In Defense of the Tough In-Hospital Based Family Medicine Residency Program

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Family Practice as a specialty has been recognized for only a short period of time, and we are still in the process of defining what a family physician is and what he does. As a result, the best method of training a physician for this task is still under investigation. Three years beyond medical school has been set aside as a reasonable period in which to improve the knowledge and skills of a physician for this broad-based specialty. Because of the time limitation imposed by 36 months of formalized postgraduate education, we must set priorities for the training program. It is also true that different programs should take fullest advantage of the strengths of the milieu in which they are located and, as a result, there will be family practice residency programs with somewhat varying emphasis. This is desirable as it will provide the resident applicant an opportunity to choose the program which seems to best represent the optimum path to his goal.

I am repeatedly questioned by applicants to the Family Practice Residency Program as to what the Boards in Family Practice are going to mean to them in the future. They especially wonder about hospital privileges in the specialty units after they have finished their training. I reply that only with tough academic training that the resident gets on the inpatient services will the resident truly be equipped to tell the hospitals' credentials committees that he is prepared to work in the ICU, CCU, or the Emergency Room when the critically ill arrive. In addition, I tell these young physicians that even though they may spend over 90 percent of their time in the office, they will always be in the position of helping their families make decisions. My own experience in over 20 years has been that my patients almost always will readily accept referral to a sub-specialist when I recommend it. However, almost as regularly, they will come back to me for one or two reasons, either to help interpret the specialist's plan or to aid them in the decision as to whether to follow the plan. Only by being aware of the advances in the various sub-specialties can the family physician properly refer his patients and appropriately help them in this decision-making process.

One of the facts that we must also recognize as family physicians is our obligation not to refer patients unless we are reasonably certain that the benefits will outweigh the problems and expense. We, as family physicians, are all aware that the patient who refers himself to a specialist often chooses the wrong type of physician. We must be on our toes as to the state of the art in the sub-specialties if we are to avoid this pitfall ourselves. We must have a goal and a reasonable idea of what benefits the consultation may have for the patient. This may mean referral for diagnosis and therapy, or only for diagnosis. Our consultant, as well as the patient, must know what is expected.

I have stated at Los Angeles County Harbor General Hospital and at numerous meetings, that I feel the proper role of the well-trained family physician is to essentially replace the general pediatrician and the general internist. I think that our residents should be able to care for patients to the point where the physician recognizes the need for the sub-specialists. However, this type of care is only possible if the family practice resident has rotated through the specialty and sub-specialty departments in his second and third year as a first-class citizen with the responsibilities and privileges of other specialty residents. This competence cannot be gained through too heavy an emphasis on outpatient care.

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