Training of Family Practitioners: How and for What?

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Reading about training programs in family practice at times leaves one somewhat up in the air with regard to basic goals and philosophy, even in the more advanced programs in the United States.[1] What is essential in the training of family practitioners? What should be the focus of residency programs? Clearly, the focus should not be limited only to the disease or the sick organ. Should it be "standards of competence" or projected "practice content"? In working towards defining standards of competence, family practice certainly does not differ from other training programs except that we have been grappling with this issue since our inception, while the training programs of other specialties are just now becoming more concerned as a result of the threat of PSROs and other mechanisms of enforced standards. In reference to practice content, other specialties have long been defining their own spheres of endeavor, while in family practice we want to encompass it all.

What else? Should the focus of the residency program be information about what practice will be like, in terms of patient types and situations, as gathered through use of computerized practice data? Every physician will have to make adjustments to the problems of practice which he may or may not anticipate. Certainly, to help prepare him for this continuing self-education is vital. If the computer can recognize, better than the physician, where he should direct his effort, then he should know something about how to use it. This does not, however, seem to me to be the core of the family practice "specialty." This is not what is different from other areas of medicine.

How about the problem-oriented approach in learning, practicing, and record keeping? Is this the hard core of the training, to become genuinely "problem-oriented?" Certainly not. This is just a framework for thoughts and actions, an aid in sharing medical information about a patient.

What about audit and peer review built into the family practitioner's career beginning in the training period? To me, this sounds something like, "Let the inexperienced judge and teach each other, they have, after all, committee-made cookbook standards by which to judge, and they are more comfortable with peers than superiors anyway."

What is the role of self-teaching material and self-assessment examinations? These are useful tools, but more so for practitioners than for physicians in the training situation. Although residents have preparation for board examinations in mind, these aspects of training should not be allowed to take up very much time from more direct contact with patients and with teachers. The same goes for management and business aspects of office practice.

But now, working with the health care team: surely this is the job of the primary care physician. Well, it does involve some interpersonal and interdisciplinary skills. And most important, if the physician is going to be able to take on his role as the leader of a team, he has to feel reasonably sure of himself in his role as physician and in his physician-patient relationships. If he learns this, he can take charge of a team with minimum discomfort, and things should fall into place by utilization of other team members where appropriate. This, then, brings us closer to the area where there is a core that truly belongs to the family physician. And it is not the family either! The family aspect is important. It is new and intriguing. The discipline is certainly going to bring something new to medicine through work and discoveries regarding patients and their families. However, patients today, when they are sick and need help will be just as intolerant towards the doctor who insists on enrollment of the whole family, as the patient with an acute abdomen has always been towards questions regarding his grandmother.

But let us not forget the number one focus: the patient himself, our relationship with him, our care of the patient. Is this special for the family practitioner? It would be slightly irreverent to the rest of the medical world to claim this whole territory for family practice. But certainly, the need for and movement towards increased interest in primary care and training in family practice has come from deficiencies in this area. The specialist gains excellence in his field, but excludes responsibility beyond his special diagnostic and therapeutic procedures. He hands the patient over to another specialist or leaves him in a vacuum.

Think for a minute of the times before our modern medical miracles. Without the last 100 years, sometimes it seems that there would not be much we could do. Yet our profession is so much older. The apprentice still has to accept and extract from patients, teachers, and time what he needs to assume the responsibilities of a helper and, in the best circumstances, healer.

This has to be the focus. The single patient, not his family, his problem, or his record. The patient's care, laboriously learned in a continuum of experiences under guidance. Here lies the purpose and the unique features of the educational experience in a family practice residency program. The model practice has to be geared to this difficult but rewarding task: to help the residents on their way to becoming physicians in a wide sense, scientifically, clinically, and humanly. This certainly involves more than standards and algorithms, and more than office practice administration in an efficient, economical, data-controlled, and peer-approved manner.

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Reference

1. Andrus LH, Burr BD, Fowler FN, et al: Residency series: How they're training FPs at UC-Davis. Patient Care 9(5):98-114, 1975