On Defining Quality in Family Practice Education

John P. Geyman, MD

The current emphasis on quality control in family practice education is an integral and vital part of the continued growth of the discipline as it enters its eighth year as a recognized specialty in the United States. The major organizations in family practice are according high priority to the maintenance of quality in family practice teaching programs at all levels. This is being addressed through energetic approaches to such areas as program review, accreditation, teacher development, competency objectives, audit, and research. The Residency Assistance Program, for example, jointly sponsored by the American Board of Family Practice, the American Academy of Family Physicians, and the Society of Teachers of Family Medicine, represents an important new approach to the continued improvement of residency training.

While we can all agree with the overriding importance of "quality" in our educational programs, there is less agreement on what this word means. Some equate quality with university hospital settings and wonder how achievable it is in community settings. Others define quality by the number of full-time faculty involved in a program, the size of the hospital involved, the amount of time devoted to a curricular area or other related aspects of a teaching program. The definition of a "quality education" appears to be as elusive as previous attempts to define the "good physician."

Family practice is a unique specialty in medicine in terms of its clinical breadth, range of concerns, and methods of delivery. It is logical and appropriate that a majority of family practice residency programs have developed in relation to community hospitals, where the educational setting can best approximate the future practice setting. In calling for medical education which is relevant to medical practice, Hilliard Jason has observed that, "being a student *should* imply that one is, at all times, practicing the very activities for which one is preparing. Education, ideally, is a form of supervised rehearsal for the part one is to play in one's career."[1] How, then, are we to evaluate quality in a community-based program when most measures of quality which have been traditionally used have been developed particularly in the university setting?

Perhaps the essential first step toward measurement of quality is to recognize the limits of our current definitions and the complexity of the problem. Felch reminds us that, "medical education must impart to the physician a number of *skills*, which, taken together, give the physician the *competence* to deliver good care, so that, when faced with a patient, the physician's *performance* will result in beneficial *outcomes* for the patient."[2] Quality control, therefore, involves the four basic parameters of skills, competence, performance, and outcomes. In this context, such simple yardsticks as the size of a teaching hospital or the number of full-time faculty may not have any bearing on the learning, performance, or effectiveness of care of an individual resident in training. A resident in a 200-bed hospital with a small full-time faculty may develop greater competence and provide better care than an equally motivated resident in a 400-bed hospital with a large full-time faculty. Surely the variables in quality of a teaching program are numerous, and include such dimensions as varied resident needs, motivation, and learning styles; spectrum of clinical exposure, responsibility for patient care; enthusiasm and qualifications of faculty, whether full-time, part-time, or volunteer; and many other elements.

There will be many important measures involved in further defining what we mean by quality in family practice education, some of which will apply more to family medicine than to other disciplines. If we are to make progress in this direction, we must avoid both unproven assumptions and prematurely set criteria. We will need to take a flexible and unbiased approach to identify useful yardsticks to measure quality of teaching programs in different settings. "Quality" is not a static or fully measurable standard, and should probably be viewed as a constant *process* of improvement requiring continued self-assessment.

References

1. Jason H: The relevance of medical education to medical practice. JAMA 212:2092-2095, 1970

2. Felch WC: The continuum of medical education. AHME Journal 8(3):1, 1975-76