills could be included. This would certainly be a fertile area for research and constructive thought.

Consultants

Consultants are those individuals in a family physician's practice who, because of their specialty or subspecialty, possess knowledge and skills outside a particular family physician's competence. In a well-organized and functioning family practice in which there exists good patient management there must be an excellent relationship between the physician and his consultants. There must be mutual understanding, respect, and free communication. There should be no unmentionable subjects, no biases. The physician should respect the consultant's skills in his field and the consultant should recognize the family physician as an expert in patient management and as an individual who knows his areas of competence. How fortunate those patients are who enjoy the care of such a combination! Figure 1 indicates that the consultations may occur in any of the parameters of family practice.

Comment

This paper has provided a brief look at family medicine as an academic discipline and family practice as a special clinical entity. It has been emphasized that patient management is the sine qua non of every family physician. Patient management involves every member of the family. Any physician who claims the distinction of "Family Physician" must be prepared and willing to accept the unwritten contract of responsibility for the health care of any patient entering his/her office. No other specialty fits this mold; if it does, then it is family practice.

The family physician must have a good base in the biomedical and behavioral sciences because of the nature and variety of problems with which he must deal. Many problems presented in the office of the family physician are not well described in the medical literature, if they are there at all. Consequently, the physician must have as broad a base as possible to correctly approach many diagnoses in a logical fashion and to apply proper and reasonable therapeutic measures. Simply put, many problems seen in the family physician's office are not in the book and one must have a scientific base by which to apply common horse sense. No member of the allied health-care field should attempt solo practice in primary care. The lack of a firm and adequate foundation in the basic sciences makes it impossible for one in that field to cope with the great variability of problems to be faced each day. Those who believe otherwise simply have had no experience in primary care. The nurse practitioner, however, who is trained to handle specific situations, is an invaluable adjunct to family practice.

A thorough grasp of the scope of family medicine with its intellectual and academic base in patient management, its roots in the biomedical and behavioral sciences, and the parameters it encompasses, together with the incorporation of allied health-care personnel and the proper use of consultants in each of those parameters, makes a major contribution to the family practice training program and excellent patient care. The concepts involved lead to a solid curriculum, proper and useful conferences and seminars, and finally an easy and valid system of resident evaluation. Increased emphasis on total patient management and all of the parameters of family medicine rather than too much stress on the care of acute and chronic disease will give a much better balanced educational program and will be more likely to make family practice the specialty of the future. There is no intent here to advocate the elimination of acute and chronic problems which are included in the family physician's practice today; rather the intent is to urge the broadening of the scope of training and practice so that this area of medicine will more completely meet the health-care needs of a changing society.

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