Cooperation Between an Academic Subspecialty Department and a Community-Based Family Medicine Department: A Developmental Model

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While new, community-based family practice residency programs desperately need support from sister departments in academic centers, a variety of problems frequently prevents such cooperation. At the University of Wisconsin, Madison, the Department of Human Oncology, which is University Hospital-based, has worked to develop an appropriate educational program in oncology, together with and for the Department of Family Medicine and Practice, which is community-based. This paper, relating how and why these two departments have cooperated in this project, is presented to assist other departments in similar situations.

Throughout the United States, an increasing number of family practice residency programs are preparing medical graduates to become family physicians. Some of these programs are based in hospitals in academic-centers, but many are located in geographically separated community hospitals. While such physically separated and fledgling programs desperately need support from their sister departments and divisions in the academic centers if they are to survive, much less fully achieve their goals, this support is often not volunteered.

There are several reasons for poor relations between academic center-based subspecialty departments and community-based family medicine departments. Academic centers fear that family medicine programs in community hospitals are attracting patients who would otherwise seek care in university hospitals. New family medicine programs in community hospitals have been able to attract and maintain full complements of patients in their teaching practices. However, the relationship between the increase in patients served by one and the decline in those served by the other is not likely to be direct. Rather the increased numbers of community-based specialists, together with the increased availability of sophisticated diagnostic and therapeutic resources in community hospitals, are probably more important factors in the decreasing numbers of patients coming to university hospitals. The growth of family medicine teaching practices, on the other hand, has been aided by the public's renewed interest in having a personal family physician, at a time when the number of private general practitioners is steadily

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declining. Even in the face of such arguments, some physicians in academic centers believe that family medicine is treading on their "patient turf."[1]

There are other attitudes which characterize this variation of town-gown animosity. Some in the established specialties may look upon family medicine as an academic discipline without an intellectual base, without a peculiar collection of knowledge;[2] furthermore, some may see family physicians as carrying their antispecialist feelings too far in practice, to the detriment of patients' care.[3] On their side, family physicians may see the other primary care specialties of internal medicine and pediatrics as ignoring comprehensive care, and particularly as unwilling to provide continuing care for their patients in times of health as well as sickness. Family medicine spokesmen have emphasized the important of behavioral science skills for their specialty practice, contending that the other specialty graduates have often been judged somewhat insensitive to the total needs of individuals and their families.[4]

Unfortunately, all such attitudes have interfered with the development of what can clearly be mutually beneficial relationships between academic medical center subspecialty and community-based family medicine departments. Obviously there is much common ground in the goals of medical academic departments, primary care or otherwise, university hospital-based or community-based. The purpose of this paper is to describe how one busy university hospital-based subspecialty department has started to develop a cooperative relationship with a model teaching program for a community-based family medicine department, to the prospective short and long-term mutual benefit of both departments.

Family Medicine—Oncology Interaction at the University of Wisconsin

The Department of Family Medicine and Practice at the University of Wisconsin was begun in 1971, based in a community hospital about 1 1/2 miles from the University Hospitals, which are the main facility for the medical school subspecialty departments, including oncology. The family medicine program graduated its first group of family physicians in 1973; by 1976 the program had become statewide with affiliated programs in three other cities; and in 1977 there will be 14 graduates most of whom plan to practice in the state. There are plans for two additional affiliated programs, and by 1980 the statewide programs are projected to have 34 to 40 graduates a year.

During this period of rapid growth in teaching responsibilities, the faculty in the family practice residency programs have been assisted principally by individuals in various subspecialties, usually physicians in practice in the same community hospitals. Academic subspecialty departments (including oncology) have arranged "rotations" for family practice residents but these have not taken place in the family medicine environment, have involved teaching about patient problems family practice residents are unlikely ever to see again, and often have been judged not worthwhile by the residents who have participated in them.

In 1976 the Departments of Human Oncology and Family Medicine and Practice began discussions about mutual interests and responsibilities in an effort to find ways of assisting each other. In considering the provision of optimal care in cancer medicine to the population in the region, it was mutually agreed that the most efficient way to achieve this common, long-term goal would be by teaching basic oncology to prospective primary care physicians in the region before they begin practice. The residency-training period of family physicians is one critical time during which habits are developed in caring for patients with cancer and of practice in the prevention and early diagnosis of cancer.

The Department of Oncology recognized that active involvement in the teaching of family practice residents could bring more patient referrals to the Department of Oncology from these physicians when they subsequently went into practice in the region; however the department did not see this possible result as the goal of such involvement. Further, the Department of Oncology saw the Department of Family Medicine neither in terms of a teaching resource for medical students or fellows nor as a clinical laboratory where studies in clinical oncology might be done. Finally,

the Department of Oncology appreciated the delicacy of the situation, the importance of interdepartmental ties, and the need for a thoughtful approach to developing a sound program in cancer medicine for the family practice residents.

For the Department of Oncology, a faculty who were extended to their limits in teaching, patient care, and other time commitments, the means for developing a program came when a fellowship applicant expressed an interest in such work. The prospective fellow was interviewed by the Department of Family Medicine.

The oncology fellow had a background typical of physicians who are currently trained in the medical subspecialties: medical internship, medical residency, and some previous fellowship training. Specifically, he had no personal experience with family medicine or family physicians. The specialty of family medicine had been developing during his postgraduate training years, so that he could have very little idea of what spokesmen for this specialty considered to be the essential knowledge, skills, and attitudes for physicians training in this discipline. The relationships among primary care, community medicine, preventive medicine, family medicine, family practice, and general practice were, to him, confused and unclear. The oncology fellow sought out recent articles about the specialty of family medicine,[4-11]* about the kinds of problems family physicians see in practice,[12-17] and about the areas of conflict with other specialties.[1] This literature suggested that in initiating contacts with the Department of Family Medicine for the purpose of designing an oncology program for its residents, it was important to:

1. meet the residents and faculty of the Department of Family Medicine in their own environment and strongly consider that any program planned be conducted in family medicine clinics and hospitals;
2. state the purpose for visiting the Department of Family Medicine solely in terms of how the Department of Oncology could help; and
3. be cognizant of the feelings of family medicine faculty and residents as relative newcomers in the academic family.

Over a three-month period, the oncology fellow went to the community hospitals and clinics of the family medicine program, seeking the advice of members of the family medicine and oncology faculties concerning the content and methods of a teaching program in oncology and asking about materials or papers on family medicine. In particular, he sought any teaching materials or papers that the family medicine faculty members themselves had written. He visited the teaching rounds repeatedly. He conferred with members of other departments who were working closely and successfully with the Department of Family Medicine.

In time it became clear that an oncology program suitable for the needs of residents in family medicine would have to be specially designed, emphasizing prevention and early diagnosis of cancer, and presented by methods other than periodic lectures. The specific aims of the program were defined as follows:

Residents will be taught to take active measures:

1.0 To prevent cancer in their patients by:
  - 1.1 looking for and recognizing risk factors for cancer in their patients, and
  - 1.2 reducing or eliminating risk factors for cancer found in their patients.

2.0 To ensure early diagnosis of cancer in their patients by:
  - 2.1 influencing their patients to behave so that cancers can be diagnosed at early stages, and
  - 2.2 looking for and recognizing early cancer in their patients.

3.0 To render effective continuing and rehabilitative care to patients with cancer and their families.

While writing the drafts of a detailed program proposal, the oncology fellow continued to seek input from residents and faculty. A final formal proposal for oncology teaching in the family medicine program contained objectives for knowledge, skills, and attitudes cognizant of the real life needs of family physicians, and methods for achieving those objectives compatible with implementation in the existing family medicine curriculum struc-

*College of Family Physicians of Canada: Canadian Family Medicine-Educational Objectives for Certification of Family Medicine. Willowdale, Ontario, College of Family Physicians of Canada, 1974, unpublished.

ture and teaching forums. The proposal was reviewed and enthusiastically supported by the curriculum committee, and by resident and faculty members of the Department of Family Medicine.

Discussion

The Departments of Human Oncology and Family Medicine and Practice at the University of Wisconsin have developed a mutually satisfying relationship between two departments usually on opposite sides of a community-university center, town-gown polarization. The following elements were important to this success:

1. the departments identified a common, long-term goal;
2. the purposes for working together were openly stated;
3. the Department of Oncology took a deliberately thoughtful and cautious approach, duly considering areas of conflict and suspicion between similar departments; and
4. the Department of Oncology sent its representative to spend a generous amount of time on site in the Department of Family Medicine. This indicated to family medicine physicians genuine interest, concern with special needs of family medicine, and willingness to try to understand what family medicine was all about.

The benefits to family medicine and oncology of the new relationship are several. The Department of Family Medicine gains in becoming more integrated into the medical academic family and in acquiring a subspecialty teaching program designed to meet the special needs of its residents. The Department of Oncology broadens its concerns with diagnosis and treatment of advanced disease to include prevention, early diagnosis, and rehabilitation—aspects of cancer care focused on by family physicians. Oncology benefits from good will aroused by its efforts in teaching family practice residents around the state. Finally, the oncology department will very likely gain long-term benefit from closer working relationships accompanied by an increased number of referrals from practicing family physicians graduating from the program.

It would seem that similar benefits might be enjoyed by other family medicine departments and subspecialty departments, building upon selected elements of this experience. Departments of family medicine need support from their sister departments if they are to create residency programs of high quality, and subspecialty departments need the good will of primary care physicians if they are to fulfill their various missions.

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