Pediatric Training in Family Practice Residencies

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Child health care represents an important and integral part of family practice. In 1975, over 33 million office visits were made to general/family physicians by patients less than 15 years of age in the United States. This figure comprised about 15 percent of office visits in general/family practice in that year.[1] The responsibility for child health care in this country is almost equally shared between general/family practice and pediatrics. Forty percent of all visits made by children and adolescents under 18 years of age to office based physicians during 1975-1976 were to pediatricians, while 34 percent of these visits were to general/family physicians.[2] The annual rates of office visits for patients less than 15 years of age are nearly identical for general/family practice and pediatrics—0.8 and 0.9 visits, respectively (according to Preliminary Data from the National Ambulatory Medical Care Survey, unedited draft, July 15, 1975, p 34).

The current guidelines recommended by the Residency Assistance Program (RAP) for the content and duration of pediatric training in family practice residencies call for a *minimum* of four months of formally structured rotations in general pediatrics in addition to the supervised ongoing care of children in the family practice center (and often family practice service when admitted to the hospital) over the full three years of residency training. These RAP guidelines further recommend that a balance be maintained between ambulatory and inpatient training, and that the following areas be included: (1) newborn care; (2) neonatology (including support and transport of the critically ill neonate); (3) well baby care, growth and development, and nutrition; (4) infectious disease; (5) allergy and immunology; (6) behavioral problems; (7) learning disabilities; (8) childhood illness; and (9) adolescent care.[3]

Two papers in this issue of *The Journal* represent the first formal national studies of the adequacy of pediatric training in family practice residencies. Rabinowitz and Hervada surveyed all 236 US family practice residency programs which had graduated residents by July 1978. Based on an 82 percent response rate, they found that the main duration of pediatric training was 9 months, in-

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cluding 5.6 months on pediatric rotations (inpatient 3.9 months and outpatient 1.7 months) plus an additional 3.4 "pediatric equivalent months" in the family practice center.[4] In a second paper, addressing the area of school health, Collins and Graham surveyed 63 family practice and 125 pediatric residency programs, all based in university medical centers. Based on response rates of 81 percent and 76 percent for these two fields respectively, they analyzed specific areas of teaching, and found common strengths and weaknesses in both fields, as well as certain gap areas particular to each field. In family practice, for example, gaps were noted in such areas as management of the hyperactive child and school problems of the physically handicapped child.[5]

Additional information relating to the adequacy of pediatric training in US family practice residencies is provided by some graduate follow-up studies which have just been published. Graduates of the family practice residencies in the statewide networks of the University of Minnesota and the University of Washington, for example, felt adequately prepared in the areas of newborn care, well baby and child development, and acute and chronic childhood illnesses, but many feel underprepared in the areas of developmental disorders and learning problems of childhood.[6,7]

These studies are helpful and timely in beginning to assess the adequacy of pediatric training in family practice residencies and also in pointing the way for further evaluation of this important area. Still needed are concerted efforts along four related lines: (1) more specific comparison of the spectrum of existing pediatric training with the RAP guidelines; (2) development of additional teaching strategies to meet identified learning needs; (3) more effective evaluation of resident performance in selected competency areas (eg, resuscitation of the newborn); and quality of care assessment within family practice residencies and in the community practices of their graduates.

References

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