Family Practice Forum

Training Gaps in the Family Practice Center

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As an evolving specialty with a strong emphasis on comprehensive care, family practice is rapidly establishing itself in all patient care arenas: hospital, office, home, and chronic care facility. Each of these four sites poses a unique set of rewards, challenges, and pitfalls.

Because of its direct relationship with other specialties, the hospital is often the site of conflict, as evidenced most dramatically by controversy over hospital privileges. However, as reflected by the recent American Academy of Family Physicians (AAFP) national survey reported in *The Journal of Family Practice*,[1] family physicians are successfully acquiring appropriate hospital privileges. In fact, 95 percent of the family physicians surveyed by Clinton et al[1] had privileges they had requested and felt satisfied with their hospital privileges. These favorable circumstances resulted from a clear recognition of the importance of hospital privileges and the vigorous efforts made to secure them.[2]

Based on the desire for continued success in the area of hospital privileges, family practice residency programs have designed specific educational objectives, sought out and obtained appropriate training, carefully documented this training for each resident, supported residency graduates in their efforts to gain desired hospital privileges, and looked toward organized family medicine for support and direction. The AAFP survey clearly demonstrates the utility of this approach. A significantly higher percentage of the younger physicians (39 years or younger) than older physicians performed routine obstetrical care, complicated deliveries, high-risk obstetrics, surgical assisting, newborn care, intensive care, coronary care, treatment of fractures, and psychotherapy/counseling. What about effectiveness in the other three arenas?

Another study by Fischer et al[3] in the same issue of *The Journal of Family Practice* addresses one aspect of this question. Results of their national survey of office laboratory teaching in family practice residency programs contrasts sharply with the results of the AAFP study. The meticulous planning and attention to detail so essential to achieving hospital privileges are not widely apparent in teaching strategies for office laboratory. The great majority of family practice residency programs had no formal teaching in this area, and many lacked basic laboratory equipment in their model practice units. Even though the Residency Assistance Program recommends a laboratory medicine curriculum in each residency,[4] only 15 percent had such a curriculum in place. Address-

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ing this same issue of medical education in the ambulatory setting, a recent study in Connecticut[5] evaluated electrocardiographic interpretation among primary care residents. When presented with electrocardiograms generated in a model practice unit, both internal medicine and family medicine residents failed to correctly interpret many of the tracings. All residents in the study had formal conferences in electrocardiography and read tracings with cardiologists daily during their cardiology rotation. Their training was intensive but had not been geared specifically to include educational objectives for ambulatory based electrocardiography. In fact, a published family practice curriculum in electrocardiography[6] fails to include many tracings that represent the ambulatory component of electrocardiography.

Although office laboratory and electrocardiography are two specific examples, other questions about education in the model practice unit arise immediately. Can residents properly use a head mirror or light in the model practice unit to examine a patient's pharynx and vocal cords? Can residents correctly interpret audiograms or know when their office spirometer is malfunctioning? Do they know how to appropriately teach and then delegate many of the common office procedures (eg, Schiøtz tonometry for glaucoma testing) to their office assistants?[7] Can residents accurately evaluate and appropriately manage a family in crisis presenting to them in the model practice unit?

Ambulatory medical education in the model practice unit is a well-accepted priority in family practice residency training.[8] What are the possible explanations for this contradiction of better performance in the hospital arena than the ambulatory arena? Certainly the importance of hospital privileges for family physicians cannot be underrated; with hospital privileges comes recognition and status among medical colleagues. Traditionally, medical care and ambulatory medical education have stressed hospital care.[9] Ambulatory care was regarded as drudgery. Although medical education in the ambulatory setting now enjoys high priority,[10] status equal to hospital-based education is yet to come. Now that family physicians are succeeding in the higher status hospital arena, will family practice educators focus more energy on specific educational objectives for model practice units? Greater precision in teaching ambulatory care should promote more pride in this vital component of family practice education.

Based on the previously discussed strategies used to gain hospital privileges, the formula for more rigorous medical education is clear. Greater attention to general goals and specific educational objectives for the model unit will generate a number of educational experiences aimed at achieving these goals.

Will family practice educators pursue this perceived need? If Fischer et al[3] repeat their survey in three years, will more residency programs have office laboratory curricula in operation? Furthermore, hospital privileges are granted on the basis of observed clinical performance; providing an intensive curriculum in office laboratory will not necessarily result in improved performance in actual patient care.[11,12] Family medicine educators thus need to make sure that residents not only understand the details of office laboratories (ie, cognitive knowledge), but that they also use this information correctly in caring for their patients (ie, clinical performance) in the model practice unit. Success in making the model practice unit truly a model for ambulatory medical education will require the same thought, meticulous planning, and attention to detail so visible in the efforts to establish hospital privileges.

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