Family Practice: Exclusive, Inclusive, or – Heaven Forbid – Both?

We are at a crossroads in family practice where we must look critically at our specialty to find out whether our goals for shaping the specialty as we know it and our goals for increasing the number of students choosing family practice are compatible or are in conflict.

The original model, the foundation of family practice, is the well-trained generalist prepared to provide comprehensive care for patients of all ages, in all venues (clinic, hospital, home, or other facilities), no matter what the problem. This original model of family practice on which we based our training programs and certification procedures included the care of patients of all ages, maternity care, and hospital care. To this day, even with our emphasis on training in the Family Practice Center, we have considerable amounts of training in the hospital. Now, however, we find that many family physicians and recent graduates of our training programs limit their practices and do not provide the breadth of care inherent in the traditional model.

The original model has served us well in many areas—from rural communities to the inner city. I had the opportunity to develop this model in the largest multispecialty clinic in the United States. When I arrived at the Mayo Clinic, friends and foes alike asked, "Who will come to see you, a family physician, in this environment where all the specialties are so well integrated?" My answer was, "Give me an office to see patients, and give the patients the opportunity to choose a family physician as well as any other physician, and let's see what happens." Because of my conviction that the original model was the best (based on 30 years of family practice that included maternity and hospital care), I designed the practice and the residency at Mayo to model and produce well-rounded family physicians who included maternity care, hospital care, and procedures in their practices.

Within the first several years of this experiment, the following occurred. Family practice was one of the most rapidly growing departments in the institution, an active family practice hospital service was developed, 25% of the obstetric deliveries were done by family physicians, 40% of the newborns were cared for by family physicians, and a successful training program was developed. The Family Practice Center was located in a nearby rural community, and after two major expansions, it now provides care for more than 30,000 patients per year. Currently, that department has more than 30 family physicians, and the Mayo Foundation has six family practice residency programs in the United States. I relate this information to account for my longstanding commitment to the original family practice model.

I have also been a proponent of the philosophy that training as a generalist is the best preparation for any career in medicine. (Don't get me started on the rotating internship!) Through my involvement with the American Board of Family Practice, I have been involved with the development of certificates of added qualifications (CAQs) in geriatrics, sports medicine, and adolescent medicine. For some, these certificates have caused concern about the potential for dividing and fragmenting our specialty. I am not sure how to measure the possible division or fragmentation, but so far, we at ABFP have not seen any evidence of such happening, and we feel that these CAQs actually enhance the specialty of family practice. We have national leaders, and students and residents have excellent family practice role models teaching and doing research in these special areas.

How does one explain this paradox of supporting both the original model and the new models? It requires the discipline of defending and maintaining the core principles of the original model while adjusting to the changes in the desires of patients and family physicians. Family practice, more than any other specialty, has shown great ability in adjusting to changes in the system and should continue to do so.

We must redefine the special characteristics of our discipline. For instance, continuity of care, the

hallmark of our specialty, does not simply mean one patient seeing the same physician all the time. It is a system of continuity made possible by group practice, good communication, and use of information technology that allows continuity to exist without the patient being dependent upon one particular physician all of the time.

We have always had multiple models of family practice, yet we have not excluded family physicians because they no longer deliver babies or do hospital care. Many medical students want the type of practice that family practice offers, but they also want the flexibility in their practice so they can devote more time to family and other pursuits. We need to support this healthy attitude and incorporate it into our definition of a family physician. I fear we are losing some of our best candidates because they do not realize the broad potential available in family practice.

So what do I mean by exclusive and inclusive?

By exclusive I mean we want students and residents who subscribe to the original model only, and not branch out into other areas and practice styles.

By inclusive I mean we recruit students and residents who want broad training in family practice, but who also might consider careers that branch into other areas and practice styles.

To me a major question is, "Should we promote the original model exclusively, or can we attempt to provide other opportunities without causing harm to our core values?" The original model has served our patients very well and *should never be abandoned*. All Americans deserve access to the care of a well-trained family physician. We must also look at the actual current model, not the idealized one. Using maternity care as an example, ABFP statistics show that of all recertified diplomates of ABFP (39,252), 74.4% (30,397) do no obstetrics, yet there is general agreement that all residents should learn to deliver babies despite the difficulty in finding family practice faculty to teach this skill. Other examples are that 14,920 (38%) do no orthopedics, while 9,232 (23.5%) do no pediatrics. Can these physicians be truly viewed as family physicians? Are they any more a family physician than those who provide geriatric care or sports medicine? I say they are all family physicians as long as they continue to promote the core values of patient-centered, accessible, continuing care to patients and their families. ABFP, to defend these core values, requires all holders of CAQs to remain certified in family practice, and if they do not, their CAQ is immediately rescinded.

What is happening in medical schools? Within the last several years there are fewer US medical school graduates choosing family practice. Reasons given include the following:

1. Debt. It is easier to pay off debt in a higher paying specialty.
2. The feeling that there is too much to know to be a family physician.
3. Worry about future jobs. It is better to hedge your bets and choose pediatrics or internal medicine, where you can be a generalist or train as a specialist if the job market changes.
4. Not interested in doing obstetrics or hospital care.
5. Family practice role models in many faculties are overworked and unhappy with family practice and turn students off.
6. The primary care backlash.

We have been unable to meet our goals for the number of students that should go into family practice. Is it time to face reality and change those goals? How can we improve on the services we provide so the demand for our services increases? What should we do if the student interest in family practice continues to wane? What should we do about teaching in core curricular areas where we do not have faculty qualified to teach? I hope the Future of Family Medicine project will give us some answers.

It is my view that we should continue to promote the original model that I described as part of my practice and academic career of more than 35 years, but we should not promote it exclusively. We should have excellent role models in our family practice training programs who can demonstrate and teach family practice in breadth. We should also have excellent family physician role models practicing and teaching geriatrics, sports medicine, and whatever else comes along that family physicians can do well. In addition, we should have role models who show that it is possible to have a healthy balance between personal and professional life while still practicing good family medicine. If medical students see these role models, they might choose family practice as a career for a variety of reasons that will meet their career goals.

Perhaps our identity problem results from how we define ourselves as family physicians. We have

always defined family practice by what we do. Perhaps what we do is an insufficient description, because the practice of family practice is so variable and diverse. Furthermore, family practice is more than performing a flexible sigmoidoscopy or delivering a baby. We must define our discipline, not by what we do, but by who we are—the physicians who provide personalized, comprehensive, community-oriented, coordinated, and accessible care to all who seek care. Perhaps accessibility is the hallmark. I was intrigued by Bill Phillips' statement at the Keystone III Conference. He stated, "You can pretend to know, you can pretend to care, but you cannot pretend to be there." Family practice is by definition a specialty that goes where the patients need care—in all settings—rural, urban, suburban, solo practice, group practice, multispecialty groups, community health centers, urgent care centers, and on and on.

What is the answer to my original question, "exclusive, inclusive, or—heaven forbid—both?" I say the answer is both. By continuing to produce the original model family physician, we will provide the excellent family physicians needed in many communities. These family physicians not only provide care of the underserved, but also to the overserved—those who bounce back and forth between different specialists without a physician to coordinate their care. By promoting inclusiveness, we can retain our core values and offer wider opportunities for those students who embrace the concepts we espouse but who want a breadth of practice different from that which many of us enjoy. How we accomplish incorporating both will take creative thinking of all the leaders within family practice in an open, nonpolitical manner. I am confident that the discipline of family practice can, as we have so often in the past, produce solutions to these dilemmas.

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