Isn't It Time For One Family Of Generalists? The Case For An American Board Of Physicians

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FIRST, I BRING TO THIS DISTINGUISHED ASSEMBLY, CELEBRATING THE 20TH anniversary of the American Board of Family Practice, the warm congratulations of the American Board of Internal Medicine. The American Board of Family Practice has fulfilled its professional responsibility in standard-setting in an outstanding fashion. Today ABIM shares with Howard Lewis, Truman Schnabel, Worth Daniels, and Norton Greenberger admiration for your several seminal accomplishments and gratitude for our friendship. Next, I wish to make a case for training and certifying one general physician. A few historical references set the stage for my thesis.

In 1959, 30 years ago, the Chairman of the American Board of Internal Medicine was approached by Dr. James Appel, soon to become the American Medical Association's president. The AMA trustees recognized the inevitability of a certifying board in family practice and preferred that certification of primary physicians be under the aegis of ABIM. The Board, half of whom were department chairmen, rejected the invitation as ridiculous. The American Academy of General Practice showed no more foresight when it overwhelmingly voted down resolutions to sponsor the American Board of Family Practice spearheaded by Dr. Nicholas Pisacano, et al.

But the AMA Council on Medical Education, along with the Association of American Medical Colleges and the Academy, persisted, and in 1964 its Willard Committee recommended what became the framework for organizing residencies in family medicine and a new certifying board.

The American College of Physicians reacted by proclaiming that internists function principally as family physicians, and ABIM joined with the American Board of Pediatrics in 1967 to create the two-plus-two program, euphemistically called a "quality" or "leadership track," to prepare better primary care physicians. But it was too late. Internal medicine defaulted. The emergence

The opinions in this paper are those of the author and do not necessarily represent the policies or opinions of the American Board of Internal Medicine.

of group practices blunted incentives to create physicians with a broader clinical base, or as Henry Christian of the Peter Bent Brigham Hospital had advised in 1948, "family physicians with the training of the specialist in internal medicine." This was also the era of burgeoning subspecialty divisions in departments of internal medicine, fueled by NIH grants that strengthened the discipline with research. Internal medicine was preoccupied with grander transitions. A missed opportunity had permitted the creation of a new specialty. A generation later, few live to regret their mistake.

AT THE SAME TIME, ANOTHER SUCCESS STORY OCCURRED IN CALIFORNIA. To improve patient care, in 1962 the state eliminated the licensure of osteopathic physicians and grandfathered them all as MDs. One standard, one general physician. University of California, Irvine, became the ultimate replacement of the California College of Osteopathy and its clinical service at Los Angeles County Hospital. Many will not be surprised by this unusual and preemptive action. After all, Californians embrace Eselen, holistic medicine, acupuncture, sun-dried tomatoes, and fundamentalist religions. But health care was not compromised, and what was perceived as the better medical practitioner prevails. A generation later there are few who remember.

Let us leap ahead 20 years, to the mid-1980s. Family practice has astutely played on the mandates to state legislatures and the federal medical establishment to provide more primary care, especially in underserved and remote areas, and to fund training programs and faculties. But competition, malpractice insurance premiums, another new specialty and board in emergency medicine, and expanding technological expectations force family physicians out of operating, delivery, and emergency rooms. Neonatology and the relative excess of general pediatricians, now that the baby boom has passed, reduce the market share. The reimbursement rate for most of their activities does not favor family physicians.

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At the same time, reimbursement arrangements responding to rapidly escalating health care costs reduce the utility of hospitalized patients for training residents in internal medicine. In some ways internal medicine's "eminent domain" over hospital privileges has become a kind of albatross. Intensive care, oncological illnesses, AIDS, and high-tech procedures dominate inpatient censuses. Common illnesses, such as diabetes, endocrinopathies, and rheumatism, should seldom require hospitalization, and more specific and sensitive testing in the office negates the need for admission for the traditional workup. Doctors and patients bypass the consultant-internist for the technology and sophisticated care of subspecialists and intensivists. Internists also compete for market share with fellow subspecialists, family physicians, and such other professionals as osteopaths and nurse practitioners. Only nostalgia can recapture the elite consultant role of the general internist. The contemplative discipline has been confronted with the "productivity imperative."

THE LITANY GOES ON. NEITHER MEDICARE REIMBURSEMENT PRACTICES NOR patients can make clear distinctions between the services of the family physician and the general internist. Students see little promise in the primary care specialties, often unrewarding both in terms of lifestyle and patient care outcomes. The AAMC's graduation questionnaires disclose a not unexpected

fall in interest in primary care, mainly at the expense of general internal medicine. Service obligations, especially in urban institutions serving an underprivileged, uninsured population, and now accreditation authorities restricting resident hours led to the creation of more housestaff positions in internal medicine than our students either need or want. Neither family practice nor internal medicine is doing well at attracting medical students. Both await the results of each match with trepidation.

To many, the specialties of family practice and internal medicine, certainly general internal medicine, share the same goals and treat many of the same patients. To many outsiders, we present the same look. It is time to recognize this and to amalgamate the best features of training in both specialties into a new residency curriculum, a curriculum that prepares its graduates to fulfill as many patient needs as possible. A second opportunity beckons — 30 years later.

Four years ago in a retreat of the ABIM's executive committee, I asked its startled members to contemplate an all-encompassing "American Board of Physicians." This concept was calculated to accomplish three things: (1) to apply ABIM's standards to certification in primary care, geriatric medicine, and emergency internal medicine, as well as all our subspecialties; (2) to enhance the attractiveness of careers as general physicians to students; and (3) to reduce the confusion for patients over which generalist to seek care from. There would be only one standard — one certificate — one-stop shopping. The rubric was one board.

DOES THE ARGUMENT MAKE SENSE? "THE MISSION OF THE AMERICAN Board of Internal Medicine is to improve the quality of medical care by developing standards that assure that certified internists possess the knowledge, skills, and attitudes essential to the provision of excellent care." Doesn't that formal statement also describe the primary goal of the American Board of Family Practice?

Don't the two specialties share the same capable substrate? With an amalgamation, need there be a compromise in the quality of trainees? I doubt it. GPAs and MCATs no longer distinguish those who enter internal medicine, family practice, or even orthopaedic surgery. Furthermore, I reject as shibboleth the claim that the personalities of those who select family practice are different, that they are more people-oriented than general internists or pediatricians. Your recruits may be more content to grapple with the enormous breadth of medical knowledge, but they have no lock on the caring function of our profession.

What aspects of competence are essential for certification in internal medicine? Are the seven skills presented in Table 1 so different from those required of a certifiable family physician?

There are other justifications for this logic. Family practice residencies require at least 12 months of training by internal medicine departments, the most of any other specialty. More family practice residents receive

Table 1. Components of Clinical Competence.

1. Clinical judgment
2. Medical knowledge
3. Clinical skills
   - History-taking
   - Physical examination
   - Procedural skills
4. Humanistic qualities
5. Professional attitudes and behavior
6. Medical care (use of laboratory tests, etc.)
7. Moral and ethical behavior

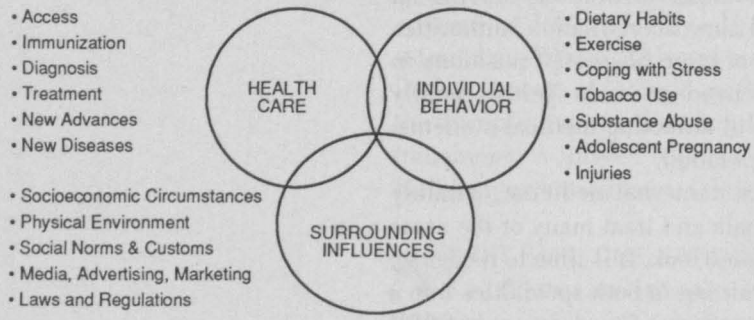

Figure 1. Determinants of health. Adapted from Tarlov AR. The rising supply of physicians and the pursuit of better health. J Med Ed 1988; 63:94-107.

their medicine training in departments of internal medicine, side by side with internal medicine residents, than in departments of family practice. Why not, as Henry Christian had advised, increase that to the extent that they become curious, scholarly primary care internists? At the same time, we internists have much to learn from your concentration on the family unit, experience in the ambulatory training center, recognition of the community, and emphasis on health and prevention. Neither specialist need become a Brand X generalist, and the resulting general physician can be a broader internist and a deeper family physician, a fine clinical gatekeeper, and a well-prepared advocate for the bewildered patient in a welter of subspecialists and surgeons, Dr. Brucker's "quarterback" (page 15). Both specialties see room for better residency training. Among the determinants of health, Alvin Tarlov of the Kaiser Foundation points to individual behavior and surrounding influences, as well as health care (Figure 1).[1] Internal medicine has concentrated too heavily in training future physicians on illnesses, the tiny apex of the pyramid of points of intervention in health (Figure 2). Family practice does a more systematic job approaching prevention and behavioral norms, Dr. Pisacano's stage zero of illness. We both can do a better job — as medical citizens — at understanding and teaching the interventions needed at the cultural and societal base of illness and poor health.

For internal medicine, new emphasis must be accorded to certain areas of training (Table 2). Aren't these also your goals for improvements? I am speaking of skills beyond expeditious triage and primary care. New physicians should be both comfortable with and willing to provide 90 percent of their patients' care — both in and out of the hospital. Continuity of care must not be sacrificed. These generalists must be trained in primary, secondary, and even tertiary care. They must be trained in breadth and with intellectual rigor. I want a new, different, better entity — the general physician — certainly not the British paradigm. And I believe group practices, HMOs, faculties, and the public do too.

The idea is neither new nor original. Training a new general physician has concerned the historian, Rosemary Stevens; the faculty at Rockford, Illinois; your Roger Rosenblatt and Paul Brucker; Leighton Cluff of the Johnson Foundation; Gordon Moore; and the ACP's Frank Davidoff, among others. Even Eli Ginzberg would like a generalist, if he could find one in Manhattan![2]

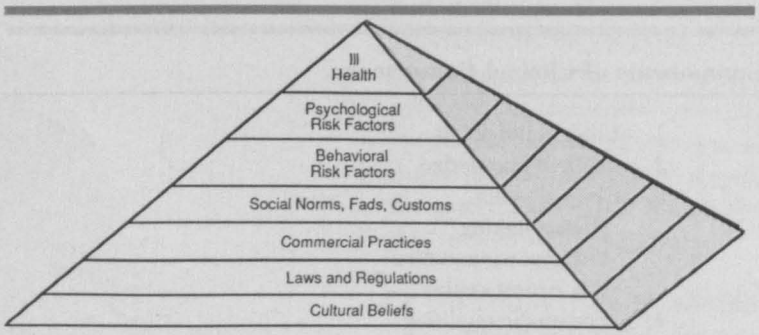

Figure 2. Points of intervention in health. Adapted from Tarlov AR. The rising supply of physicians and the pursuit of better health. J Med Ed 1988; 63:94-107.

Is such an idealistic scenario workable? There are obvious political obstacles when a negotiated merger is even hinted at, and I wish to confirm that the two Boards have not talked about merger. Threatened organizations rail at losing sovereignty — read that, power. Mergers halve the oppor-

tunities for leadership and thus prestige. Family practice does not perceive itself to be in trouble and professes to be the Hertz of primary care, number one. It is now a well-recognized specialty in the eyes of the public. But organized internists feel superior. Have a drink with FPs maybe, but don't go to bed with them. There is an enormous amount of pride at stake.

The prime minister of Pakistan recently stated that one can never survive on one's fears, only on hopes. In the United States, our ethic is to look to the future.

Table 2. New Emphasis Needed during Training.

Experience in ambulatory care
Chronic illness — rehabilitation and employability
Issues related to disability, death, and bereavement
Care of the elderly — new settings, functional assessment
Precepts and practices of preventive medicine
Consultation with other specialists
Clinical decision-making
Access to and use of medical information
Economics of medical care
Systematic self- and peer-review

SO WHAT ARE THE RISKS? NEED THERE BE the demise of internal medicine? Here, we must be clear about what we mean. I like to differentiate a discipline from a practice specialty (Table 3). Professionals in both practice specialties, internal medicine and family practice, will always need the discipline of internal medicine. Internal medicine, as defined in our textbooks and as augmented by scholarly clinical observations and investigation, is not going to disappear. A body of knowledge and clinical skills keep a discipline intact, not politics or institutional operations. The goal of internal medicine's subspecialties should be to make their patient care and technology so safe and easy as to self-destruct, playing into generalism and making the integrative mother discipline even stronger. In doing so, their expertise becomes more and more sophisticated, more and more technical, and perhaps less widely applicable. The discipline of internal medicine is secure. I don't believe we can blow that. But one must admit to perceived harm to the practice specialty — less skilled generalists, now aware of the difficulty of keeping up, of mastering the accelerating growth of clinical science.

Are there risks to the practice specialty of family medicine? In name there may be. But not if your basic goal remains to provide the best primary medical care to the public. Is it anathema to family physicians to offer competence in secondary and tertiary care, so long as they remain generalists? Doesn't the specialty certification you confer identify a specialist or diplomate with special qualification to practice at a level beyond that of the privilege bestowed by the public through licensure?

What about our relative strengths? The numbers of practitioners in general internal medicine are growing much faster than in family practice — perhaps for the wrong reasons, such as the siren call of subspecialties, more easily encompassed and lucrative, and the service needs for the cheap labor of residents — but growing in spite of reason (Table 4). The growing numbers of women in medicine — a doubling projected by the year 2000 — yield a disproportionate number entering primary care specialties. These data from the AMA manpower base generally coincide with

Table 3. Differentiating Discipline from Practice Specialty.

Discipline	A branch of knowledge or learning advanced by research and useful at some time **Internal medicine** **Surgery** **Nephrology**
Practice specialty	A field of professional work, a special interest applied to the service of patients **Family practice** **Emergency medicine** **Internal medicine**

Table 4. Comparison between Actual and Projected Physician Population.

Physician Population	*1986*	*2000*	*% Increase*
All physicians	519,411	633,100	22
General practice/family practice	68,000	75,000	9
General internal medicine	72,000	93,000	29
General pediatrics	39,000	53,000	36
Internal medicine subspecialties	49,000	70,000	41

projections prepared in 1987 for the federal Council on Graduate Medical Education.

In other words, internal medicine is not a decompensating weakling. The number of general internists is growing rapidly and suitably. It is said that there are too many subspecialists already in the training and practice pipeline and an even greater oversupply of general pediatricians.

The new general physicians must be taught by relevant internists who transmit the approaches of internal medicine, such as a keen need to understand why, anticipation through a working knowledge of pathophysiology of the applications of new science, problem-solving, intellectual stimulation, and the caring and consultative functions. They must also learn from skilled family physicians how to make decisions efficiently and how to pace the acquisition of clinical data. Look at the relative sizes of our full-time faculties (Table 5). I estimate that there may be about 1000 full-time faculty in divisions of general internal medicine, the most rapidly growing segment. By the way, the numbers of full-time faculty in both specialties are falling, each by about 300 last year, even as the capacity of our residencies increases.

Furthermore, in a 1984 survey of 351 family medicine departments, divisions, and residencies, there were only 43 physician investigators spending at least 50 percent of their effort on research. Young faculty without senior mentors have been shoved prematurely into responsible faculty positions with too little protected time. Low research productivity has been the result. That commitment will not sustain tenure, turnover, or, more significantly, a discipline. That record has not conferred academic credibility.

Currently, 145 institutions, 61 of them university medical centers, sponsor accredited residencies in both internal medicine and family practice, and many of you are directly involved. These present opportunities for respectful collaboration and curricular reform in our residencies.

I reiterate that neither specialty can boast of its attraction to medical students. We both offer far too many noncompetitive residency positions and depend on substandard recruits outside the match to fill them.

The number of internal medicine positions (5714) continues to grow but captures fewer graduating seniors (63.5 percent positions filled) (Table 6). Both the IM-Peds and primary care tracks recruited less well in the past 2 years than earlier. IM-Prelim residents are not included in the adult primary care total because most will go into neurology, dermatology, ophthalmology, psychiatry, and so forth. Family practice has stabilized the number of its R-1

Table 5. Full-Time Faculty.*

Internal medicine	14,065
Family practice	1581

*AAMC, 1988–1989 (125 schools).

Table 6. 1989 R-1 Match.

	Programs	*Positions*	*Filled U.S. Seniors*	*Total Matched*
Internal medicine	406	5123	3057	4173
Internal medicine/Pediatrics	83	249	137	154
Primary care	64	342	234	281
Family practice	370	2456	1468	1745
Total		8170	4896	6353

positions but also filled only 60 percent of them with U.S. seniors last spring. In both specialties, 1660 positions were not filled at all in 1989, even with foreign medical graduates. And pediatrics is no better off.

The bottom line is 2500 positions too many in programs to train our graduates to become general physicians. Two thousand of these are in IM residencies and probably are used primarily to provide that "S" word, service, and service primarily for inpatients. Recall, too, that primary care residencies live off unpredictable government subsidies — in family practice's case for one-third of the cost.[3]

Furthermore, we adulterate our educational goals with altruistic but enervating dedication to certain societal needs, such as care for the indigent. Donald Seldin scores this wanton "medicalization" of societal issues; for example, the care of the elderly sick through Medicare is commendable, but responsibility for the enfeebled and the stopgap care of conditions attributable to homelessness should not fall disproportionately on medical education institutions. Internal medicine clinics must take all comers and, to no one's surprise, can't find enough faculty or space. Family practice wisely confines its training to panels of families in model practices; so hospital directors must stick traditional internal medicine training programs with the overflow.

For educational purposes, or revenues for that matter, internal medicine needs neither all these training slots nor the patient loads. Think of the training money to be saved by the bottom line — the totals of qualified trainees preparing for the primary care of adults.

Finally, in terms of trainees, family practice (and most others) believes it attracts a different personality — those more willing to treat than to explore, those willing to rely on fewer tests and consultants. Those traits can be good and bad. But if such mind-sets characterized more residents in departments of internal medicine, the reflexive use of consultations for patient care and the unnecessarily high subspecialization rate might be curbed. Remember that foreign medical graduates are far more apt (more than 80 percent of them) to enter subspecialty fellowships than U.S. medical graduates (about half of them). Doesn't that say something about that surplus of residency positions internal medicine offers today!

What then about one family of generalists? Can we meld our goals and resources to improve patient care? Can we apply the deep admiration the Boards have for each other to training and certifying the general physician?

Table 7. R-3 Positions Filled (1988–1989).

	Family practice	*Internal medicine*
Residencies	381	438
Residents	2400	5646

HOW CAN WE GET TOGETHER? THE ABIM has had some practical and reassur-

ing experience with collaboration over certification in geriatric medicine — the same qualifications for admission to the examination and the same examinations prepared together. When it came time to set the standard to pass, representatives of the American Board of Family Practice quickly took the high road, knowing full well that its diplomates might suffer more. Its forthright position was that those of its people who were successful met the same high standard as had the internists who passed. Now, better teachers of geriatrics could be identified for family practice residencies, and patients should be better off. To its credit, without buckling, ABFP has taken far more heat for the high failure rate than has ABIM. ABFP leaders are not apologists for mediocrity and recognize that we have something of value to exchange. And avoiding subspecialization is an article of faith for both your board and your academy — and insofar as geriatrics is concerned, for ABIM as well.

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The complexities of a new model and the threats to associated phenomena, such as departments of internal medicine or family practice, must not frighten us from confronting such issues. That you can tolerate my question today is encouraging. The practice specialties are all mixed up with the paraphernalia of organized medicine, the human condition (i.e., rivalry, power, money), and convention (e.g., professional societies and their officerships). Primary care demands very talented people, and, ideally, there should be but one strong species.

DANIEL FEDERMAN HAS PROVIDED ABIM WITH A TYPICALLY ERUDITE warning about a hybrid between family practice and internal medicine. There are contradictory genetic consequences of hybrids. Some show "hybrid vigor," combining complementary strengths to cope with adverse selective processes, like reimbursement schedules, legislative support, and tenure. But some hybrids, like the mule, are sterile. So in planning a hybrid, we must select genes for strengths. The public certainly wants such a survivor.

John Gardner wrote in 1968 that "Most organizations have a structure that was designed to solve problems that no longer exist." Referring to industry, Tom Peters regards the era of sustainable excellence in pursuing a single purpose as over. While preserving the traditional values of the professional, we must redefine ourselves to comport with society's needs. We both ask our trainees to be mature enough to deal with uncertainty. Like the personality traits needed by the new general physician, organizations can sustain quality only through flexibility within systems, the ability to adapt to change, and responsiveness to patients' values.

Transitions in life are difficult, but instability is intolerable. The current system of training and certifying the best general physician is incoherent and needs correction. Organizing to prepare the new general physician should start very soon and should:

- Assist the public in identifying the best general physician.
- Merge the best features of educational philosophies.
- Upgrade postdoctoral training.
- Attract better residents into fewer positions.
- Consolidate teaching resources and reduce administrative overhead.

- ♦ Extend current trends (e.g., internal medicine into ambulatory and extended care settings, family practice into decision analysis and tertiary care).

I am encouraged by the mutual respect and genuine admiration our two certifying Boards share. Certification in geriatric medicine has been a success story in standard-setting, and now we embark on a second voyage together in sports medicine with our colleagues in pediatrics. The Boards are not alone. Officers of the Society of Teachers in Family Medicine and the Society of General Internal Medicine have maintained contact for several years. The two residency review committees met amicably and constructively for the first time last July. Together, we can preserve what we cherish in our heritage and add to its potential. We shall always be guided first by what is best for our patients. If that be so, the next 20 years will be even more remarkable.

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