
Family Practice Forum

Academic Credibility: Can Your Department of Family Medicine Meet the Challenge?

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In May of 1983 I met with the Society of Teachers of Family Medicine and presented a paper entitled "The Absolute Truth and Other Uncertainties." I would like to quote from it the following paragraph, which I think is relevant to the topic discussed in this paper.

"The title of this talk may sound facetious but it really is not intended to be. The absolute truth, of course, is that family medicine is now a card-carrying, dues-paying member of the academic medical establishment. The uncertainties revolve around two questions—Will family medicine be

able to retain its full membership in academe? And if so, what strategies must it employ to be certain that it remains there?"

The answer to the first question, "Will family medicine be able to retain its full membership in academe?" is a qualified "yes"—qualified only because the phrase "card-carrying, dues-paying member" of the academic establishment does not automatically carry with it academic credibility. Academic credibility is dependent upon acceptance into that fraternity of academic disciplines in which outstanding patient care may or may not be a part, but in which high-quality education and research are always a part. I know personally of no departments of family medicine that have yet achieved this acceptance, although there may well be some.

Two issues are raised by this first question. First, why is academic credibility important for family medicine? After all, most family physicians' primary interest is in providing patient care, and academic credibility has little to do with that.

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However, academic credibility has a great deal to do with something that is crucial to the future of family medicine: full acceptance into the academic community. That acceptance, in turn, will enhance the recruitment of sufficient numbers of outstanding medical students into the discipline. Although some good family physicians will always be recruited from other specialties, the most sought-after recruits will be graduates coming directly from medical schools. It is in US medical schools that academic credibility will enable family medicine to become a respected peer among the other specialties, a specialty viewed with respect and admiration by academicians and the public, and representing a discipline that the best students will enter with pride.

The second issue is that although clinical skills are not integral to academic credibility, the acceptance of departments of family medicine by other departments in a medical school is greatly enhanced by the opportunity for family practice faculty and staff and their residents to demonstrate their clinical skills to fellow faculty members and to nurses, house staff, and students. This opportunity is possible only when a department of family medicine has a reasonable number of beds in the main teaching hospital of the medical school, wherein the department can be openly observed and judged for its quality of patient care, for its appropriate requests for consultants, and for its thoughtful use of pathology and radiology services.

Of course, to some extent this type of desirable exposure can be obtained in the outpatient clinics of the school's primary teaching hospital. The impact of such visibility in those settings, however, is less, except in the emergency room, where the family physician can be a splendid role model.

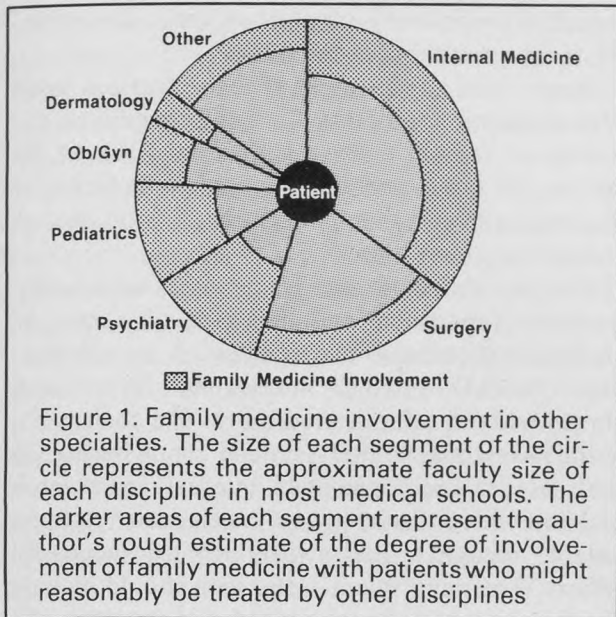
Now back to the second question raised in May, "What strategies must family medicine employ to retain its full membership in academe?" My answer centered then, and it does now, on whether departments of family medicine will be able to establish the quality of teaching and research programs necessary to develop and maintain academic credibility. We will look in a moment at possible strategies concerning these programs for family medicine, but first some background observations on academe and academicians.

In universities most scholarly activities, in undergraduate areas at least, are based primarily on the general, not the specific, and on concepts

rather than actions. Academicians are believed to be contemplative and thoughtful, or at least they like to appear as such. As stated by Dudley,¹ however, "Everyone who sits on university or medical school committees knows the academic mind has a demoniacally destructive ability to see five facets of a four-sided problem simultaneously." Enright² sees the matter in much the same way when he writes, "Academics customarily possess such a gift for subtle reasoning and fine distinction, such exquisite professional scrupulosity and verbal dexterity that even an intelligent and shrewd observer may fail to perceive that much of the time their basic motive is simple cynicism and self-interest." He then goes on to say, "If you are in trouble, throw yourself on the mercy of the nearest peasant, publican, or policeman but never go to an academic—you will be dead long before he is finished formulating his attitude towards you and your problem."

His comments may be partly tongue in cheek, but even so there is truth there, and at bottom is the fact that academicians are notoriously reluctant to accept change. Since the inclusion of family medicine in academe is perceived as a change, the first task will be to look more closely at universities and the academic world to determine how family medicine may proceed in order to storm its bastions.

Universities, as known today, did not come into being in reasonable numbers in the United States until the mid-19th century. As a result, most medical instruction, until very near the 20th century, was carried out in fly-by-night, for-profit medical schools that had no connection with universities or colleges and certainly had no scholarly or scientific atmosphere. It was not until the 1870s that Charles Eliot, at Harvard, insisted that a university's standards of excellence could be met in medical schools, and only then did there begin the rise in medical schools of what Greene³ has defined as "professionalism"; this quality, he says, is "found in individuals who by virtue of advanced standing and training have become experts in a field, who combine their expert knowledge with investigation for the generation of new knowledge, and pass on to others their knowledge through teaching." Thus were the beginnings of that creature today recognized as an academician. But it was really not until after the Flexner Report⁴ in 1910 that "medical education became for the first time a form of uni-



world of fields such as genetics and molecular biology lends hope to family medicine, as they also are horizontal disciplines that have blurred specialty boundaries. It is hoped family medicine will move faster into academe than did anesthesiology, which did not appear as a specialty until the 1950s.

The acquisition of high-quality faculty is essential to gaining academic credibility for any department. University academicians are, or should be, appointed because they have shown evidence of significant ability in teaching or research or preferably both; they should not be appointed for administrative ability, clinical skills, or political connections. Further, there is a third and most desirable qualification that good academicians should possess beyond their skills in teaching and research—a state of mind characterized by a spirit of inquiry, innovation, creativity, and independence. This quality of mind is essential to stimulating scholarship in students. If the lessons of scientific thought—hypothesis, experimentation, observation, and deduction—are not clearly demonstrated to students, they may never come to appreciate, indeed may never understand, the degree to which science is involved in the practice of medicine. In a world in which science and technology are moving so rapidly, a student must be well versed in the scientific method to remain a lifetime learner.

Having looked briefly at academe, academicians, and academic credibility, it is now time to ask whether family medicine, which we recognize as medicine's newest specialty, is really an academic discipline and, therefore, in a position to develop academic credibility. Does family medicine really represent an identifiable body of knowledge, the study of which can be referred to as an intellectual discipline? If so, then it belongs among the university's community of scholars. Or, is family medicine an important clinical activity, but really a specialty with a minor academic role, a discipline more concerned with patient care than with the generation and teaching of scientific knowledge?

Various authors^{5,6} have proposed that family medicine does have an identifiable body of knowledge, that it has methods of teaching that are dictated by this knowledge, and that the development of this knowledge requires active research. These characteristics, if achieved, would certainly qualify family medicine as an academic discipline.

versity education with scientific and research focus."³

Nevertheless, most universities lingered well into the 20th century before encouraging academic or scholarly programs in medical schools, and even then certain disciplines, notably anesthesiology and dermatology, lagged substantially behind the others because they were thought to have little scientific basis. The slow development of anesthesiology as an academic discipline is of particular interest because this slow acceptance was partly due to anesthesiology being, as is family medicine, a discipline that crosses the classical boundaries of several disciplines such as internal medicine, obstetrics, pediatrics, and surgery (Figure 1). Universities and medical schools were not accustomed to thinking in terms of disciplines that cut across traditional boundaries, in either clinical or basic science departments. Pharmacology is another good example of a transdepartmental discipline in the basic sciences. Therefore, overcoming this traditionalism is certainly a factor that will have to be kept in mind when the speed with which family medicine can reasonably expect to join the rest of the so-called intellectual disciplines is assessed. The recent acceptance into the academic

However, once again, remember that both dermatology and anesthesiology had essentially these same characteristics going for them 30 years ago, but neither achieved academic credibility until many years later, when their research programs began to receive national recognition. Dermatology and anesthesiology were helped in their development by acquiring departmental status and independent boards, and now family medicine has both of these. But its research programs are still in early stages of development.

So, in response to the question "Does family medicine have academic credibility?" my answer would be no, for four reasons: First, few family medicine research programs are really productive at present, although in the specialty's brief 15 years of existence, development of a host of significant investigative programs could hardly be expected.

Second, because of strong legislative encouragement or mandate, family medicine arrived in most medical schools with at least one and, in many instances, two political parents, and the academic community has traditionally looked upon such heritage with considerable skepticism.

Third, approximately 80 percent of family medicine residency programs are located in community hospitals. The teaching of clinical skills in these hospitals may be superb, but most of the programs lack academic credibility because research projects are relatively few, and there is rarely opportunity for contact with basic scientists. If state societies of family medicine insist that they, rather than medical schools, control family medicine educational programs in community hospital settings, then there are grave doubts that family medicine will ever achieve academic credibility. The specialty will certainly not attract to its ranks the best of the graduating medical students. For this reason it is crucial that medical schools and state societies cooperate closely on high-quality educational and research programs, putting aside battles for "turf" and prestige.

The fourth reason family medicine departments have yet to realize academic credibility is that most medical school departments of family medicine are still small and lack the critical numbers of faculty and residents needed to provide the intellectual excitement and cross-fertilization of ideas so essential to developing research programs. This smallness also means that faculty time is swal-

lowed up by patient care and teaching, leaving little, if any, time for investigation.

Now, does all this mean that the battle is lost? Will academic credibility for family medicine departments remain forever just beyond reach? Of course not, but to achieve it will take much careful planning, some political pressures, a good deal of cooperation, and time.

The planning must take place within each family medicine department and should involve most or all faculty members. The acquisition by a department of a PhD or two as "hired guns" for research simply will not achieve credibility. The chairman's enthusiasm is absolutely crucial for inspiring, in both faculty and house staff, interests in research and innovative teaching, and the chairman must be able to recognize and swiftly reward successful efforts. The department's planning should include careful thought as to which areas of research will be most appropriate, according to the size and composition of each individual department. It would be presumptuous to suggest any such areas; but, since form follows function, cooperative research programs with epidemiologists, sociologists, anthropologists, psychologists, and even historians and futurists might well mesh with family medicine's orientation to the family unit and to office and community practices. In many localities family medicine has been given not only the practices, but also the clinical research opportunities of general internal medicine, for, as internal medicine departments have subspecialized, they have relinquished many of their generalist functions. Family medicine must take advantage of these opportunities.

The planning process must also take into account the difficulties of starting significant research programs in a calculated, premeditated fashion in departments without previous investigative experience—in other words, without the slow evolutionary process that has characterized the development of research in other fields. This prospect may be formidable, indeed frightening, to many departments in which space and funding for research do not exist, and for which the administration may feel little enthusiasm.

I can only encourage you to plunge into these icy waters, because I am convinced that there are many research areas to which family medicine can contribute substantially, and even uniquely. As an example, family physicians see disease developing

in its earliest stages and therefore have the unique opportunity to observe and study emotional problems, hypertension, malignancies, and other illnesses at a time and in populations not ordinarily available to other disciplines.

Political pressures will be needed to get the necessary visibility and funds to enlarge departments of family medicine. Such an increase in size will enable departments to achieve that essential critical mass, or numbers, of faculty and house staff needed to stimulate research efforts. Most departments of family medicine already have strong political support, and now is the time to capitalize on it, because future medical schools are unlikely to have sufficient state or university funding for extra faculty positions for family medicine or, indeed, for any department. Consequently, political urgings should be external to the school and, therefore, directed at governors and legislators. In some states, it is heretical merely to think of separate line-item budgets, but I firmly believe that where possible, state dollars, whether going to a private or a state medical school, should be specifically line-itemed to family medicine departments so that these funds cannot be subverted for other purposes. On the side of family medicine certainly, in dealing with politicians, is the fact that important discoveries in this discipline's fields of research are more readily understandable to them than are discoveries concerning thymectomized mice or monoclonal antibodies.

It is in the acquisition of these state dollars that the cooperation of family medicine state societies will be of the utmost importance. They, too, must come to understand that strong medical school departments of family medicine are essential to the growth and prosperity of the practice of family medicine throughout the state.

Time, of course, is needed for all the foregoing activities to evolve, and time, in this sense, is a strategy to be managed. Remember that it took dermatology and anesthesiology 20 to 25 years to achieve any sort of academic credibility. Since family medicine already has on track many educational programs of high quality, attention now should be concentrated on the development of research programs that will generate new knowledge in those areas of practice that either are unique to family medicine or are best done by family physicians. Each departmental chairman, representing the leadership of family medicine, must decide,

and soon, on what these specific research programs should be, and where various sources of funding will most likely be found in order to implement them.

As the discipline of family medicine matures, keep in mind that in response to societal changes, the objectives of medical education are also changing, and these in turn are causing changes in the objectives of medical research. Research objectives are changing in two ways: first, basic biomedical research is becoming increasingly disease oriented; and second, there is now a much greater emphasis on research outside the laboratory, for example, in health-care delivery systems, in disease prevention, in the economics of health, and in demography and epidemiology. There is urgent need for research in all of these areas, and any of them could be appropriately studied in a department of family medicine. I firmly believe that both these changes will favor the development of productive research programs in family medicine. It is now up to the specialty to take advantage of this favorable climate.

I must not conclude without looking beyond academic credibility toward the bigger picture. The achievement of credibility is absolutely necessary, but the challenge for family medicine goes well beyond proving credibility to academicians. In the next decade family physicians must prove to students and to the public that they are also masters of the art of medicine, the touching, listening, communicating, and giving of encouragement and hope that characterize the elusive talent of so caring for patients and their families as individuals that each person has complete faith and trust in his family physician both as family friend and personal physician.

Sixty years ago an internist who was also a fine scientist recognized this need. Francis Peabody,⁷ in 1923, wrote with remarkable foresight,

In the light of the development of modern medicine, is the general practitioner an essential factor in preserving and promoting health, or is he a makeshift necessary only in communities too small or too poor to support a competent corps of specialists? Can the public get along without the general practitioner? To those who are in a position to see the helpless floundering of the unfortunates who pass from specialist to specialist the answer is very clear. Never was the sound general practitioner more important than he is today. Never was the public in need of wise, broadly trained advisors so much as it

needs them today to guide them through the complicated maze of modern medicine.

Dr. Peabody concludes his article by saying, "In order to get the best type of medical men to turn to general practice, however, it is necessary for the public to understand that the qualifications for general practice are at least as high as those which are requisite for specialism. . . ."

Why, then, today, 60 years after Dr. Peabody's comments, has the public not gotten this message? In my opinion, it is because family medicine has yet to achieve academic credibility, which, in the profession of medicine, will translate in short order into public credibility and thus public understanding of the true role of the family physician.

Norman Cousins⁸ in 1983 wrote,

Science puts its emphasis on research and verifiable fact. Art and philosophy put the emphasis on creativity and values—values that have something to do with the importance of being human. . . . The science and art of medicine converge at the point where physicians become basically concerned—with the whole of the human condition.

And this, as I see it, is the philosophy upon which family medicine was founded.

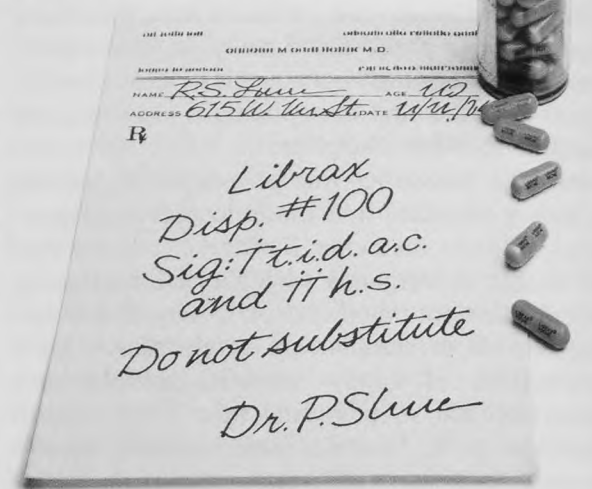
And so, it would seem to me that family medicine has the opportunity to lead all of medicine toward this convergence of science and art; and I have no doubt whatever that as individuals and departments you are more than equal to the task.

References

1. Dudley HAF: Academic surgery: Future uncertain. *Br Med J* 282:1771, 1981
2. Enright DJ: *Memoirs of a Mendicant Professor*. London, Chatto, 1968
3. Greene NM: *Anesthesiology and the University*. Philadelphia, JB Lippincott, 1975
4. Flexner A: *Medical Education in the US and Canada, Report to the Carnegie Foundation for the Advancement of Teaching, Bulletin No. 4*. Boston, Merrymount Press, 1910
5. Marinker M: Should general practice be represented in the university medical school? *Br Med J* 286:855, 1983
6. McWhinney IR: General practice as an academic discipline. Reflections after a visit to the United States. *Lancet* 1:419, 1966
7. Peabody FW: *Doctor and Patient*. New York, Macmillan, 1930
8. Cousins N: *The Healing Heart*. New York, WW Norton, 1983

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