Family Practice Forum

Excellence—The Next Priority in Family Practice

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Two priorities, survival and parity, have dominated the academic and practice worlds of family medicine. To survive in the clinical world, family physicians have had to maintain a practice base, protect hospital privileges, and maintain prestige. Within the academic world, issues such as start-up funding, the development of residency programs, and the achievement of a stable academic niche have been major issues.

Within recent years the priority has shifted from the issue of survival to the question of achieving parity with other disciplines. More substantive penetration into the curriculum was sought and in many cases achieved as family medicine departments increasingly became equal partners with other departments in an overall educational process. In the clinical world, family physicians have stabilized their positions and maintained or increased hospital privileges, and residency graduates have become a respected force in many medical communities as their skills and training have won them recognition.

The specialty is now starting to shift to a third priority, that of excellence within the academic and clinical practice worlds. To be effective in meeting this new goal, family physicians not only must prove in the practice world the meaning of cost effectiveness in the current sense of the term, but must redefine this term more broadly so that it reflects the comprehensiveness of long-term care of families and individuals. Within academia the trend toward conservatism and the new emphasis on rigor present an opportunity for departments of family medicine to set standards for educational excellence in their course offerings. Family medicine should assist medical schools in establishing more rigorous and exacting curricula with better teaching and evaluation while bringing about needed innovation.

Family medicine departments can offer leadership in a number of areas within medical education, areas that will help not just future family physicians, but students in all disciplines. Involvement in medical education should extend to students taking a variety of subjects other than those identified with family medicine, eg, histology, pharmacology, or obstetrics. Just as family physicians in practice should be taking a broad-based look at their patients' problems, so should departments of family medicine within medical schools be taking a broad look at the problems of education, working with all departments and using every available resource to bring about more effective education. In short, departments of family

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medicine should be the "family physicians" for education.

Family medicine can assist in building a new foundation for medical education, especially in the preclinical years, by stressing independent thought, intelligent questioning, and effective self-learning. Adding problem-based learning to existing curricula is one way to effect a change without generating a massive curricular revolution (which would be difficult in many institutions). Perhaps by more subtle means, intellectual spice and missing educational nutrients can be added to an otherwise bland recipe. Where is, after all, "the basic science" in the medical schools? Many facts are taught, but there is little attempt in the more traditional schools to teach students to think critically or scientifically.

Family medicine should take the lead in medical schools in training primary physicians. Note the word "primary" is used here as it was used originally in the Millis report,[1] to define a physician who is the central physician in the care of the patient; primary is not to be synonymous with "primary care" physician. Stephens[2] has alluded to this difference by suggesting that "the quintessence of family practice is patient management." Indeed, there is a broad range of knowledge and skills needed by a primary physician that, for the most part, is not taken seriously by other departments and that should become the center of family medicine educational offerings.

Skills "unique" to family medicine must also be taught. These skills are fewer in number than most would like to think, and probably not necessarily "unique." (Radiology, for example, is not "unique" to radiologists; all sorts of physicians in other specialties take and read roentgenograms as well.) One area does seem to stand out: the provision of care with "horizontal continuity." This continuity, which results from the contact of one physician with many members of a family, allows a physician who is dealing with the follow-up of a child to talk with the mother about how the father is doing on his low-sodium diet for hypertension.

Family medicine can also contribute in terms of attitudes. Perhaps the difference is subtle, but family physicians do not teach entirely about problems. Rather, they teach about patients, who they are, who physicians are in relation to them, and what to do about their problems. Family physician teachers should provide experiences that encourage students to bond with their patients—to experience what Balint[3] has called "the mutual investment company" of patient and physician. Other departments can also be involved in these issues; historically many other departments have been. At this time, however, other specialties do not seem to be inclined in this direction. Family medicine should be. Family physicians are patient oriented clinically and should take advantage of this orientation.

Family medicine should be cautious for two reasons. First, although programs may survive the fire fights of politics and funding cutbacks, they cannot survive without excellence. Second, the family physician is asked to provide everything—excellent research, excellent patient care, excellent teaching of students and residents, excellent administration, and university and community service as well. Related to this is the question of what happens to family medicine if it deserts its grass roots origins. If family physicians cease to be individually, continually, and personally attentive to their patients, residents, and students, what of the future?

Departments of family medicine cannot be content to rest even though many seem to have achieved relatively secure positions within medical schools. As a discipline family medicine has, within less than two decades, risen from its own ashes. To avoid returning, much work remains to be done. A leadership role must be taken despite increasing problems of funding and trends within universities and medical schools that may run counter to the goals of family medicine.

References

1. The Graduate Education of Physicians (Millis JS, chairman). Report of the Citizens Commission on Graduate Medical Education. Chicago, American Medical Association, 1966

2. Stephens GG: The intellectual basis of family practice. J Fam Pract 2:423, 1975

3. Balint M: The Doctor, His Patient and the Illness. New York, International Universities Press, 1953, pp 249-250