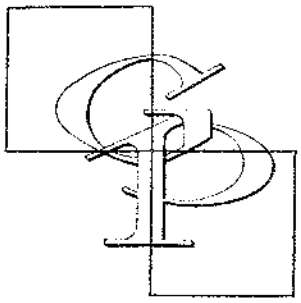

Special Features

Specialist in Family Practice—Prototype of a Doctor

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A lot of words have been written in the last several years about the specialist in family practice, a new kind of doctor who will rescue general medicine from the brink of oblivion and fill the void in the health care of the public left by the slow but sure demise of classical general practice.

A verbal avalanche has come in the last few months, since official approval in February of a certifying board. Out of this there still has not been drawn a clear picture of who, what, when, where, how, why— a word profile of this essential provider of comprehensive health care, the family physician.

That is the purpose of this article, to draw it all together as clearly as possible, to provide a broad brush-stroke portrait of the future diplomate of the American Board of Family Practice—the specialist in family practice.

First off, in a very real sense, it can be described as an attitude!

The basic *practical* difference between the new specialist ("new" only in the sense that he is being newly recognized as the most important element in the health team, and that a new concept of training is being devised to fit him for this role) and today's competent general practitioner is attitude—the way he views his practice and his patients. The diplomate might well be called a third-phase generalist, in the jargon of the space scientist—his approach to medicine will be built on the foundation of yesterday's country doctor and today's general practitioner, but developed from that foundation into something different.

The attitudinal difference lies in when and on what basis the patient is treated, and who the patient is. The new specialist must function as a continuing medical advocate to his patients. His care is of a nature closer to that of a lawyer on a retainer than of the corner filling station operator who sells gasoline to his customers on a stop-in basis. In short, the new diplomate will practice medicine on a continuing, comprehensive basis as an advocate rather than on an emergency, episodic basis, as most medicine now is practiced. This means the new specialist will emphasize preventive medicine as much, or more, than curative medicine, within the context of his group of family units.

Family Unit Approach

This brings up the matter of who the patients are. While the classical general practitioner has tried and often succeeded in bringing whole families into his practice, the new specialist will virtually have to have family units as his patient entities, because of the fundamental interaction factors in his comprehensive-care approach. He will see each person as a patient but each patient must be considered against the backdrop of the family unit.

Many feel a great number of "good" general practitioners have been doing this for years. True, but they were not trained to do it—they developed this inclusive mode of medical practice through an inherent concern for their patients and as a result of indigenous social forces that dictated this approach in their particular communities.

The curriculum did not emphasize this kind of medicine in medical school, nor did their graduate training. One rather generally

Exam Date Set

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accepted view of medical curricula since World War II is set forth in a recent editorial by Morris Fishbein: "The modern student arrives in medical school after four years in a college or university where he has been brought abreast of the newer chemistry, mathematics and physics. When he emerges into the clinical years, he is apt to concentrate on tests, studies and records relating to the patient rather than on the patient himself. He is a better educated scientist than the physician of the past, but somewhere en route he has lost the basic humanities of the healer." The editorial indicates that what is needed . . . "is an approach to education based on insight into the nature of human relationships." The new diplomate will be taught according to the precepts of this approach, beginning in his undergraduate years and during his family practice residency.

How can one be taught concern, which is basic to this kind of practice? You don't teach concern but you can teach existing knowledge that will be useful in the hands of the concerned person, such as basic sociology (how man interacts with his fellows), ecology (how man interacts with his environment), basic economics and other disciplines that are vital to understanding people's problems and helping them to overcome them. There is no lack of raw, unchanneled concern in the young, and never has been. The trick is to channel it effectively to produce results. This can be taught, and will be taught in the new specialty of family practice, via formal training in the behavioral sciences and the informal, but far more meaningful, vehicle of experience with patients in the family practice unit.

Working Definition

So, if the basic practical difference between the future diplomate and the average good family physician today is an attitude or approach, how is this new doctor defined within the total spectrum of medicine?

A working definition, devised by the American Academy of General Practice on the basis of the "Essentials for Residency Training in Family Practice," is thus:

The specialist in family practice will be an examination-certified family physician who:

1. Serves the public as the physician of first contact and as the means of entry into the health care system;

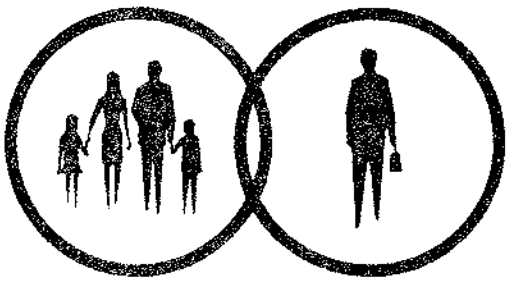
2. Evaluates his patients' total health needs, provides personal medical care within one or more fields of medicine and refers patients when indicated to appropriate sources of care while preserving the continuity of his own care;

3. Develops a responsibility for his patients' comprehensive and continuous health care and acts as a coordinator of his patients' health services, and

4. Accepts responsibility for his patients' total health care, including the use of consultants, within the context of their environment—the family or comparable social unit and the community.

Another simpler, but more inclusive set of related definitions have been used by Dr. Roger Lienke, director of the Family Medicine Division of the University of Oklahoma Medical Center. They read: "Family medicine is a body of knowledge or science comprised of the principles and techniques for comprehensive and continuing health maintenance of families. Family practice is the application of these principles and techniques. And the title family physician refers to the doctor who assumes responsibility for such medical management."

Other descriptions from the growing body of literature on the subject are necessary to flesh out these bare-bones definitions, however. From James E. Bryan's *The Role of the Family Physician in America's Developing*



Medical Care Program come these descriptions:

"The purpose . . . is to create a physician whose main task is to understand people, to interpret to people their own problems and to help them solve those problems." . . . and, "Essentially the task of this new physician is to exemplify all of medicine to the patient." . . . and ". . . this new physician's special calling will be based on function—on the care and management of whole patients, and patients contemplated in the context of their families, homes, jobs and personal histories. . ."

Also:

". . . he will be a specialist by *inclusion* – in contrast to the classical clinical specialist who specializes by *excluding*. His aim is to broaden his concern, to *widen* his skill; he seeks to *accept* responsibility; not merely to pass it along. He utilizes specialists, rather than surrendering to them."

And:

"Possibly the ultimate distinction between the new family physician and members of the existing clinical specialties will be the former's ability to relate the parts to the whole, the machinery to the purpose, the special talent to the basic task."

And, quoting Dr. Richard E. Magraw, formerly with HEW: This new physician "sees the disease process, whatever it is, as being incidental to the patient; whereas, in general, the consultant-specialist sees, as I think he should, the patient as incidental to the disease."

And, finally, according to Bryan:

"The new physician essentially, then, will be a specialist by function—whose area of concern is undelineated by particular organs, age groups, therapeutic modalities or specific diseases. He will be engaged in patient care—in the management of the patient whole, within the environment that surrounds him. His progress as a physician will be a process of broadening, of embracing new insights—not of sharpening his focus. He will grow in a different dimension from his fellow practitioners in the limited specialties. He will manage patients, and, to do so, he will have to manage all the specialists who can contribute specifically to the welfare of his patients. His is the task of synthesizing where his fellows particularize.

"His view of patient care is oriented to the patient rather than the disease, and his concern is the continuing welfare of the patient in the full context of his life situation rather than the episodic care of a presenting complaint."

Some psychologic features of this new doctor, while neither unique nor new, become particularly essential, given the accuracy of the preceding descriptions.

1. He is more concerned with people than with things.

2. He tends to view things holistically rather than as elements or parts. (A play on a popular simile might describe him as "seeing the forest instead of the trees.")

3. He is inclined to be something of a "pathfinder" instead of a traditionalist.

4. He sees medicine as a means to helping his fellow man, and by instinctive action makes others aware of his service orientation.

5. He views himself more as an "artist" in dealing with others and their problems—a healer—rather than a "scientist" dealing with disease processes or malfunctioning organs, though he has great respect for the values of science. However, he sees it as a means to an end rather than an end in itself.

6. He probably is more concerned with his community as a whole than many of his colleagues because, to him, the community is an extension of his patient-family units and, in a sense, a "laboratory." Also, because he is concerned with people and humanity, he is concerned with the success of human organization.

The "Ideal" of Medical Practice

This kind of medical service this new doctor is expected to provide, his very *raison d'être*, not only is the substance of an increasingly vocal demand on the part of the American public, it also is a rearticulation of the "ideal" of medical practice. One observer noted that the end result of successful practice of this new specialty may well be the bringing of medicine "back to a balance between biology and humanism."

In another sense, the new specialty might be classified as the one that the majority of medical students would enter prior to their junior year. It is the niche for the young doctor who does not flinch at medical challenges, trusts his own judgment and common sense and is confident in his ability to do a good job of medicine. At the same time, the three-year graduate training requirement will inculcate an expertise worthy of this self-confidence and of the confidence of medical peers and patients alike. The comprehensive written examination is a final guarantee of competence in that it measures a representative spectrum of his working understanding of the body of knowledge rapidly being codified in the field of family medicine.

This brings up another subtle but salient feature of the new specialist: He must be a medical "thinker" as well as a "doer." His direct antecedent—the general practitioner—has been categorized as medicine's "doer"; this new family specialist must contribute to the newly evolving body of knowledge as well as utilize it. It is essential that he and his family practice colleagues apply creativity to the discipline, and report their creative efforts, in order to give it vitality and progressive impetus. Family practice is the least didactic of all medicine's specialties and, therefore, requires at least as lively a professional literature as the others, in terms not only of quantity but of quality

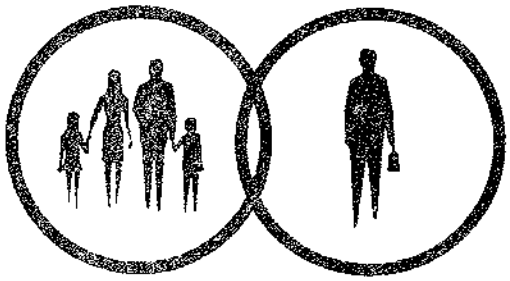
Competent Teachers

An important aspect of this requirement to vitalize the discipline is the development of competent teachers of family practice at both undergraduate and graduate levels. If the specialty is to flourish, and take its place alongside the others in the academic sphere (and the quest for adherents is at its peak in the academic years), it must have a cadre of highly competent, impressive teachers capable of holding their own with the *dons* of medical education. They must be not only *in* medical education but *of* it. The prototype subject of this article must be a practitioner within the specialty, but he should be capable of *becoming* an accepted teacher of family practice.

When Will He Emerge?

When will this new specialist emerge? In discussing a representative, or "prototype," specialist in family practice, the emphasis has been on a residency-qualified diplomate. They are the true heirs of the efforts of the Academy, the Section on General Practice of the American Medical Association and the AMA's Ad Hoc Committee on Education for Family Practice to establish a certifying board in family practice. They are the standard-bearers of the future. They are the ones who will build the specialty into a dominant force in medicine. But they probably will not begin to emerge in any significant numbers until the mid-1970's or later.

Undergraduate and graduate training programs must be fashioned in far greater numbers than now exist. Medical educators must be won. A reasonable number of students at all levels are inclined now toward this kind of medicine, but they must be given the vehicles to exercise their inclination. Much is being done, but much needs to be done. And time is required.



Meanwhile, another category of potential diplomates is poised to take the examination. This is the practice-eligible group of established physicians, generally from the ranks of general practice.

These doctors, who will form the vanguard of the new primary-care specialty, will bear the burden of the organizing years. Their role is paramount in importance now, but will give way gradually to the residency-trained group as they succeed in developing numbers of quality training programs capable of producing more and more residency-trained diplomate candidates. Indeed, the practice-eligible category will cease to exist within 10 years. Meanwhile, however, the working general practitioner who has been in practice a minimum of six years and can prove satisfactory completion of at least 300 hours of acceptable continuing study (acceptable to the American Board of Family Practice), or the educator who has been engaged full-time in medical teaching for at least six years, are eligible for certification.

If they achieve an acceptable grade, they will be accorded diplomate status by the Board. In the case of AAGP members, membership in the Academy for a minimum of six years (two consecutive re-elections) is deemed satisfactory qualification. No one will be certified without satisfactorily passing the examination, according to the Board's current bylaws. The Board has announced that the first group of applicants will be examined, probably in several cities simultaneously, in February of 1970.

Where Will He Establish Himself?

Where will the new specialist tend to establish himself? Family practice will become the most universal specialty, in terms of broad-scale need and flexibility of operation. Consulting limited specialists are vital, as are hospitals or medical centers, but the scope of the specialty, and the diversity its breadth of orientation allows, enable it to be practiced in different ways in different areas, and according to the requirements of the area. Consequently, the specialist in family practice will be capable of practicing virtually anywhere, without the taut lifelines to medical centers required by many limited consultants. He will need reasonable access to consultants and centers, but only that access attainable via motor car, helicopter or available electronic means. His range of procedures will be dictated by his access to available consultative service. However, the scope of his training also will operate in the manner of a bellows —where he does more, he will be trained to do more. The governor will be the needs of his patient-families.

This flexibility will enable the primary-care specialist to function in the small city or town on much the same basis as the current general practitioner. And, with much greater numbers of these primary-care men expected to emerge in the reasonable future, there is reason to suspect that the current serious shortage of physicians in sparsely populated areas will begin to take care of itself. Of course, a town's ability to attract a doctor involves other factors than just number of potential patients—it is dependent, too, on availability of suitable educational and cultural facilities for the doctor's family, satisfactory nearby recreational areas and other personal-satisfaction features.

The growth of the specialty will have little or no effect on this aspect of the doctor shortage. However, many outlying communities are tending to become more affluent, less insular and more progressive. It is conceivable that this phenomenon and the rise of the new specialty may converge to work as agents for better distribution of physicians.

We have noted that the primary distinction of the specialist in family practice is an

attitude or approach to medical practice in which the patient is considered as a whole and as a human being in the context of his life situation, within an atmosphere of concern. Some elements of this attitude's genesis have been noted, including the fact that it, or elements contributing to it, will be taught in the undergraduate and graduate training phases.

The "essentials" that will govern the residency programs, in terms of basic standards, set forth two guidelines:

1. The resident's base of practice will be in a model family practice unit, where he will usually spend a portion of each day. Over the three-year period a major portion of his training will be devoted to this aspect of the field.

2. In addition, education and supervised training in the following disciplines should be available during the three-year period: medicine, pediatrics, surgery, obstetrics-gynecology, psychiatry, community medicine and electives.

These guidelines incorporate the elements of a basic family practice.

The family practice unit, the vehicle for achievement of practical knowledge, is absolutely necessary. It should consist of a clinical service, with content determined by the needs of the participating family practice residents. Patient composition of the service should be such that continuity of care would be a reasonable probability for most patients, and continuity of experience by the resident would result. Where feasible, efforts should be made to bring undergraduate students into the unit to function under the family practice residents' observation and direction.

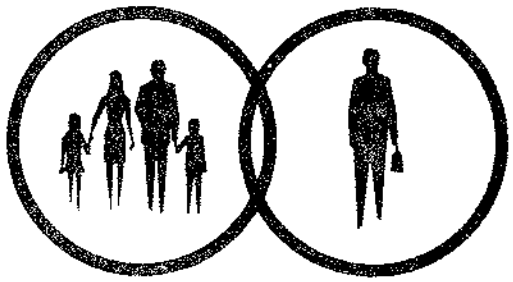
These additional clinical elements must also be incorporated into the family practice graduate program:

Internal Medicine.—Internal medicine, by nature of its integrative functions, is recognized as a major foundation for programs in family practice. The family practice resident should receive regular instruction and gain experience that will permit him to develop judgment in assessing the condition of the patient, in the use and interpretation of laboratory procedures and in applying the principles of differential diagnosis, as well as proper therapeutic management of the patient. Emphasis should be placed upon the history and cause of disease and should provide the resident an opportunity to become familiar with the major causes of diseases and the principles of rational therapy.

Pediatrics.—There is much overlap and reinforcement between internal medicine and pediatrics, but the special contributions of pediatrics relate to the problems of the newborn, to congenital malformation, to growth and development through adolescence, to nutrition, mental retardation and the behavioral and emotional problems of children and their management.

Psychiatry.—This discipline is one of the necessary bases for a family practice program. The resident should learn how to diagnose and manage most psychosomatic and emotional problems. He should become competent to deal with the common tensions, anxieties and depressions that initiate or complicate a substantial proportion of the problems with which the family physician will be faced. The resident should learn to recognize the neuroses and psychoses and to provide for the aftercare which many patients require following discharge from a mental institution.

Obstetrics and Gynecology.—The resident should be provided the instruction necessary to understand the biologic impact of pregnancy, delivery and care of the newborn, upon a woman and her family. He should acquire skill in the provision of antepartum and postpartum care and the normal delivery process. He should also have an understanding of the complications of preg-



nancy and their management. He should become adept at managing the problems of medical and office gynecology.

SURGERY—The resident should acquire competence in recognizing surgical emergencies and when appropriate referring them for necessary specialized care, an ability to evaluate conditions that require elective surgical management, an understanding of the kinds of surgical treatment that might be employed and the problems that may result from surgical procedures and their management.

Cautionary voices—some Cassandra-like—warn that the public's demand (and all voices acknowledge this demand) for a primary, comprehensive-care physician may not be met by the new diplomate in family practice.

Some say the Board may not succeed and that other approaches to the problem of comprehensive, continuing health care will take the fore. A front-runner among these is the dual residency program in internal medicine and pediatrics.

According to Dr. William R. Willard, chairman of the AMA's Council on Medical Education and a key figure in approval of the new certifying board, establishment of good family practice residency programs is the measure of success. Also vital, he says, is the development of a spirit of cooperation and good will among the various disciplines and elements of organized medicine. He sees the need to fashion a true specialist in family practice, a new kind of highly competent, comprehensive, primary-care physician, in sufficient numbers to serve the American public, as the basic order of medicine's business today.

The need for the "prototype" described in this article has been articulated on every hand, including the expressions of two "blue ribbon" citizens commissions—the Citizens Commission on Graduate Medical Education (the Millis Commission), and the National Commission on Community Health Services (the Folsom Commission). Said the Millis Commission:

". . . the patient wants, and should have, someone of high competence and good judgment to take charge of the total situation, someone who can serve as coordinator of all the medical resources that can help to solve his problem. He wants a company president who will make proper use of the skills and knowledge of the more specialized members of the firm. He wants a quarterback who will diagnose the constantly changing situation, coordinate the whole team and call on each member for the particular contributions that he is best able to make to the team effort."

And the Folsom Commission report echoes: ". . . every individual should have a personal physician who is the central point for integration and continuity of all medical and medically related services to his patient. Such a physician will emphasize the practice of preventive medicine, through his own efforts and in partnership with the health and social resources of the community.

"The physician should be aware of the many and varied social, emotional and environmental factors that influence the health of his patient and his patient's family. He will either render, or direct the patient to, whatever services best suit his needs. His concern will be for the patient as a whole and his relationship with the patient must be a continuing one. In order to carry out his coordinating role, it is essential that all pertinent health information be channeled through him regardless of what institution, agency or individual renders the service. He will have knowledge of the access to all health resources of the community—social, preventive, diagnostic, therapeutic and rehabilitative—and will mobilize them for the patient."