

completed by faculty and residents of these programs. This stakeholder-based process and teaching strategy will provide for a scaleable in-depth approach rooted in our discipline's core values and traditions while incorporating IM's innovative ways to educate and practice primary care. The areas of emphasis include:

1. Relationship-centered care, communication and motivational interviewing,
2. Collaborating with broadly conceived teams of health professionals including complementary and integrative practitioners,
3. Recommending a full spectrum of evidence-based, cost-effective therapeutic options for our broadly constituted, ethnically diverse, and underserved communities,
4. Using a mind-body-spirit, bio-psycho-social approach to treat and support the health of each individual,
5. Respecting the natural capacity of the body and the patient to heal,
6. Acknowledging the importance of physician self-care and well-being.

The possibilities for enhanced training are myriad, particularly for many chronic conditions in which traditional medical interventions may come up short. Some examples of integrative approaches include: the use of fish oil as part of secondary prevention of cardiovascular disease, management of elevated triglycerides, as well as for stroke prevention; the use of an elimination diet to assess gluten sensitivity or milk product intolerance in the treatment of irritable bowel syndrome; and the use of mind-body interventions for migraines.

IM has become a leading edge of thought, practice, and education at a time when FM has to respond compassionately and comprehensively to patients within a dysfunctional and unsustainable health care system. Faculty development and teaching methods must keep pace with providing practices that empower both future physicians and patients toward maintaining health. We believe this cohort of pilot programs will provide an excellent model for residency education as we all move forward into this uncharted terrain.

The flowering of our specialty as it renews itself in the years ahead is supported through the principles and values of IM. This change is firmly rooted in FM's tradition of leadership in educational innovation and dedication to the primacy of whole-patient care.

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Dr. David declined to respond since he is in agreement, but would like to acknowledge their innovative initiative in residency education.

The Case For A Broad Base

To the Editor: The article by Dr. Whitcomb¹ in the July–August issue was most interesting and timely. In discussing the future of family medicine, it is imperative that we as a discipline solicit input from those outside the specialty and from outside of the field of medicine, as he so eloquently stated, to ensure that the changes we contemplate are in the public's best interest. As physicians, our professional self-interest must take a back seat to what is best for our patients. The invitation to an intensivist to share his opinions on the future of our specialty in the *Journal of the American Board of Family Medicine (JABFM)* is an important step in the right direction. May this dialogue continue!

Dr. Whitcomb's observation regarding the strength and opportunities for our specialty in the area of outpatient care of chronic illness is most astute and indeed mandates increased focus in family medicine's training programs. However, the suggestion of changing the focus of the discipline to exclusively chronic disease management may not be in the best interest of either the public or of the specialty.

Family medicine has traditionally included a very broad-based training. Although individual family physicians often tend to narrow the scope of their practice over the years, they begin equipped for a wide range of practice possibilities. These "pluripotent stem cells"² of the medical profession may later be found staffing emer-

gency rooms, serving as hospitalists, and practicing occupational medicine, as well as in the stereotypical outpatient clinic. Family medicine is becoming a basis for global health activities, where a broad scope of clinical skills and knowledge are imperative. If Dr. Whitcomb's recommendations are followed, from where will broad-based training come? General internal medicine? Not according to Alan David's article³ in the same issue of the *JABFM*. Perhaps only general pediatrics will provide comprehensive training, but even their training is limited in maternity and geriatric care.

The dismissal of preparing broadly trained family physicians to practice in small and rural communities as an outmoded goal because "the great majority of residents will chose to practice in major metropolitan communities" is unfortunate and contrary to the lofty goal of ensuring "what would be best for the American public" voiced earlier in the article. Thirty percent of the American public live in communities with populations less than 50,000.⁴ These populations, already underserved, would find care much less accessible for the next generation should the training of future physicians preclude provision of comprehensive care locally.

It is true that the suburban family practice provider may not use the full scope of their training available in the current situation. However, it is difficult to envision how an abbreviated residency, devoid of inpatient or procedural training, equips providers differently than other, already extant career paths, eg, advance practice nurses.

A focus on chronic disease management, a field already moving in the direction of becoming primarily algorithm ("clinical guideline") based, is unlikely to attract additional medical students to the discipline. Lack-

ing either the adrenalin rush of some specialties, or the intellectual satisfaction of making the diagnosis and developing a plan of other specialties, the best and brightest will probably look elsewhere.

Our discipline is at a cross-roads. As Dr. David³ points out, we need a clear definition of our specialty. Are we to be "full-spectrum" physicians, or are we to be chronic disease specialists? Or perhaps family medicine is destined to be a discipline divided into 2 subspecialties: Comprehensivists⁵ and Outpatientists (alá Hospitalists)?

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