



New Skills for the Improvement of Clinical Performance: A Paradigm Shift 1971-2011

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TECHNOLOGY TRANSFER PROJECT

In the USA, there has been a dramatic decline in the number of general physicians. In 1930, over 80% of the physicians in the USA were generalists. By 1960, the percentage was 50% or less. In my opinion, the true percentage today is less than 15 %.

A “generalist physician” predictably provides comprehensive health care unrestricted by age, gender, organ system, and location of service. The term “primary care” was coined in the late 1980’s, and generic primary care does not follow this operational definition. To survive, family medicine will need to do more than primary care.

Traditional physicians cared for children, delivered babies, managed simple fractures, attended the hospital, made occasional house calls, managed an office, and when all else failed, comforted the dying. They went from the nursery to the nursing home, without taking the patient to the poorhouse along the way. As “General Practice” disappeared from the academic environment, there was a corresponding decline in the quantity and quality of the general medical curriculum. Breadth of care in diagnostic and therapeutic skills continued to shrink while technology-assisted procedures grew in various medical and surgical subspecialties.

Since 1983, a group of educators, supported by the American Academy of Family Physicians, has constructed a series of technology-assisted demonstration projects providing modern diagnostic and therapeutic skills for all physicians. Although some viewed this as “proceduralism,” it represented the desire of physicians to remain clinically excellent in pursuit of serving their patients. No amount of psychosocial expertise can overcome the credibility lost when a physician cannot perform basic clinical services on behalf of her or his patient.

By developing continuity of care in the office, in the hospital, and with many procedural services, patients and physicians are better served. A bibliography is presented in the accompanying attachment.

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TECHNOLOGY TRANSFERS
AN ENVIRONMENTAL IMPACT REPORT ON MEDICAL PRACTICE
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I. ASSUMPTIONS

- A. In health care, accurate and early diagnosis is of public value.
- B. Dissemination of diagnostic and therapeutic skill to a broader base of physicians is desirable, if the costs are acceptable. This improves access.
- C. Training resources are limited, costs are significant, and tax support for medical education has been deflected away from the training of generalist physicians in the community.
- D. Technology is quietly transforming the biomedical model and the psychosocial model. A new paradigm is evolving, but political resistance is substantial

II. PREDICTIONS

- A. Some offices will evolve into health centers offering urgent care, preventive care, team care, patient education, counseling, resource management, procedures, and office surgery.
- B. New diagnostic and therapeutic skills will gradually blend the technical power of the hospital with the high touch environment of the office (community health center).
- C. For example, the power of diagnostic imaging will return to the office. Defragmentation of health care will enhance continuity and patient satisfaction.
- D. Digitized images, computerization, and other advances will create electronic information management systems linking offices into efficient primary care research networks. Outcomes will be measured, analyzed, and published.
- E. Health care quality will improve, legal liability will decrease, and health care costs will not increase. Access to health care will be improved.
- F. Parallel health care systems will persist and compete. Without painful reconfiguration, parallel systems of medical education will persist and compete.
- G. The absolute numbers of general physicians will grow slowly. Generic "primary care" will compete with procedurally enhanced generalists for training resources. Comprehensive care physicians (much needed in rural and underserved communities) will constitute less than 10% of practicing physicians until a sustained crisis precipitates change or until economic and technologic events shape evolutionary change.

QUOTE TO REMEMBER

"Everyone is in favor of progress, it's the changes that they don't like." Anonymous.

Source: Mary MacMillan Rodney MD 1882-1968

III. BACKGROUND DATA AND EXAMPLES

- A. Megatrends noted.
1. These and many other techniques take the physician to the bedside of the patient. These skills will enhance the profession's number one tool--**THE BOND OF TRUST AND MUTUAL RESPECT IN THE DOCTOR-PATIENT RELATIONSHIP.**
 2. Other bedside techniques will advance and also create change for the better. Time and space prohibit a complete list.
- B. Primary care endoscopy arrived in the 1980's. Listed below are specific examples. Each procedural skill is followed by the years in which the first and subsequent studies were published.
1. Procedural skills established and accepted in Family Practice
 - a) Flexible Sigmoidoscopy *1982-1989; replaced by colonoscopy*
 - b) Endoscopic Biopsy *1984-1989, A nonissue by 2000*
 - c) ENT Endoscopy *1988-1991; never became popular*
 2. Procedures established, but still contested
 - a) Colonoscopy *1986, 1988, 1992, 1996, 1998,2005*
 - b) Esophagogastroduodenoscopy *1979, 1990, 1992, 1994, 1997, 2005*
 - c) Polypectomy *1991-1996, bundled into colonoscopy*
 - d) Endoscopic Hemostasis *1991-1993, bundled into EGD*
 3. Videoendoscopy transforms the nature of care by blending distinct technologies. Interspecialty boundaries are transformed. *1985, 1986, 1987*
- C. Women's Health Care Emerges as an area requiring special skills.
1. Colposcopy training in Family Practice residencies follows a dissemination curve similar to that of flexible sigmoidoscopy. *1987, 1990, 1994*
 2. Ultrasound improves access to maternal and fetal health care in a community health center. Training pathway for obstetricians and OB-capable family physicians is created. *1988-1992, 1995, 2001,2004-6.*
 3. A structured course in obstetrical emergencies (ALSO) is adopted by the American Academy of Family Physicians in 1993. By 2010, over 70,000 physicians and nurses in 26 countries had been trained.
 4. Cesarean section skills (operative obstetrics). 1995, 1996, 2002, 2004, 2006, 2010
- D. Enhancing family medicine curriculum in maternity (OB) care, emergency medicine, public health, and dentistry in the development of health centers for underserved communities.

“Study the past, diagnose the present, foretell the future, practice these acts. As to disease, make a habit of two things: to cure, or first above all, do no harm.” Hippocrates 460-377 B.C.

IV. REFERENCES**A. ENDOSCOPY AND INFORMATION MANAGEMENT**

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B. WOMEN'S HEALTH CARE CERVICAL CANCER SCREENING/COLPOSCOPY

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F. MISSION HOSPITAL

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V. MISCELLANEOUS RESOURCES

A. Website: www.AAFP.ORG

American Academy of Family Physicians
Phone: 1-800-274-2237

1. **Task Force on Obstetrics, 1989-1995**

Concise bibliography describing the scientific basis for prenatal, perinatal, and postpartum care by family physicians.

2. **Commission on Scope and Quality of Practice** (overview of policies from AMA, JCAHO, HCFA, and other health care agencies).

3. **AAFP Task Force on Procedural Skills, 1993-1995.**

Miscellaneous data and policy.

B. Procedural Skills and Office Technology Bulletin at PSOT.com, Advanced Family Medicine Specialists, Association for Rural and Emergency Medicine; www.psot.com

C. **Wm. MacMillan Rodney, M.D.** Check the internet (www.psot.com), fax 901-754-8119, or e-mail Wmrodney@aol.com.

VI. NEEDED DEFINITIONS AND UNANSWERED QUESTIONS

What is a general practitioner? What is a family physician?

What is a primary care physician? What is a generalist?

What are the educational implications if these terms are used interchangeably?

REFERENCE: HALVORSEN JR. J AM BO FAM PRACT 1999; 12:173-177.

Should society train a better generalist or is this best left to nurse practitioners and physician assistants? See Barondess and Greimeder *JAMA* 2000;284: 2873-4.

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VII. DISCUSSION

- A. Without faith and courage, you will practice no other virtue—Andrew Jackson
- B. The medical specialty that cannot provide its own training, certification, and privileges has been reproductively sterilized.
- C. Has the tree of family medicine been lost in a forest of generic primary care?
- D. Does Family Medicine need to be rebranded to incorporate Surgical Family Medicine Obstetrics?
- E. What is the international equivalent? Spanish example below
 - a. Obstetricia con Medicina Familiar Avanzada
 - b. Especialista Medicoquirurgica
 - c. Desde la maternidad a la ancianidad
 - d. Centro Diagnostico

Your consideration and comments are always appreciated,

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