Re-entry of the Family Physician Into Academic Medicine

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The past five years have seen rapid emergence of the specialty of Family Practice and its companion academic discipline of Family Medicine. The American Board of Family Practice came into existence in February, 1969. Thirty residency programs in Family Practice were accredited by the end of that year. A handful of medical schools had departments of Family Medicine. Now, five years later, 206 residency programs are approved and in operation. More than half of our medical schools have departments or programs in Family Medicine. This change has required significant numbers of family physicians to assume new and unfamiliar roles in academic medical centers.

What have been the effects of this influx of family physicians into academia? Often, the physicians themselves have suffered "identity crises" as they adapt to new roles. The institutions they have joined have redefined priorities and objectives. The communities they serve (both professional and lay) have expected immediate and dramatic solutions to multiple problems. Those who have organized and directed Family Medicine departments have faced a seemingly endless array of choices among the opportunities and challenges presented daily. Should the department be located centrally in the medical school's academic and research facilities, or should it be out in a community setting more typical of Family Practice? Should the department begin with student teaching responsibilities or residencies or both? Should it confine its efforts to education and training of physicians or invest heavily in the training of other health professionals? What kinds of research efforts should be encouraged? Can the developing department solve staffing problems in the emergency room, walk-in clinic, neighborhood health center, etc.? Do these represent teaching opportunities or reasonable service commitments? On which administrative committees should the department be represented?

An analogy from the space age is appropriate (see Figure 1). We are talking about re-entry of Family Medicine into the academic sphere. As a parallel, upon re-entry of a space capsule into the earth's atmosphere there is a very narrow, critical angle which defines an acceptable course. If the capsule enters too steeply, it burns up. If its approach is too shallow, it bounces back into space forever.

Similarly, the developing Family Medicine department or program must steer a narrow course. If it fails to contribute meaningfully to solution of the parent institution's more pressing problems — if it steers a separate and aloof course — it has no lasting impact and is returned into space. On the other hand, as a department interested in a wide range of general medical problems and primary health care, it risks burning up on re-entry by accepting too many responsibilities — all of which can be justified as relevant for the family physician. The critical angle is narrow and course corrections are required daily. Clear department goals are necessary to serve as navigational aids. The limits of the critical angle may vary in different settings. Hopefully, the angle will widen with the passage of time and increasing experience. But, it is likely to remain a relatively narrow one. JP

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