Responses to Questions Frequently Asked by Medical Students About Family Practice

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During their medical school years medical students are frequently exposed to misinformation about family practice from faculty members in other specialties. Responses to 26 questions frequently asked by medical students about family practice are presented with a review of recent literature. These responses may assist medical students and their advisors when considering careers in family practice.

Medical students frequently have questions about the specialty of family practice. Exposed to academic tertiary care specialists throughout most of their clinical rotations, many students are given misinformation about family practice. There are common misconceptions or myths perpetuated in the academic environment that can be destructive to a student's interest in family practice as a career choice.

The following is a list of questions gathered by medical students at the University of California, Davis, and the University of Wisconsin-Madison. Responses were compiled by residency-trained family physicians from their experiences and a review of recent literature. These responses may be useful to medical students and their advisors as a supplement to a predoctoral program for developing careers in family practice.

Question 1: What is a family physician, and how does this role differ from that of a traditional general practitioner?

Response: By definition the family physician is "educated and trained to develop and bring to bear in practice unique attitudes and skills which qualify him or her to provide continuing, comprehensive health maintenance and medical care to the entire family regardless of sex, age, or type of problem, be it biological, behavioral, or social. This physician serves as the patient's or family's advocate in all health-related matters, including the appropriate use of consultants and community resources."[1]

Family practice residencies were developed in response to a need perceived by the public, the medical profession, and government for the development of a well-trained generalist. The general practitioner of the past usually began practice after an internship or brief residency largely consisting of inpatient rotations. After World War II came an age of specialization during which very few graduates selected general practice. To fill the need left by the decline in general practice, family practice became a specialty in 1969, the twentieth specialty recognized by the American Board of Medical Specialties.

Family practice follows the general practice tradition, but has some major differences. Before entering practice, in addition to a broad inpatient training, family physicians receive extensive training in outpatient medicine for all ages. As a specialty, family practice has stringent requirements for continuing education and board certification.

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Family practice combines the content of general practice and other clinical disciplines, including the behavioral sciences and preventive medicine, and integrates them into a single specialty with a focus on patient care in the context of the family and community.[2]

Question 2: Is it possible to be a competent family physician? How can one know enough about the many clinical areas in medicine?

Response: The amount of knowledge necessary to be a good family physician is not greater than the amount of knowledge necessary to be any other specialist such as a pediatrician or a neurologist.[3] The difference is that the body of knowledge in family practice spreads across many disciplines without the need for an esoteric depth in any discipline. Seventy percent of all the problems seen by a family physician fit into 30 diagnoses.[4,5] It is not extraordinarily difficult to acquire and maintain high-quality clinical skills to manage the great majority of common problems that patients bring to physicians in a primary care setting.

Question 3: Do family physicians refer many of their patients to other specialists?

Response: Family physicians manage exclusively over 90 percent of problems they encounter with the confidence that they are handling these problems as well as or better than any other specialist. A consultation is requested for about 7 percent of problems, and the family physician continues to manage the patient. When a referral is made (0.9 percent to 3 percent of problems), the family physician remains active in the care of the patient.[6-8]

Question 4: What will be the role of the family physician in the future, when there is a surplus of other specialists?

Response: The public, third-party payers, and government health officials recognize that family physicians are the appropriate providers to manage most health problems. Because of the efficiency and cost effectiveness of having a family physician as the entry into the health care system, the role of the family physician seems secure.[9] Current trends in government and other third-party reimbursement systems suggest that family physicians will maintain and probably will enlarge their role in the health care system.

Question 5: Will family physicians be able to maintain hospital privileges, particularly in obstetrics?

Response: With well-documented residency training, it is not likely that family physicians will be denied hospital privileges. The American Academy of Family Physicians has established the maintenance of hospital privileges for family physicians as a top priority.[10,11] Criteria have been negotiated with other specialty organizations for the approval of hospital privileges for family practice residency graduates. These criteria have been tested in court, and generally the family physician has won.[12] A recent survey of family practice residency graduates has shown that over 96 percent have all the hospital privileges they requested, with 89 percent having privileges in intensive care units and 64 percent of graduates doing obstetrics.[13,14] As long as the profession of family practice in this country considers hospital privileges to be an important priority, it is unlikely there will be any significant change in the hospital-based role of the family physician.

Question 6: Is family practice a satisfying career choice, or does it become monotonous?

Response: Surveys of family practice residency graduates in practice indicate high levels of personal and professional satisfaction.[13,15] Only 4 percent of recent graduates find boredom to be a problem.[15] The variety of medical problems is such that no day in the office is the same. In an average month, a family physician may see patients with up to 400 different diagnoses.[16]

The family physician receives the greatest satisfaction, however, from the intense involvement in the changing lives of his or her patients rather than from the treatment of the health problems with which they present. Being a family physician is a fascinating and privileged role that increases with time as the physician gains a deeper understanding of the people in a community.

Question 7: Do family physicians take care of patients with serious illnesses?

Response: Patient visits to family physicians include not only preventive care and health promotion, but also the management of acute and chronic illnesses, be they minor or serious. A large survey of patient visits to family physicians indicated that about one third of visits were for serious or potentially serious problems (for example, cardiovascular disease and abdominal pain).[16]

Question 8: Are family physicians adequately trained for their job?

Response: Residency training in family practice

is designed specifically to prepare family physicians for their job. Surveys indicate that recent graduates feel well prepared for their work as a result of their residency training.[13,15] Only 1 to 2 percent of recent graduates indicate having to care for medical or surgical problems beyond their training as a serious problem.[15]

Question 9: Do family physicians see too many patients to do a good job?

Response: In the 1980 the average number of patient contacts per week for family physicians was 172, compared with 160 for pediatricians and 112 for internists.[17] More recent figures from other sources show that family practice residency graduates have an average of 141 patient contacts per week.[4] The range is great, since physicians may set their own pace. The data suggest that family physicians may spend somewhat less time with patients at each visit but see them more often.[4] Only 8 percent of residency graduates rate having too many patients to see as a serious problem.[15]

Question 10: What is life like for a family physician: Is there time for a good personal and family life?

Response: The typical family physician works 50 to 60 hours per week in direct patient care.[13,14] About 80 percent of residency graduates practice in partnerships or group practices that have call-sharing arrangements.[13,18] Family physicians in solo practice may also share calls with a group. Coverage arrangements can be made so that the physician may work part-time and be on call only when desired and still maintain a continuous involvement with patient care. Most family practice residencies train their graduates to work with colleagues so that they will have ample time for personal and family priorities. A survey by the Robert Wood Johnson Foundation has shown that family physicians spend more time with personal and civic activities than do general internists, most medical specialists, obstetrician-gynecologists, and some surgical specialists.[19]

Question 11: What about malpractice insurance; could the high cost prevent family physicians from doing obstetrics and other procedures?

Response: Family physicians enjoy special malpractice rates formulated for their specialty. A family physician can do basic obstetrics, surgical assisting, vasectomies, dilation and curettage, and office surgeries in an intermediate category with very affordable insurance rates. The mean malpractice insurance costs for family physicians in the United States in 1981 was about $2,000 per year, with considerable geographic variation. This compares with mean malpractice insurance costs for obstetrician-gynecologists and other surgical specialists of over $10,000 per year.[20,21]

Question 12: What practice opportunities will be available in the future for family physicians?

Response: Although the United States is heading for a potential physician surplus by 1990, a continuing need for primary care physicians, including family physicians, has been projected.[22] Many areas of the country are greatly underserved and need family physicians. Family practice openings are numerous in urban, suburban, and rural locations. A recent *Physician Placement Bulletin* of practice opportunities in California listed more family practice positions than internal medicine, pediatrics, and obstetrics and gynecology combined.[23]

Family practice has an advantage over other specialties in that a population of 2,000 is adequate to keep a family physician busy. It takes an unserved population of over 10,000 to accommodate most other specialists.[24] Hence, growing communities frequently need more family physicians.

Question 13: Is family practice only for rural communities, or is this specialty appropriate for urban areas?

Response: There is a great public demand for family physicians in all locations. While it is true that communities with fewer than 10,000 people are best served by family physicians almost exclusively, family physicians also enjoy nearly the same role in urban areas, where there are many other types of specialists.[10,11,16] Surveys of recent graduates of family practice residencies have shown that although about 50 percent practice in communities of less than 25,000 people, 25 to 30 percent practice in cities with more than 100,000 people.[25,26]

The presence of many subspecialists does not preclude the need for family physicians. The family practice model is so embraced by the public that family physicians have little difficulty competing with other specialists for primary care.

Question 14: How do family physicians keep up with medical advances?

Response: Continuing education occurs in a variety of ways, including dialogue with colleagues, learning from consultants, reading medi-

cal journals, and attending courses and medical meetings. The number of major advances each year altering patient care on a primary care level is not great.

The American Board of Family Practice was the first specialty board to require recertification for ongoing membership. Recertification involves a cognitive examination and an audit of a selected number of the physician's office practice records. No other specialty requires a comparable degree of continual updating of medical knowledge and skills.

Question 15: Can I specialize in a field such as general surgery or obstetrics and gynecology and still do family practice?

Response: Although there is nothing to restrict any licensed physician from doing general practice, physicians in practice readily acknowledge their lack of expertise in handling problems outside their specialty area. The ability to manage confidently a wide variety of problems from sick infants to orthopedic problems to chronic disease in the elderly requires years of generalist training beyond medical school. There has been a documented rapid decline in broad clinical knowledge during the first year of residency training in specialties other than family practice.[27] Furthermore, board certification in family practice requires residency training in family practice.

Question 16: Can a family physician be an expert in anything?

Response: The family physician is an expert in the evaluation and management of common health problems, with an understanding of the whole person in the context of a family and community, and with an emphasis on disease prevention and health promotion.

Along with this expertise, many family physicians develop a special interest in certain areas. For example, family physicians commonly have a special interest and expertise in sports medicine and fitness, preventive medicine, care of the elderly, and hospice care for the dying. The variety in family practice allows the physician to have expertise and be active as a community leader in diverse areas.

Question 17: After family practice residency training, what career options are available, for example, in emergency rooms, health maintenance organizations, student health centers, public health, or international medicine?

Response: A family practice residency provides a broad and liberal training that gives the graduate many options besides a traditional practice. Many family practice residency graduates work in community hospital emergency rooms, student health centers, and health maintenance organizations. Often the family physician is in a management role in these locations. The great variety of opportunities is illustrated by the offerings in the *Physician Placement Bulletin*[23] or the classified advertisements of many medical journals.

Family practice residency training also prepares a physician to pursue a role in public health and international medicine. The World Health Organization is becoming increasingly aware of the value of family practice training, and the residency format in this country is spreading throughout the world.

Question 18: How do physicians' assistants, nurse practitioners, and midwives fit in with the role of the family physician in the future? Will they replace the need for family physicians?

Response: Physicians' assistants, nurse practitioners, and midwives developed as new members of the health care team, particularly in response to the need for providers in medically underserved areas. They were never intended, nor are they trained, to replace family physicians. These practitioners can extend the breadth and quality of family practice, particularly through health promotion, screening, and patient education; however, the family physician is an essential provider of comprehensive and continuing care for families. In addition, as a substantial physician surplus is developing, the number of training positions for physicians' assistants and nurse practitioners is decreasing.

Question 19: What is a family practice residency, and how does it vary in structure around the country?

Response: In the United States all family practice residencies are three years and provide a relatively standard curriculum. About 70 percent of family practice residencies are located in community hospitals that usually do not have other residency programs. About 30 percent of family practice residencies are in academic teaching centers. Most community hospital programs are affiliated with a medical school.[28]

The most striking characteristic of all family practice residencies is an outpatient experience in a family practice center that allows the resident to assume the role of a family physician for a limited

number of individuals and families throughout the three years of residency. The amount of time spent in the family practice center increases with each year in the residency.

The hospital experience during the first year of residency is similar to that of a rotating internship. During the second year, the resident assumes greater responsibility for hospitalized patients and usually has some elective time. In the third year the resident commonly has more outpatient rotations, electives, and inpatient rotations with greater responsibility.

Important aspects of family practice residency training include behavioral science, counseling skills, practice management, and an approach to health maintenance and preventive medicine. All of these are integrated to develop a physician with an orientation to the whole person and to families. Flexibility is usually built into the curriculum to allow the resident to pursue such diverse interests as high-risk obstetrics, clinical hypnosis, and research. In other words, the third-year resident will usually select training experiences that fit a future practice interest.

Question 20: How difficult is it to get into a good family practice residency?

Response: There are currently 387 family practice residencies in the United States.[28] A Residency Review Committee* carefully evaluates these programs to maintain an overall quality. While considerable competition exists for the most popular programs, it is not difficult for a student of at least average academic standing to match into a good family practice residency.

Question 21: Is it possible to do a flexible internship and then enter a family practice residency?

Response: Although this option is possible, it is more difficult than entering a family practice residency the first year. The attrition rate for family practice residencies is very low. For those limited number of available positions in the second year, there is generally great competition. Residents completing a flexible internship would have to compete with physicians having practice experience who would want to complete a family practice residency.

Question 22: What are the academic qualifications of students entering family practice?

Response: In one study, the average Part II National Board Examination scores for students entering family practice residencies was 541. The average of the entire group of students entering all specialties was 539. For Part III, the score was 549 for family physicians and 526 for all specialties.[27] Another study done in 1982 indicated that the premedical academic qualifications of students selecting family practice (as measured by undergraduate GPA and MCAT scores) are comparable to those of students selecting other specialties.[29] In general, students entering family practice have the same qualifications as those entering other specialties.

Question 23: What is the average income of a family physician, and how does this compare with other specialists?

Response: Family physicians enjoy an income that compares favorably with other specialists in primary care. A recent survey in *Medical Economics* indicated that the average net income for family physicians in 1981 was about $70,000 per year.[30] This amount was slightly greater than that for pediatricians and general practitioners and slightly less than for psychiatrists and internists.

Question 24: What are the opportunities for teaching in family practice?

Response: Since family practice is a relatively new academic discipline that has grown rapidly, there are many unfilled teaching positions. Family physicians teach full-time or part-time in both medical schools and community hospital programs. There is also a great need for family physicians to teach medical students and residents in their office settings. Sixty percent of recent family practice residency graduates are currently involved in some form of teaching.[18]

Question 25: What are the opportunities for research in family practice?

Response: The opportunities for research in family practice are varied and are receiving increasing support. The spectrum for family medicine research includes the natural history of disease and illness behavior in individuals and families, clinical studies of diagnostic and treatment methods, the organization of health services, and public policy.[31,32] The developing collaborative networks among practicing physicians will provide a rich base for future research.[33] The American Academy of Family Physicians (AAFP) and the Society of Teachers of Family Medicine (STFM)

*With representation from the American Medical Association, the American Academy of Family Physicians, and the American Board of Family Practice

have active research committees that work to improve research skills and stimulate projects. The Family Health Foundation of America (FHFA), the philanthropic arm of family practice, provides increasing support to research activities. The National Institutes of Health (NIH) recently held a symposium on family medicine research.

Question 26: Is family practice a growing specialty?

Response: The number of board-certified family physicians has risen from 0 in 1969 to nearly 30,000 in 1982. In the same period, the number of residencies has gone from 0 to 387. The number of residents in training has increased yearly, exceeding 7,200 in 1982. The AAFP, with over 55,000 members, is the largest specialty organization in the world. There is a projected growth of 10 percent in the number of family physicians between 1980 and 1990.[22] The numbers reflect a discipline that is well established, growing, and here to stay.

Comment

These responses reflect the wisdom of several recent residency graduates who are enthusiastic about the specialty of family practice. There is room for further elaboration and varying opinions. Most students with an interest in or a healthy skepticism about family practice will have other questions not listed above. While many academic specialists in other fields will readily give their opinions about family practice, it is hoped students will obtain counsel from family physicians. Departments of family practice in medical schools should have a group of family practice advisors who are readily accessible and who frequently meet with students to discuss these questions.

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