Family Practice Forum

The Family Physician in a Tertiary Care Center

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The curriculum in most medical schools provides medical students little exposure to the concepts of continuing, comprehensive, personal care that are the hallmarks of family practice. Because of the recent emphasis placed on family practice by federal and state legislatures and because of the large number of medical students expressing interest in primary care, there is a need to develop methods of more effectively presenting these concepts and techniques to physicians in training. Adding a family physician to the patient care team in the university teaching center would be an appropriate step towards meeting this objective. The patient, the referring physician, the hospital-based physicians and students responsible for providing care, and the institution would all greatly benefit from this addition.

The patient may arrive at the medical center ill, frightened, and without family or friends. He needs the expertise provided by the specialists, but he also needs a medical ombudsman to see him through the diagnostic and therapeutic maze of the complex tertiary care center. A broadly trained physician caring for the patient and coordinating the input from the numerous services and consultants would greatly increase the safety, appropriateness and acceptability of the patient's hospital experience.

Most of the physicians who refer patients to the center are familiar neither with all the services offered nor with the best method of insuring that the patient receives the needed medical care. This is particularly true when the patient has multiple problems. Consider, for example, an elderly, depressed, hemiplegic patient who has moderately severe diabetes, varicose veins with chronic stasis ulcer, and a partial bladder neck obstruction. To whom in the medical center should this patient be referred? It is theoretically possible for the six system specialists (psychiatrist, neurologist, endocrinologist, dermatologist, general surgeon, urologist) to meet, examine and discuss the patient and his problems, and plan for his management. Actually, this type of meeting is usually impossible to schedule, so each specialist is forced to generate a written consultation without the advantage of group discussion. Each specialist can only "do his own thing" with the blind hope (and prayer) that his investigation and treatment will not overlap or aggravate the problems outside his area of expertise and main concern. If all these consultants are successful, there is no problem. If they do not succeed, there is no built-in protective device for the patient, and some aspects of his medical care may become less than optimal. In the case of disagreement among the specialists (rare, but not unheard of), how can the difference be resolved? In many specialty-oriented tertiary care hospitals there is no rational, consistent procedure for determining priorities except possibly "first-come-first-served" or "the-bigger-the-department-the-higher-the-priority." The system-oriented subspecialist often has an unconscious bias and tends to consider the problems relating to his own specialty field as major while relegating others to a lesser status. Because of this, he is not the ideal arbitrator. A patient-oriented physician is needed to keep the whole therapeutic-investigative process in proper perspective. This physician must hold a dual citizenship – he must possess a working knowledge of academia, as well as an interest and expertise in the problems that are important at the primary and secondary levels of patient care.

There are many family physicians who have or could easily acquire the qualifications for this role. With a family physician sharing the responsibility for patient care, coordinating the input from the specialty services, acting when needed as a patient advocate, and serving as a surrogate personal physician, the quality of patient care and patient satisfaction will be improved. By having a family physician work in close cooperation with the specialist in the medical center, both will develop an understanding and appreciation for the needs and concerns of the other, and both will become better physicians because of this association.

The referring physician will appreciate knowing that a person-oriented physician is participating in the care of his patient and that a physician in the medical center who knows about the problems of primary care is available to assist in planning for post-hospital treatment of the patient.

The residents and medical students entering primary care need to have a relevant educational experience. They need to have the opportunity of working with a physician who has chosen to practice in this area of medicine. Since the specialists in the tertiary care center are usually concerned with patients who have esoteric and complicated medical problems, they tend to place too little emphasis upon identifying or teaching the principles of medical practice important at the primary and secondary levels of medical care. A physician serving a community needs to have an educational background that prepares him to recognize the full gamut of medical, surgical, psychological, and sociological problems that arise, and to treat those that are within his area of competence and interest and to make appropriate referrals whenever indi-

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cated. Medical education does not easily meet this goal when it is based upon the study and treatment of the 0.1 percent of the population with unusual problems, hospitalized in a tertiary care center associated with a medical school. This skewing of the patient population must not be used as an excuse to ignore or downgrade primary care education. It must be recognized as an obstacle that has grossly distorted medical education in the past and a problem that must now be quickly resolved.

Patients who require subspecialty care also have problems that are within the domain of a primary care physician. In a specialty-oriented hospital setting, it seems quite appropriate that a specialist in primary care (ie, family physician) participate in their medical management. Meeting their prosaic medical needs will improve patient care in a way that the average patient understands and appreciates, while failure to adequately meet these needs will make even the most expert scientific care unacceptable to the patient. This is a truth all physicians and medical students must confront every time they offer medical care to a patient.

Having a family physician on the staff to accept referrals of patients who have multiple problems, act as coordinator, and assist in the medical management of the patient can also be beneficial to the institution. By freeing expensive subspecialty talent from the time-consuming "routine care," the medical dollar will be more appropriately utilized. When the institution has a reputation for providing concerned, humanistic, high-quality scientific medicine, more patients will be willing to use the services provided.

It has been proposed that a general internist with broad clinical training might also serve the patient the same way as the family physician. The closer the internist's educational background approaches the family practice educational program, the better he will be able to fill this role. Internal medicine has in the past two decades drifted more and more into subspecialty orientation. The concept of a truly general internist appears to represent a radical deviation of viewpoint and philosophy from the concepts and practice of the majority of teachers of internal medicine. There is still a need for subspecialists in medicine. The lure of federal money or student acceptance should not seduce these specialists from their chosen field. The concept of a medical coordinator needs to be developed more, and this appears to be a viable ecological niche in the medical school environment that is best filled by the family physician.

The Interview in Family Practice Resident Selection

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The paper by Gordon and Lincoln, "Family Practice Resident Selection: Value of the Interview,"[1] claimed to measure the reliability and validity of the structured interview as a tool in selecting among residency applicants, and concluded that these measures were so poor as to encourage abandonment of the interview process. Their study offered little to support that conclusion.

Gordon and Lincoln generalized conclusions about the reliability of the structured personal interview from data examining only agreement between interviewers. Reliability is that quality of information that describes how closely repeated assessments will agree. Demonstrating that there may be little correlation between several different interviewers does not prove that the interview process itself is an unreliable tool; it simply suggests that the separate tools of different interviewers are individualistic. To conclude, as the authors do in closing their discussion, that such nonstandardized assessments only mislead a program into believing they may have learned anything about the applicant, is to ignore the individuality among faculty, residents, and applicants that can make family practice residency programs rewarding settings for personal education and patient care.

Validity is the quality of information that describes how well an assessment actually measures the subject of interest. The authors offer no definition of what qualitative or quantitative standards are seen as the actual goals of applicant interviewing in their program, and present no data to suggest that the interview process cannot validly reach those goals. Thoughtful discussion of the actual goals of family practice training programs, and of resident selection, might be of greater value to individual programs and to the field of family practice than the presentation of one program's rationalization for abandoning a challenging, if difficult, process.

The authors present statistical evaluation of data not supplied to the reader but do report that, of 240 applicants, only 53 were interviewed by more than one person and included in the study group. Applicants getting more than a single interview must be different from those less extensively evaluated and may well tend to be those of special interest to the program, those with conflicting information in their applications, or those most aggressive in pursuing their application. The biases in this selection make that small group unrepresentative of the total applicant pool and limit the value of any conclusions drawn from the data. Nine interviewers were involved in the process and data are presented illustrating the lack of agreement among them. No examination, however, was made of agreement either between certain subgroups of interviewers or regarding certain applicants, or of the factors that might be associated with such instances of agreement in a positive attempt to help identify valuable aspects of the interview process. Statistics for unseen data suggest that there is little correlation between

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arbitrary scores on the scales used in this single trial of interviewing, but there is no testing of alternative scales or grading formats and no information presented to support the authors' fundamental claim that "there was no agreement among interviewers in their impressions" of the general assessment of each applicant.

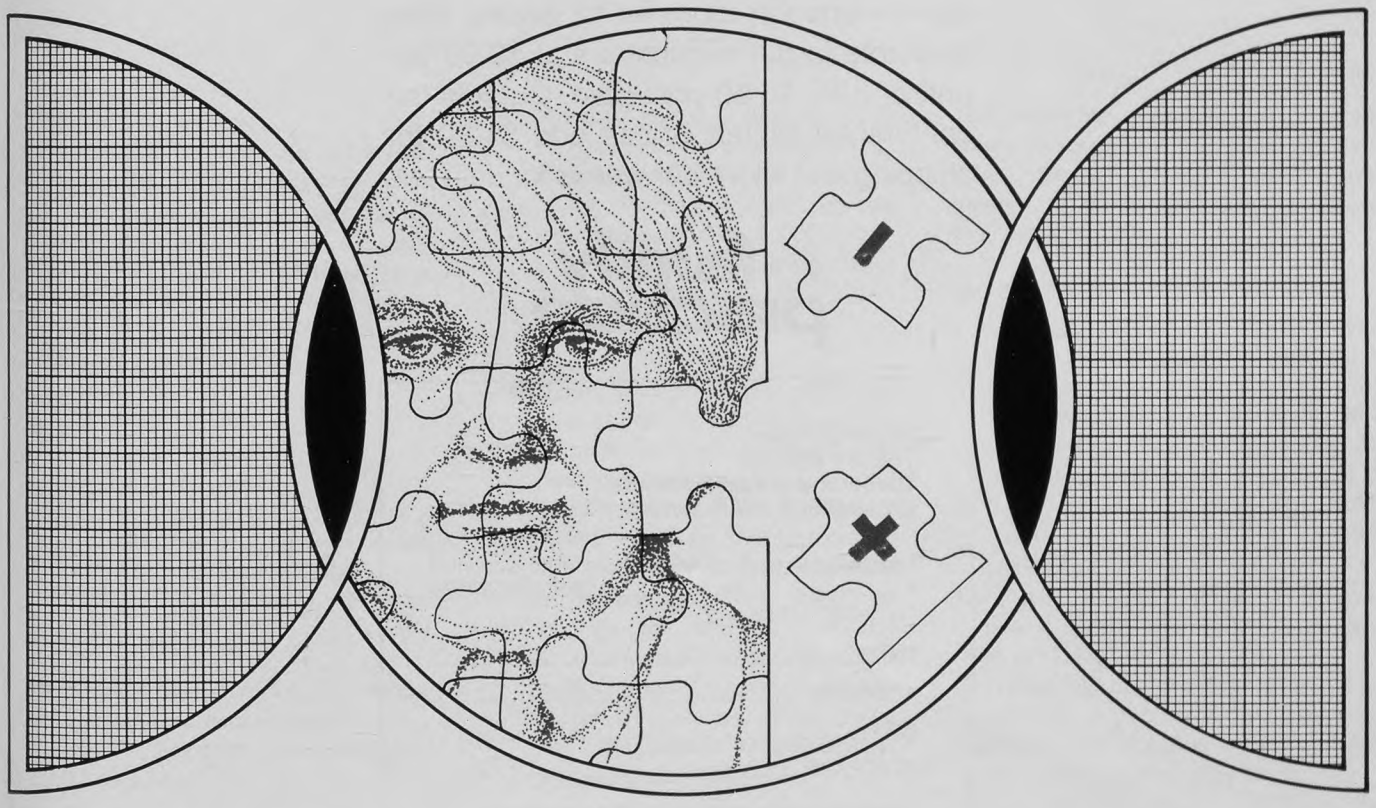
The authors correctly describe the interview as a multipurpose tool. They ignore its unique function of helping transmit between applicant and program representative their respective styles and personalities – factors important to a successful training experience. The halo effect that the study demonstrates does imply that strong impressions are made by outstanding applicants, but identification of those individuals may be important to a program required to choose between 240 applicants for six positions. It is to be expected, as the authors note, that positive interview relationships are idiosyncratic to the applicant and interviewer. Perhaps such idiosyncrasies are important components of the complex teacher-student, physician-partner, and co-health team member relationships that help create the atmosphere for optimal learning and health-care delivery in a family practice residency program.

Without some personal form of assessment such as the interview, the resident selection process must depend upon limited information of questionable quality. The transcript has become a useless tabulation of pass and fail grades. Letters of recommendation echo the traditional litany that their name implies. With failure of these sources to supply meaningful information, greater reliance has fallen upon the Deans' letters, which have responded in kind by becoming increasingly vague and noncommittal. Federal statutes now prohibit even asking applicants for a photograph or basic personal data, and it has become necessary to meet the prospective resident to simply identify the application with the applicant – the paper with the person. The failure of these methods of collecting information about an applicant makes imperative the need for some personal media for assessment. The personal interview (perhaps with the autobiography as a substitute) remains the most powerful technique available for learning about an individual residency applicant.

Examining interviewer correlation is only one way of evaluating the process of the interview. The question asked in its most meaningful form would require an evaluation of outcome: "Can a personal interview help select applicants who are most likely to help the program meet its goals?" Answers would require study of applicants both accepted and rejected from programs by assessment processes including and excluding the element of the personal interview. It would also require clear thought about program goals, careful consideration of individuals' potentials for contribution toward those goals, and interest in learning about those individuals in a personal way that remains unique amidst the growing battery of objective assessment techniques. The conclusion that such interest and effort is "non-productive activity" that "must be curtailed" in the interest of efficiency, belies the commitment of family practice to its expansive regard for the whole person.

Reference

1. Gordon MJ, Lincoln JA: Family practice resident selection: Value of the interview. J Fam Pract 3:175-177, 1976



This section of the journal is designed to present clinical problems which focus on patient management, problem-solving, and other elements integral to family medicine. It features reinforcement of major teaching points through further discussion and supplemental references which appear on the following pages.

Self-Assessment in Family Practice

These materials have been prepared by members of the Self-Assessment Panel of *The Journal of Family Practice*. Membership: R. Neil Chisholm, MD, Chairman (University of Colorado, Denver), B. Lewis Barnett, MD (Medical University of South Carolina, Charleston), Paul C. Brucker, MD (Thomas Jefferson University Hospital, Philadelphia, Pennsylvania), Laurel G. Case, MD (University of Oregon Medical School, Portland), Ian R. Hill, MD (Plains Health Centre, Regina, Saskatchewan), Kenneth F. Kessell, MD (MacNeal Memorial Hospital, Berwyn, Illinois), John A. Lincoln, MD (University of Washington, Seattle), Richard C. Reynolds, MD (University of Florida, Gainesville), Gabriel Smilkstein, MD (University of California, Davis), William L. Stewart, MD (Southern Illinois University, Springfield).

Question A:

A 24-year-old, white male, who has been a known asthmatic for ten years, calls your home at 10 PM and claims to have had a one-day bout with cough and worsening asthma. He states that he has been unable to control the asthma with his home medication and feels that he needs help.

A. Write down five high priority questions that should be asked over the phone to clarify the patient's clinical status.

B. Write down five complications that should be considered if the patient has experienced anterior chest pain.

C. Patient's status is such that you recommend his transport to the Emergency Room.
Write down five high priority physical examination and laboratory items for the data base after you have obtained the history.

D. Your studies suggest that the patient has worsening bronchial asthma without infection. He had been using an isoproterenol inhaler prior to his Emergency Room visit. In the Emergency Room a trial with epinephrine aqueous 1:1000 failed to improve the patient's status. He is considered to be in status asthmaticus. Patient in moderate/severe distress. Write down five therapeutic measures that you would initiate.

The following questions all relate to family therapy and are either true or false. Answer all questions before turning to the answer page to assess your responses.

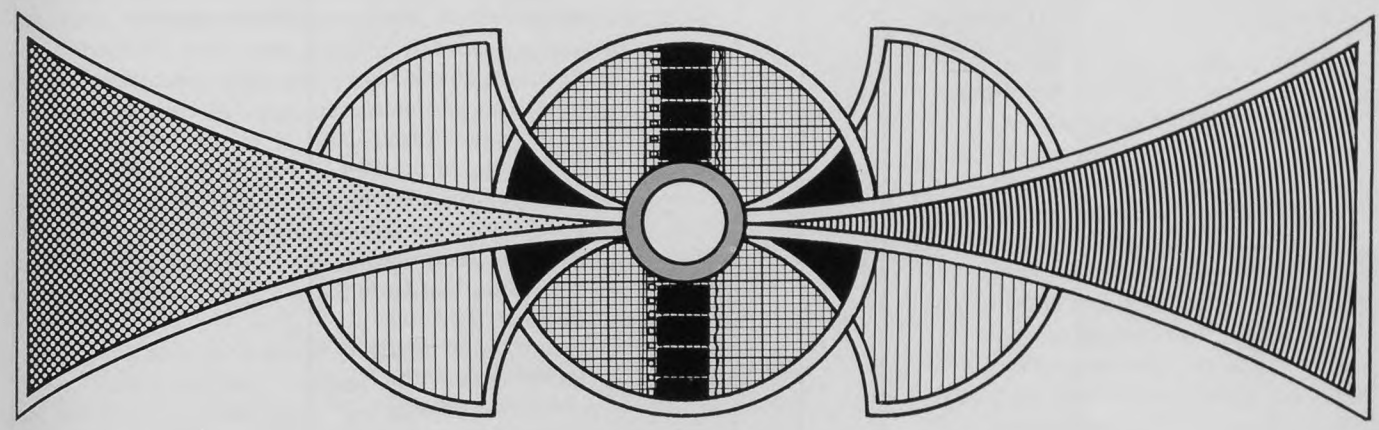
Question B:

1. The family therapist should never appear to be unfair to individual family members.
2. Diagnostic labels are damaging because they easily become self-fulfilling prophecies.
3. It is best not to have a structured initial interview with a couple having marital problems.
4. "Cure" of the identified patient may heighten dysequilibrium within the family.
5. Psychological probing does not mobilize a psychosis, because it is known that psychoses do not alternate with psychosomatic episodes.

Reviews of Audiovisual Materials

AUDIENCE
1 Family physician
2 Family practice resident
3 Family nurse practitioner/Medex
4 Medical student
MEDIA
A 35 mm slides
B 16 mm film
C Video tape
D Models

The following audiovisual materials have been reviewed by the Audiovisual Review Committee, an *ad hoc* group of the Education Committee of the *Society of Teachers of Family Medicine.* Membership: John P. Geyman, MD, Chairman (University of California, Davis), Richard M. Baker, MD (University of California, San Diego), Thomas C. Brown, PhD (University of California, Davis), Thornton Bryan, MD (University of Tennessee, Memphis), Laurel G. Case, MD (University of Oregon Medical School, Portland), Wendell B. Garren, MD (Geisinger Medical Center, Danville, Pennsylvania), James L. Grobe, MD (Phoenix, Arizona), Warren A. Heffron, MD (University of New Mexico, Albuquerque), Brian K. Hennen, MD (Dalhousie University, Halifax, Nova Scotia), Thomas L. Leaman, MD (Pennsylvania State University, Hershey), I. R. McWhinney, MD (University of Western Ontario, London), Donald C. Ransom, PhD (Sonoma Community Hospital, Santa Rosa, California), Philip L. Roseberry, MD (York Hospital, York, Pennsylvania), Rafael C. Sanchez, MD (Louisiana State University, New Orleans), Robert Smith, MD, (University of Cincinnati, Cincinnati, Ohio), William L. Stewart, MD (Southern Illinois University, Springfield), John Verby, MD (University of Minnesota, Minneapolis), Raymond O. West, MD (Loma Linda University, Loma Linda, California), Hiram L. Wiest, MD (Pennsylvania State University, Hershey). Reviews of each type of media were carried out by subgroups of the committee.



SOURCE	PROGRAM	MEDIA	AUDIENCE	COMMENTS	OVERALL APPRAISAL
National Audiovisual Center National Archives and Records Service Washington, DC 20409 ($68.00)	Seasons	B	1 2 3 4	The objectives of this program are implicit in its visual presentation and consistent with the title which suggests concern for the aging process and problems of the aged. The program addresses the issue of why some people age with grace and dignity, while others have major problems. The physiology of aging is briefly presented, current problems of care for the aged are outlined, and models for improved care of the aged stressing prevention are suggested. Preventive approaches including medical and social action are recommended to deal with identified problems. The program represents an effective use of audiovisual materials. Ambulatory approaches to care of the elderly patient are emphasized as a viable alternative to institutional care.	Highly recommended