Family Practice Forum

Idealism vs Realism: Reflections on Primary Care Practice and Training

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In recent years, there has been an increasing emphasis on the preparation of physicians to provide primary care services. This preparation has taken many forms, and primary care programs have developed in family practice, internal medicine, pediatrics, obstetrics/gynecology, and psychiatry. Receiving the training is only an initial step; the successful use of this clinical knowledge in the community is the real and often difficult challenge. This paper presents one physician's reflections on the realities of primary care practice and some suggestions for improving primary care training.

Idealism vs Realism

Toward the end of my residency training in family practice, I decided to work in a community that had a definite need for more health care providers and one that appeared willing to accept new ideas and approaches. The practice in which I chose to work had two energetic young physicians, and together we hoped to provide new suggestions and programs both for our practice and for the local hospital. I was probably more guilty than my partners of the enthusiasm with which I encouraged the introduction of the innovations. I questioned, for example, why a hyperbaric oxygen chamber for infants was still in use in the obstetrical delivery room; why tonsillectomies were done with such frequency; why buccal pitocin and amniotomies were still used in the outpatient setting. I also coordinated efforts to obtain hospital privileges for the nurse midwife who was practicing with our group, and with each effort I consistently met with skepticism and resistance.

Our group also tried to develop a system that would provide us with a satisfactory professional and personal life-style. Yet, criticism came our way because we set up a group on-call system rather than have each of us take call for our individual patients. Furthermore, we did not see as many patients per provider in our office as did the other physicians in town. We felt that the quality of our care would diminish if we had inadequate time to spend with the patients we were serving. These differences in our approaches were frequently negatively compared to the work habits of the older physicians.

The Impact on Me

By the time I had been in the community for one year, I found myself becoming discouraged and losing some of my enthusiasm and spirit. These feelings resulted from my perception that the physicians in the other group practice and key hospital personnel did not appreciate the extensive time and energy that was being devoted to initiating what I perceived to be constructive changes. Because I met with such resistance at every turn, I found myself becoming isolated. I experienced increasingly frequent bouts of depression, and I started giving serious consideration to moving to another community where my presence would be better appreciated.

How Could Things Have Been Different?

As I reflect on it now, I can identify several things that could have eased or prevented the problems that I encountered.

First and foremost, my formal training gave me

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minimal preparation for the issues and challenges which I encountered when I moved to the community where I was working. Simply providing medical knowledge and practice management information did not prepare me for the difficulties that I faced. I would have benefited from some formal training about "how to introduce change into an already established medical community" and "how to develop community support for new programs and ideas in health care." Such a training program might address some of the following concepts and approaches:

1. Acknowledge the good of what has occurred in the past before suggesting changes for the future. Provide positive feedback to those who have been working in the community, for there are opportunities to do this in sincere ways

2. Expect other health care professionals to be threatened by the new ideas and approaches. Therefore, slow the rate at which attempt is made to introduce change, and prepare the case well before proposing the changes. When disagreements occur, discuss them fully in an effort to prevent lingering angry feelings

3. Work behind the scenes to acquaint people with new suggestions before they are brought up in committee or in other formal settings such as Medical Staff meetings

4. Define goals clearly and develop a realistic timetable for attaining the goals

5. Avoid the tendency to get into a win/lose posture. Use a compromise approach for introducing change

6. Recognize that personality clashes will arise and try to prevent them from obscuring goals and directions

7. Work within the system. Do not ignore the rules, but do question them when appropriate

8. Work closely with community health and consumer groups and learn how to mobilize them when their support is needed

9. When moving into a new community, expect to be viewed as "an outsider" and realize that acceptance of new people comes very slowly

How can knowledge such as the nine points listed be taught? I believe that these issues should be addressed during medical school and residency training. Small group seminars would be a logical setting, facilitated by people who understand these issues. The participants can role play and/or problem solve some hypothetical situations; hopefully educational materials will emerge from such seminars which can be used for subsequent groups.

In addition, preceptorships in primary care practices will expose students and residents to some of these important issues. By working in a community where primary care is done, the preceptees will have an opportunity to see and experience some of the challenges they will face later.

It is hoped they will learn that being a good physician does not involve only being a good clinician, but also being a good strategist and politician.

When a new physician completes formal training and enters clinical practice, a support system should be available to him/her. Such a support system can be developed on the local scene with other physicians, through county or state medical associations, or through university outreach programs. The recognition that one is not alone in the world but has others who are striving for similar things and undergoing similar challenges would do much to ease the impact of some of the frustrations which occur when entering a new practice.

Conclusion

I still work in the community which I have described in this paper, and many of the changes which our group hoped to introduce have come about. These changes have not come easily, and the price has been much emotional and physical work. We look proudly on what we have accomplished in the time that we have been here, but we also look sadly on the errors we have committed in the process of bringing about the changes. As I review the past few years, I recognize these errors could and should have been avoided. If we had known what to anticipate, learned from the experience of others in communities such as ours, we might not have been destined to repeat the errors of the past.

All of us have to learn from our mistakes, but I believe that there is a fund of knowledge which needs to be developed and shared during the training of all primary care physicians and health care professionals, which will permit them to be more effective and efficient workers when they complete their formal training. If this fund of knowledge can be developed and shared widely, the satisfaction of everyone involved in providing primary care will be increased and their longevity in their communities will be extended.