Public Policy Implications of Graduate Follow-Up Studies in Family Practice

Robert Graham, MD
Washington, DC

The growth of family practice as a specialty in the last ten years has been a result of the interaction of a complex set of issues, interests, and individuals. In this context, the immediate task of a paper purporting to analyze "policy" as it relates to family practice education is to provide some workable definition of that amorphous term. Many perceive policy as a tangible entity—something which can be set, decided, or handed down—that can be assessed in discrete aliquots. However, policy is highly subjective, with the description as to its nature, intent, and impact being open to as many interpretations as there are observers or points of view. This assertion is not intended to lay the groundwork for a denial that policy evaluation can be attempted on the last ten years of family practice graduate education, but is simply to make it clear that certain guidelines and limits must be specified at the outset. In addition, policy analysis must achieve at least two objectives: first, it must provide a context wherein results can be evaluated and discussed, and secondly, it must lay out a framework whereby future questions may be posed and issues anticipated.

This paper will examine the common elements of the policy expectations of public, professional, and political bodies in 1970 regarding family practice, and compare the results of the last ten years to these expectations. Then, based upon these results and the present status of family practice, an attempt will be made to anticipate the policy issues by which the specialty will be judged during the coming decade.

Dr. Graham is a Professional Staff Member, Senate Subcommittee on Health and Scientific Research, Washington, DC.

Background

The task of preparing a policy analysis dealing with elements of the last ten years' growth in family practice education is complicated by the paucity of explicit objectives defined by the several "constituencies" of the family practice movement in the late 1960s. The general concerns regarding physician manpower and the availability of general medical care were first widely articulated in a series of commissioned reports sponsored by pub-

0094-3509/80/110779-06$01.50
© 1980 Appleton-Century-Crofts

lic, private, and professional entities beginning in the mid 1960s.[1-4] Although the scope and focus of each of these reports differed as a function of their sponsors and participants, each reflected in its recommendations a growing level of public and professional concern regarding the decreasing availability of personal physicians. In this pre-1970 era the term "primary care" was yet to be coined, or at least was not in general use, and thus the major focus was on the vanishing general practitioner and the relatively new concept of family practice.

There were two easily recognized outgrowths of this widespread reexamination of US health manpower policies. In the professional sector, forces were marshalled that led to the establishment of the American Board of Family Practice and the Residency Review Committee for Family Practice in 1969.[5,6] In the public sector, concern over the possible disappearance of the general practitioner found fertile ground within national and state political bodies. The fact that there was a general perception in the late 1960s of a physician shortage in the United States and that this shortage was reaching a crisis proportion in the rural areas where general practitioners once predominated, gave rise after years of hard work by advocates for family practice to the establishment of a specific federal program to support the training of additional family physicians.

Although each of the professional and public entities had their own perception as to the need for family physicians and the functions which such a doctor would carry out, perhaps the best summary of the convergence of these views was provided in the text of the House Committee Report which accompanied its versions of the Health Manpower Bill of 1971:

> The role of the family physician in the overall health care picture is especially important. He [sic] can treat the majority of illnesses which confront him, and in those instances where it is necessary to refer the patient, the family doctor assumes the role of the patient's advocate, and the professional who assures continuity of care. As importantly, he plays a key role in the prevention of illness and the maintenance of health.
>
> More family doctors must be trained. Many communities today are without physicians, and still more [are] faced with the possibility of not having a doctor shortly. If these areas are to be served, they will require the practitioners of family medicine.[7]

The eventual passage of this bill provided the first major influx of federal funds for graduate and undergraduate training in family medicine beginning in 1972 and, along with similar state statutes passed in later years, supported the vigorous growth of family practice residency programs in the mid and late 1970s.

Analytic Parameters

From the above, it is clear that the somewhat global expectations of the early family practice constituencies do not provide any easily quantifiable parameters by which the later performance of the specialty can be assessed. However, there are some general areas of agreement among the various reports, papers, and legislative histories regarding the major issues to be addressed by the new specialty of family practice. For the purposes of this policy analysis the following five areas have been selected as the parameters of performance of major concern to the early constituencies of the family practice movement: (1) production, (2) distribution, (3) comprehensive care, (4) practice viability, and (5) quality of practitioner performance.

Although reasonable arguments can be made for the inclusion of additional parameters, or the deletion of some of the above, these five have been selected because they go to the heart of the expectations of public and political communities in their support of the new specialty in 1970.

Analyses and Findings

In reviewing the various papers presented earlier in this issue,[8-13] it can be seen that the performance of family practice graduate education in the past decade has been well directed toward meeting at least four of the major policy parameters identified.

In terms of production, the growth of interest in family practice education has been one of the

major phenomena of the 1970s. The expansion of residency training positions in family practice, aided by federal and state funding and the vigorous support of professional organizations in family practice, has provided a major alternative pathway for graduate education in general medical care to post-1970 graduates of US medical schools. Although earlier hopes on the part of family practice educators of being able to provide positions in family practice residencies for 25 percent of US medical graduates by 1980 have not been fulfilled, there is reason to believe, from the continued steady growth in student interest and residency position availability, that these goals eventually will be realized.

It is in the area of distribution of family practice residency graduates that perhaps the clearest success of a "policy objective" can be identified. Given that a major concern on the part of the Congress and the public in the late 1960s was the diminution of physicians in rural America, the data presented elsewhere in this issue make a persuasive case that family practice graduates are, indeed, entering practice in areas which are both rural and underserved and are doing so in numbers that can be accounted for only by the assumption of a specific effort on the part of family practice residency training programs toward this end. Although some questions about the actual distribution of family physicians have arisen and will be discussed later, the predominant conclusion to be reached from the data presented here is that the first order questions of distribution of family practice residents to non-metropolitan areas have been successfully addressed.

Concern was also clear in the earlier studies and reports regarding the mode of practice of family physicians and their ability to deliver comprehensive care. Such terms as "continuity" and "can treat the majority of illnesses" (as reflected in the language of the House Report) were used, and have continued to be emphasized in the literature dealing with family practice education in later years. The data provided by the analysis of graduates from the three statewide systems present strong arguments to the effect that family practice residents are initiating their practices in a manner that provides a comprehensive set of services to an identified population on a continuing basis. The breadth of the graduates' practice is well documented in these surveys, and the acquisition of appropriate hospital privileges has, in most cases, been achieved. Although these surveys provide no information regarding public satisfaction with the practice models being offered by the graduates, at least the proxy measures of practice pattern and hospital privileges would appear to be responsive to the general charge provided by the Congress in 1970.

The fourth issue, that of practice viability, is more difficult to assess; and the information provided by the studies cited above is more ambiguous. On the positive side, family practice graduates do appear to be practicing in areas of demonstrable need for their skills; and the vast majority (about 95 percent) appear to be remaining in the practice of family medicine, rather than making a transition to other types of more limited specialty medical practice. On the negative side, data provided in these studies suggest that at least half of the graduates of family practice residencies surveyed have altered their practice site one or more times since initiation of practice. Since the survey itself is heavily weighted toward more recent graduates of family practice residencies, this rate of practice relocation must raise a valid question about practice stability in a specific site over a period of time. However, since the time line for tracking family practice residency graduates' practice location is so brief (less than a decade for any, with the median probably between three to four years), and since the survey results did not report reasons for relocation behavior, this issue must simply be marked as a potential area of question and one worthy of further careful observation and investigation.

It is only in the fifth policy area of quality of practitioner performance that the data presented are silent. Perhaps reflecting the pervasive problem of assessment of adequacy of physician performance, neither the reviews of the three statewide systems nor the national survey give any quantitative insight into the quality of performance of these newly trained physicians. Although it may be regarded as unsporting to expect family practice to have achieved a type of demonstration of the quality of practice of its graduates that still eludes other, more established, specialties, it must be acknowledged that family practice has a special vulnerability in this area. One set of adversaries argues that the demands of general medical care are too difficult and complex to be mastered by

any one practitioner, while another set holds forth with the view that many specialists and subspecialists do substantial amounts of "primary care" without any special training being required. Although family practice thus far appears to be thriving at the vortex of these conflicting views, the risks attendant to a continuing inability to document quality of practice are high.

To summarize the findings thus far, the results of ten years of family practice education have resulted in a pattern of expansion of the practice of family medicine that has been highly responsive to the implicit policy concerns of the public, professions, and Congress in 1970 regarding the number of generalist physicians, the location of their practices, and the scope of their professional skills. The data regarding the length of time these new physicians stay in the same practice site are inconclusive and require continuing, careful review. The area of assessment of the quality of professional practice finds little data available, thereby providing the opportunity for substantive questions regarding an issue of major importance to family practice to be raised without challenge.

In passing, an unanticipated, but nevertheless highly significant finding which emerges from the review of the research papers provided in this issue should be noted. Systems have now been developed in several states to provide a highly sophisticated feedback system between elements of the educational institution and the practice community regarding the relevance of residency training to practice, and to acquire data on the career patterns and behaviors of the graduates of the educational institution. Perhaps no greater weakness is evident in the US system of medical education than the almost total lack of linkage between the various levels of the educational ladder. It is the unusual medical school that has any comprehensive idea of the subsequent specialty training or practice location of its graduates; and, until recently, few residency programs have exercised any responsibility on their own for the tracking of their graduates into practice or the initiation of a feedback system whereby the practice experience of their graduates could be evaluated in terms of the content of the residency program. The leadership of the academic centers and national organizations in family practice in developing this type of ongoing feedback and self-correcting system for their education programs is to be applauded. This behavior should bode well for the continued ability of the specialty to assess the changing interests and priorities of the public, the Congress, and the profession, and to respond appropriately.

Prospective Issues

Having reviewed retrospectively the performance of family practice graduate education as it related to a major set of public policy questions in the last ten years, the second test of our policy analysis format is an attempt to identify ways in which the "policy environment" has evolved during the past decade so as to now provide the specialty of family practice with a set of new challenges.

Whereas the major portions of the earlier set of expectations of family practice were addressed directly as issues of availability of desired services (productivity, distribution, pattern of practice), the issues confronting family practice are now inextricably bound up in the changing perceptions of the problems related to medicine and the delivery of health services as a whole. In addition, whereas the initial impetus for family practice came from the Congress and the public (responding to a strong push from the young specialty itself) at least two other major entities—academic medicine and other professional organizations—are now raising their own issues and introducing their own agendas into the context of policy expectations directed at family practice. In this milieu, the set of issues which family practice education will have to address in the coming ten years will have at least the following major elements: (1) competitiveness with other providers, (2) cost effectiveness, (3) intellectual base, (4) practice viability, and (5) second order distribution questions.

Competitiveness with other providers is a conjoint issue, with elements of the continuing debate regarding the quality of, or need for, family practice being combined with the additional issue of the proper mix of our pool of health care personnel. Although the total level of demand for medical services in the United States is still unclear (and may depend heavily upon the evolution of our fi-

nancing systems), most professional groups seem to have accepted that it is at least finite. Given this, there has been increasing concern with how much of the slice of the pie each professional entity will be able to control. In this case, elements of all of the health care professions are beginning to pit themselves against one another in making their arguments to the public and legislative bodies regarding the pre-eminence of their own skills. Family practice is already fighting skirmishes, both major and minor, regarding hospital privileges and membership on major national organizations (eg, the Joint Commission on Accreditation of Hospitals). These confrontations presage potentially wider conflicts within the profession to obtain full latitude for the practice of the complete set of skills for which family practice graduates are being trained.

A second policy of concern is that related to cost effectiveness of various elements of medical practice. With increasing amounts of medical care being paid for by third party payors (either private or public) the payors are individually and collectively beginning to examine ways in which levels of benefits may be maintained at a stable cost. There will be increasing opportunities and requirements for competitiveness in the delivery of services. Alternative arrangements of practice may be selectively encouraged by public agencies (eg, health maintenance organizations) or by the profession (eg, closed panel, subspecialty groups) in an attempt to reduce costs while maintaining services. It should also be anticipated that the concern with cost consciousness will encourage state and federal legislators to look at the options for delivery of certain types of services by nonphysician providers, and to thereby expand the latitude that such providers have for their independent interaction with patients. The challenge to family practice in this set of policy concerns will be to continue to demonstrate that its mode of practice is adaptable to a wide range of organizational settings, and that the training of its practitioners in the residency programs equips them to provide a comprehensive set of services in a satisfactory manner to a wide variety of patients, at a cost that is competitive with other practitioner types and organizational formats.

The policy issues regarding the articulation of the intellectual basis for family medicine may not be so much of a future conflict as they are an ongoing, but enlarging, battle. With the early growth of family practice training having taken place in the relatively hospitable setting of community hospitals, the issue of academic viability of family medicine within US medical schools was not substantively joined until the mid to late 1970s. This has been a controversy in which the public and the Congress have been largely uninvolved—although there is a modest amount of federal and state funding for departments of family medicine—but which may have potentially the most profound effect on the continuing growth and viability of family practice as an identified specialty. The present economic circumstance is not one that will provide for easy expansion of programs within today's medical centers. Federal and state resources allocated to medical education are, in most instances, being held at a steady state or being slightly reduced. In this environment, the growth that family medicine seeks academically can only be perceived by established academic interests as taking place by diminution in their power, prestige, and resources. The establishment of family practice as a legitimate specialty and full partner in academic medicine will require major strides in the coming decade toward increasing the influence of each of its academic units in US medical schools, and gaining better understanding of the research base underlying the practice of family medicine.

Fourthly, the issue of practice viability will continue to be of major concern to the Congress and to the public in the coming decade. The results presented in this issue regarding the practice profiles of the early graduates of family practice residencies are suggestive, but not conclusive, of the hypothesis that family physicians can and will establish themselves in a wide variety of practice settings. However, the tenets of the family practice philosophy of continuity and comprehensiveness will require that graduates of family practice residency programs continue to provide the wide range of services for which they are prepared, and that they do so by establishing a firm and continuing base in a specific community. Should it evolve that the practices of graduates of family practice residencies become increasingly constrained, or that the graduates of such residencies relocate frequently, major issues will be raised in the minds of many who have supported family practice as to its ultimate viability as a stable source of personal medical care.

Finally, complex issues and questions regarding the distribution of all physicians, but especially family physicians, will continue to be identified in the coming decade. The early concern with locating additional physicians in "underserved" areas has now come to be seen as bordering on the simplistic. Intensive study of these questions over the last several years has raised more issues than it has resolved. There are now the divergent suggestions that either the shortage of physicians is improving naturally (because specialty physicians have a tendency to diffuse voluntarily into smaller communities) or that the shortages in smaller communities are actually becoming worse (because of the tendency for primary care physicians to concentrate within existing medical communities in rural areas).[14] In addition, although the objective assessment is that rural primary care availability has shown improvement in the last ten years, subjective evidence is that primary care in urban areas has deteriorated. A major policy issue for family practice as a specialty and for its residency graduates in the coming decade will be whether or not the highly positive public image of the "country doctor" can be extended in perception and in fact to encompass that of a "big city doctor." Because of the dominance of academic medical centers in many of the largest US cities and the present weak position of family practice in many of these medical centers, the expansion of the practice and presence of family practice as a specialty to the suburban and inner-city areas will be a particularly severe challenge.

Summary

An assessment of the progress of family practice over the last ten years, from the point of view of public policy analysis, finds that family practice has adequately and successfully addressed the majority of the policy issues of concern to its major constituencies in the early 1970s. The decade of the 1980s finds family practice as a vigorous, thriving specialty, which has met many of the early expectations of its supporters. Now, however, because of its own growth and the changing environment of medical practice in the United States, family practice faces a broad range of expectations and policy challenges from a wider, and in some cases more hostile, constituency.

References

1. National Commission on Community Health Services: Health is a Community Affair. Cambridge, Mass, Harvard University Press, 1966
2. Millis JS (chairman): The graduate education of physicians. Report of the Citizens Commission on Graduate Medical Education. Chicago, American Medical Association, 1966
3. Willard WR (chairman): Meeting the challenge of family practice. Report of the Ad Hoc Committee on Education for Family Practice of the Council on Medical Education. Chicago, American Medical Association, 1966
4. Report of the National Advisory Commission on Health Manpower, 2 volumes. US Government Printing Office, 1967
5. Geyman JP: Family practice in evolution: Progress, problems, and projections. N Engl J Med 298:593, 1978
6. Stephens GG: Reform in the United States: Its impact on medicine and education for family practice. J Fam Pract 3:507, 1976
7. Committee on Interstate and Foreign Commerce, House Report No. 92-258, to Accompany the Comprehensive Health Manpower Training Act of 1971, together with Minority Views. US Government Printing Office, June 9, 1971, p 25
8. Ciriacy EW, Bland CJ, Stoller JE, et al: Graduate follow-up in the University of Minnesota affiliated hospitals residency training program in family practice and community health. J Fam Pract 11:719, 1980
9. Mayo F, Wood M, Marsland DW, et al: Graduate follow-up in the Medical College of Virginia/Virginia Commonwealth University family practice residency system. J Fam Pract 11:731, 1980
10. Graduates of family practice residency programs in New York state. Report of a Committee of Directors of Research of New York State Family Medicine Residency Programs. J Fam Pract 11:753, 1980
11. Geyman JP, Cherkin DC, Deisher JB, et al: Graduate follow-up in the University of Washington family practice residency network. J Fam Pract 11:743, 1980
12. Black RR, Schmittling G, Stern TL: Characteristics and practice patterns of family practice residency graduates in the United States. J Fam Pract 11:767, 1980
13. Geyman JP, Ciriacy EW, Mayo F, et al: Geographic distribution of family practice residency graduates: The experience of three statewide networks. J Fam Pract 11:761, 1980
14. Madison DL, Combs DC: Location of patterns of recent physician settlers in rural America. The Department of Social and Administrative Medicine, University of North Carolina School of Medicine, 1980