The case for family practice

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The specialty of family practice evolved in the mid and late 1960s as a result of a perception of health policymakers that the general physician who would provide comprehensive, continuous care, utilizing a multidisciplinary approach, was in short supply. In 1940, 75 percent of all physicians were general practitioners.[1, p. 1272] Following World War II, there was a proliferation of medical knowledge and technology. It became necessary to train physicians to master the new science. The medical schools of America were stimulated to guide their students into new disciplines. The schools were so successful that sometime in the late 1950s it became apparent that the general practitioner was in short supply.[1, pp. 1272-73]

In 1959, the American Medical Association (AMA) Committee on Preparation for General Practice coined the terms *family practice* and *family physician.*[2] Several task forces were created in the 1960s to study the situation and to plan the future of general practice.[3] Working independently, they issued reports calling for a new specialist trained in a unique fashion and called "the family practitioner."[4, p. 104] The AMA suggested that (1) the recognition and status accorded to family practice should be equivalent to that of other medical specialties, (2) a board-certifying organization should be created, (3) the new specialty should be taught in medical schools, and (4) a unique three- to four-year training program following medical school should be instituted.[5]

Since that time, the growth of the new specialty has been exponential. The American Board of Family Practice administered its first certifying examination in 1970, and there are now over 37,000 diplomates of that board.* A mandatory recertification every six years was introduced in a quest for excellence, with the realization that the half-life of medical knowledge was about five years. In order to be a contemporary physician, one found it necessary to dedicate one's life to continuing medical education. A three-year postgraduate training program was crafted. There are now 385 residency training programs in the United States, training close to 7,500 residents in family practice.†

The graduate medical education experience emphasized ambulatory care. The founding fathers of family practice realized that the majority of the time of the family physician was spent in the office. There have been over 29,000 graduates from these programs in the past twenty years,‡ and in 1987 93 percent of them were providing comprehensive and continuous care to American citizens.[1, p. 1275] The graduates of the family practice residency program have addressed the maldistribution of physicians in the rural areas of this country. Over 40 percent of graduates have settled in communities with population under 25,000.† Departments of family practice in the medical schools were created. The presence of family medicine in the medical schools enhanced the concepts of family dynamics, continuity of care, comprehensive care, humanistic care, health maintenance, preventive medicine, life-style changes, and health promotion. There are 120 entities, including departments and divisions, in the 138 medical schools and branches in this country.‡ The American Academy of Family Physicians, the speciality organization of family practice, has reached a membership of over 68,000,§ making it the largest medical specialty organization and the second largest medical organization in the country.

The Society of Teachers of Family Medicine is the academic arm of family practice. The chairmen of the departments of family practice in the medical schools have founded an organization called the Association of Departments of Family Medicine. The American Academy of Family Physician's Foundation is the philanthropic arm. The World Organization of National Colleges and Academies (WONCA) is the global expression of family practice, representing over forty national organizations of family practice around the world.

The family physician has become the most sought after physician in America. Hospitals, the public health service, small communities, alternative health care plans, multidisciplinary groups, and academia are attempting to recruit family physicians. Despite the perceived physician surplus, graduate family practice residency programs have numerous job opportunities in varying communities and regions of the country.

During the past ten years, there has been a dramatic increase in the size of the managed care industry in the United States. The percentage of United States citizens under the health maintenance organization (HMO) banner has risen from 6 percent to 16 percent in 1988, from 5 million to 33 million people.*

Administrators and chief executive officers of alternative health care plans quickly came to the conclusion that family physicians were the most aptly trained and talented physicians to provide managed care in the country. The attestation of chief executive officers of medical conglomerates substantiates their preference for family physicians as case managers because of their scope of practice, cost-effective care, satisfaction on the part of their patients, and favorable outcomes.[6]

The Council on Graduate Medical

*Paul Young, American Board of Family Practice, 1990: personal communication.

†American Academy of Family Physicians: Annual Survey of Family Practice Residency Programs, July 1989.

‡Carole V. Tsou, American Academy of Family Physicians, 1990: personal communication.

§American Academy of Family Physicians Membership Recap 12-31-89.

*Norman, J: The flowering of managed care. Medical Economics, March 5, 1990, p. 89.

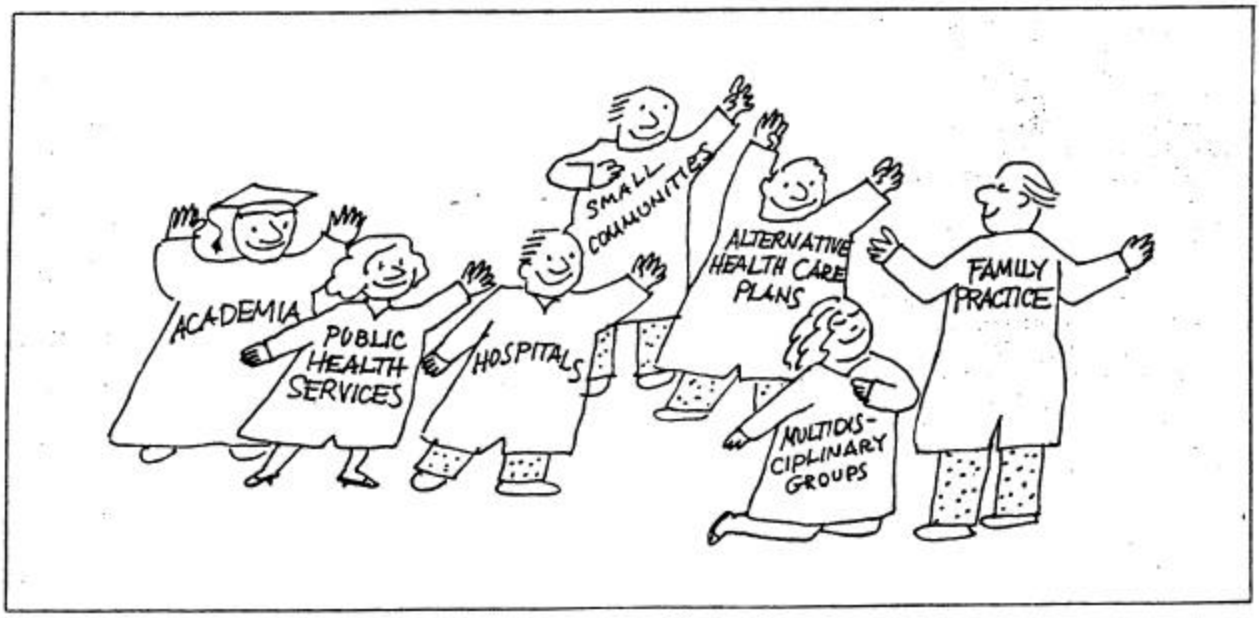
Education (COGME), created by the Consolidated Omnibus Budget Reconciliation Act of July of 1986 of the United States Congress, was charged with assessing physician manpower needs on a long-term basis. In its report of July of 1988, which was presented to the U.S. Congress, COGME concluded that there was an undersupply of family physicians in the United States.[7]

General internal medicine and pediatrics

At the time family practice was developing, internal medicine and pediatrics responded to the need for generalists with a combined IM-PEDS residency program. The IM-PEDS program was a four-year graduate medical education program, divided into two years of internal medicine and two years of pediatrics.[8, 9] The graduates were expected to be board eligible in both internal medicine and pediatrics. The goal of this new residency program was to train a physician who would care for all members of the family. As of July 1986, there were 68 active programs, in which 390 residents were being trained.[8, p. 732] There is still no residency review committee for these programs. The majority of their graduates enter medical or pediatric subspecialties, and only a small minority are in fact providing a combination of general pediatric and internal medicine in practice. The small number of programs and trainees testifies to the unsuccessful nature of this approach.

The leaders of internal medicine have admonished their colleagues that if they do not alter their training program in the direction of general internal medicine and ambulatory care, internal medicine will soon become a dying specialty.[10] Fifty to 65 percent of internal medicine residents enter subspecialty fellowships,[11] and 20 percent of pediatric residents are directed towards the pediatric subspecialties.[12, p. 2635] The general internist lacks esteem in the eyes of those entering specialty training. Internal medicine has developed an identity crisis. It has become an assemblage of medical specialties, including cardiology, endocrinology, gastroenterology, hematology, infectious disease, oncology, nephrology, pulmonology, and rheumatology.

The current training of the internal medicine house staff is not well suited for those who will devote themselves to primary care populations. There is a need for additional training in ambulatory care as it is not sufficiently covered at the present time. Graduates entering residencies in internal medicine and pediatrics encounter a training setting that is still heavily oriented to the subspecialties and largely with subspecialty role models and a predominantly inpatient emphasis.[12, p. 2632] Under the present training system, internists and pediatricians are not well prepared for practice in rural areas, as they have not been trained broadly enough. Internal medicine and pediatrics, in an attempt to address their primary care problems, have begun to change their philosophy and direction. They now propose extending the patient age restrictions of their respective specialties. They speak about a multidisciplinary approach towards the practice of medicine, increasing the medical resident's training in dermatology, office orthopedics, office gynecology, and psychosocial aspects of care.[13] They have proposed



a greater emphasis on ambulatory care and a decreased need for the resident to receive his/her training in hospital wards with exposure to acute episodic care. At the present time, these changes are in the discussion stage and have not been implemented. If instituted, these modifications will resemble the training program in family practice.

Generic primary care physician

In the mid 1980s, John P. Geyman, reviewing the "primary care problem," suggested that America could not afford to train three different types of primary care physicians: family physicians, general internists, and general pediatricians. He proposed that there be a merger and hybridization of these three into one primary care specialty.[12] This discussion was generated by the legitimate concern on the part of medical educators that an inadequate number of medical graduates were entering the primary care field.[12] It was his opinion that a combining of the three specialties would strengthen the primary care movement in this country. When one looks carefully at what exactly this new generic primary care physician would be one sees that this physician would be the same as the present-day family physician. This is the type of physician family practice has been training successfully for the past eighteen years. Reference to the primary care physician is confusing students. Some students who are interested in going into family practice now hesitate and choose internal medicine or pediatrics instead because of their concern about the future of family practice. Geyman cites a number of studies that have shown that the quality of care in family practice is comparable to that of other specialties and with less resource utilization.[12, p. 2632] In 1985 family practice accounted for about one-third of the total ambulatory visits to office-based, nonfederally employed physicians, while internists and pediatricians recorded about 12 and 11 percent of all visits, respectively.[14]

In the past decades, general internists and family physicians have both trained for three years, but the training has been very different. It has been rare for family physicians to consult general internists. They tend, instead, to use subspecialists for specific problems.[15] Other countries, like Britain and Canada, have only one model of primary care, the family physician; and the model of primary care education is that of family practice. In Canada, 50 percent of all physicians are family doctors.*

It has been suggested that family practice and internal medicine training be combined into one residency program, with complete integration of training program and faculty.[15] In my opinion, it is unlikely the two will merge organizationally, as the chairmen of departments of medicine will not likely permit the dismemberment of their departments by giving away primary care. This would leave internal medicine with only a collection of subspeciality fellowship programs, which would, under considerable pressure, shrink the size of the departments.

Fundamental changes have not occurred in the internal medicine and pediatric residency programs, and subspecialization continues to attract many graduates of these programs. Primary care internal medicine training still accommodates only a small proportion of all internal medicine residents. This track, so far, has had little impact on traditional internal medicine residents' training programs.

The creation of a generic primary care physician would require the most extensive reorganization of medical education and, in my view, is not feasible nor practical. There has been difficulty finding faculty who serve as strong role models for primary care internal medicine. Family practice, on the other hand, has been able to provide solid role models and comprehensive ambulatory training.

*Reginald Perkins, College of Family Physicians of Canada, 1990: personal communication.

Why family practice?

The specialty of family practice has matured into a well-defined system of health care that serves the patient well.[4] Today's residency-trained family physician continues to derive satisfaction more from working with people than from manipulating data or performing procedures. Family practice offers a wide variety of career alternatives, including private practice, governmental service, managed care, and academia. Family medicine will prosper in America if family physicians do not lose their innovative and imaginative zeal. Family medicine must build on the dream of broad-based family-oriented health care that began more than two decades ago. The greatest dilemma facing family practice is stunted growth. For the past five years, the number of students entering family practice in residency programs has plateaued.* The reasons are multifactorial: (1) lack of resources to start new programs, (2) increased educational costs for medical students, (3) inadequate reimbursement for nonprocedural care, (4) hostile environment in medical schools, (5) inadequate curricular time and poor quality of family practice education in schools, and (6) medical schools not addressing the social needs of our country. The emergence and rapid growth of the specialty of family practice were facilitated by federal, state, and private funding of residency training programs as a direct response to the strong political and legislative initiatives to address the need for more family physicians to replace the growing number of retiring general practitioners. Because of the increased costs and reduced revenue generated in the training of family practice residents, it is necessary for state and federal governments to assist financially in supporting family practice residencies. By doing so, they can address the overspecialization and geographic maldistribu-

*American Academy of Family Practice, Commission on Education, 1988-1989 Annual Report, AAFP Reprint # 150-C.

tion of physicians in this country and create a practitioner who has the proven ability to help control escalating health care costs. I fear that increased educational costs are causing medical students to select the high paying surgical and medical specialties, so as to hasten the retirement of the massive debts they incur during their medical school training.

I am concerned that unfriendly departments in medical schools may promulgate fallacious information regarding family practice, thereby deterring students from entering the field for a meaningful career. I believe, further, that the quality of family medicine education is sometimes deficient because of a lack of financial and administrative support by the dean's office and other departments of the medical school. There are eighteen schools in the United States, mostly in the northeast, that have no departments of family practice.* Medical schools continue to direct their students into medical and surgical subspecialities, despite the surplus of these physicians and the shortage of family physicians in the United States. Although subspecialists provide superb and indispensable care to the citizens of America and have vaulted the United States health care delivery system to a point of esteem and respect for the rest of the world, we are training too many of them.

*Carole V. Tsou, American Academy of Family Physicians, 1990: personal communication.

The future

All elements of family practice must focus on increasing the number of students entering this form of practice. Time, energy, and resources should be devoted to attracting medical students into family practice, increasing the number of residency training slots in family practice, and enhancing the quality of these programs. This can be accomplished by: (1) informing students at the high-school level and the premedical school level as to the desirability of family practice careers, (2) restructuring admission committees of medical schools, (3) providing mandatory rotation in family medicine in all medical schools, (4) developing departments of family practice in every medical school in the country, (5) rectifying inequities between reimbursement of nonprocedural and procedural care, (6) expanding the number of family practice residency positions, (7) providing general internists and pediatricians who wish to become family doctors a pathway to do so, and (8) increasing federal and state funding to enhance family practice education. A recent study at the Jefferson Medical College, published in the *New England Journal of Medicine*, concluded that "the medical school admissions process can have a significant influence on the specialty and geographic distribution of physicians, and may provide one means of increasing the number of family physicians in rural and underserved areas."[16, p. 485]

Family practice faculty and practicing family physicians should be placed on the admission committees of medical schools. While in medical school, students should be given adequate exposure to family practice. The Liaison Committee of Medical Education (LCME) has stated that every medical student should be adequately prepared to enter graduate medical education programs in family medicine or the other primary care specialties.[17] Students who have a propensity for other specialties should also have exposure to family practice so they understand the important functions of the family physician in our health care delivery system. The negative propaganda that emanates from some departments in medical schools in this country should be confronted and negated. The gap between the earning power of the medical and surgical specialists, as opposed to family physicians, should be narrowed. The Harvard Resource-Based Relative Value Study would be a step in the right direction.[18] Economics is a very important factor that drives our society. Narrowing the earning gap would result in a greater interest in family medicine as a career. As of 1987, 6 percent of residency programs accredited by the Accreditation Council for Graduate Medical Education (ACGME) were in family practice, and

only about 9 percent of residents were choosing family practice as a career.[19] In my opinion, the number of both should be increased to at least 25 percent. The Canadian and English system, with only one primary care physician — the family physician — provides the appropriate model for the United States. Existing quality family practice residency programs should be expanded where more family physicians are needed. New programs should be created in areas that, up until now, have ignored the existence of family practice, such as tertiary care hospitals and tertiary academic centers. The development of a new family practice residency program at the Ford Hospital in Detroit is an example of the change in attitude in a tertiary care center. The reason for this development was a realization that family physicians were the most logical and beneficial practitioners in managed care. This hospital has a managed care system and is now training family physicians to enter it. A welcome should be extended to those interested general internists and pediatricians who wish to become family physicians. An avenue should be provided to convert general internists and pediatricians to family doctors. A pathway for membership in the American Academy of Family Physicians, and certification by the American Board of Family Practice, should be developed. Conversion of the floundering IM/PEDS residency programs to family practice programs would address the inadequacies of these programs and add to the number of family practice slots. The goodwill and support of legislators should be brought into play to make sure that funds are available to enhance medical school education and to increase the number of family practice residencies in our country. This should be done on both the state and federal levels. The state legislature of Texas has recently mandated a third-year family practice clerkship in all medical schools in Texas.

The managed-care industry could be a potential resource for funding of family practice residencies. The medical conglomerates are tapping the pipeline of graduating family practice residencies and, in my view, will need even greater numbers of family practice graduates to care for their patients in the future.

Conclusion

Family practice is the only medical speciality totally dedicated and committed to primary care. The organizational family of specialities should be united to respond positively to today's health care issues and family medicine problems. Events of the past forty years serve as evidence that the job can be done and will meet the needs and desires of the American public. In a survey of hospitals recruiting physicians, the demand for family physicians was nearly twice that of the next specialty on the list.[20] The competition for family physicians is fierce. Discussion of a hybridization of family physicians, general internists, and pediatricians diverts resources and energies from the eventual goal of providing family physicians for every citizen of this country. Talk of the generic primary care physicians diverts attention, dedication, and devotion to developing the most logical and beneficial approach to the medical care of families in the United States.

It is time for the medical profession to dedicate itself to the promotion of family practice. It is a challenging and rewarding mission.

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