Reflections In Family Practice

Models Of Family Practice

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I recently drove to a rural area of Northern California to visit a group of family physicians. They are among the most popular of our clinical faculty with teaching and inspiring medical students. During dinner we talked about their practice. The four family physicians have separate offices in three towns along a 45-mile stretch of highway. They share call and are linked by the name of Intermountain Family Practice. One-half day each week they rotate offices to keep familiar with each practice. They meet every morning for rounds at the centrally located 20-bed hospital, where they are the only full-time medical staff. They see all the patients in the emergency department, deliver all the babies, including doing Cesarean sections, and perform many of the surgeries. A general surgeon based 1 hour away is available for elective cases and some emergencies. Our conversation was rich with stories of major trauma, harrowing transports in nasty weather, performing procedures under unusual circumstances (a chest tube in the office), and the frustration of getting outside specialists to accept referrals of low-income patients.

What was striking to me about this familiar story of traditional general or family practice was that all of these physicians were young, less than 10 years out of residency. What I was listening to was not the past but, rather, the present and the future of a model of family practice.

The Spectrum of Practice Models

Often I hear questions and comments today about the changing role of the family physician. Medical students ask, "What is the scope of family practice? What do family physicians do in the 1990s? What is the future practice model for family physicians?" Researchers study the "experts" looking to find what competencies will be needed for the future family physician and what competencies will be unnecessary.[1] Obstetrics, intensive care, and hospital surgeries have been considered unnecessary skills.

W. McMillan Rodney and William Close object, suggesting that a true generalist family physician is one who is able to set a fracture, deliver a baby, care for a sick child, run an office, and go to the hospital when necessary (personal communication, April 1991). Kaiser Health Plan is the dominant employer of graduates of the University of California-Davis program, and these family physicians rarely do any of these tasks. Their exclusive focus is office practice. My own practice is between these two ends of the spectrum. I am in a semirural area, remain active in obstetric care, assist at surgery, and make as many house calls as I do hospital visits. Ninety percent of my time is spent in the office, however, and I frequently use consultants in caring for critically ill patients. Who are the real family physicians? Who reflects the future?

Twenty-five percent of the US population and most of our country's land mass are rural and are served by family physicians who are often alone in providing health care. These family physicians practice as they do as much by necessity as by choice. There is no reason why competent family physicians performing most of their own procedures could not practice in an urban area, and some do; but like urban cowboys, they are likely to be restless, frequently having to defend their privileges. The office-only family physicians are generally found in tightly run, large multispecialty groups, which by nature exist in urban and suburban areas. Intermediate family physicians, like myself, probably evolved from the traditional model to accommodate practicing with an increasingly sophisticated range of other specialists. Intermediate family physicians are found in all areas (rural, semirural, suburban, urban) and often practice in single-specialty family practice

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groups or in multispecialty groups in which family practice has been a prominent specialty.

Discussions about the proper current or future model of family practice are generating unnecessary conflict within our specialty. Family practice has not transformed its practice model; it has expanded and become too broad to be defined by any singular model of practice. The spectrum of family practice has become so wide that practice models at either end are so different as to barely resemble each other in practice style.

Twenty years ago the picture of the practicing family physician seemed clearer than it is today. Even though rural family physicians would have performed more surgery than their urban colleagues, the style of practice was very similar. Virtually every family physician was in private practice and was active in the hospital. Most were in either solo or small-group practice. The early literature in family practice was able to describe a singular model of practice with minor variations depending upon physician training and community needs.

Currently, the practice options available to a residency graduate are numerous and divergent. Traditional private practice, solo or in small groups, continues in rural and urban areas, but differences in practice patterns are increasing. Table 1 displays the practice arrangements of 1991 family practice residency graduates compared with those who graduated in 1978.[2,3] While the single-specialty family practice group remains the most common choice, more graduates are joining multispecialty groups. There is also a decline in graduates choosing rural or small-town practice.

Table 1. Practice Arrangements of Graduating Family Practice Residents, 1978 and 1991.

	1978 Graduates (n = 1340) Percent	1991 Graduates (n = 1559) Percent
Family practice group (two or more persons)	43.4	44.0
Multispecialty group	7.4	12.2*
Solo practice	12.7	7.8*
Emergency department	3.6	5.1
	1978 Graduates (n = 1105) Percent	1991 Graduates (n = 1528) Percent
Rural or small town (< 25,000)	50.4	42.1*
Suburban or small city (25,000–100,000)	39.5	44.5*
Large urban or inner city	10.1	13.4†

*$P \ll 0.01$.
†$P < 0.02$.
Source: American Academy of Family Physicians.[2,3]

Table 2 shows differences in selected types of patient care in hospitals by family physicians in urban and rural areas according to a survey by the American Academy of Family Physicians in 1990.[4] These differences are probably even greater today, because of continued changes in urban family practice, with more family physicians joining large multispecialty groups. Multispecialty group practice is the fastest growing practice arrangement, and many are competing for family physicians. Multispecialty practices with their own insurance plans increasingly rely on family physicians to provide primary care services. Some plans such as Kaiser generally limit the family physicians' role to the office, whereas others such as FHP (Orange County, California, and Salt Lake City) encourage a broad practice for family physicians including hospital practice and surgical assisting. Some family physicians choose to work in urgent care centers or emergency departments, limiting their practice to acute, episodic care.

The American Board of Family Practice defines family practice as the medical specialty that provides continuing and comprehensive health care for the individual and the family. It is the specialty in breadth that integrates the biological, clinical, and behavioral sciences. The scope of family practice encompasses all ages, both sexes, each organ system, and every disease entity.[5] The family physician is defined as educated and trained to develop and bring to bear in practice unique attitudes and skills that qualify him or her to provide continuing, comprehensive health maintenance and medical care for 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 consulting and community resources.[6]

These definitions describe the underlying philosophy common to all family physicians, regardless of practice model. While emergency department or urgent care practice does not qualify as

Table 2. Types of Patient Care in Family Physicians' Hospital Practices, 1990.

	Rural (n = 932) Percent	Urban (n =1636) Percent
Routine obstetric care	41.6	20.4*
Caesarean section	14.9	2.2*
Surgical assisting	54.6	36.8*
Major surgery	11.2	3.1*
Intensive care unit	71.3	54.8*

*$P < 0.01$.
Source: American Academy of Family Physicians.[4]

family practice because of a lack of continuity and comprehensiveness of care, other divergent models are reflective of the specialty if the family physician takes responsibility for being the personal physician to a group of patients, providing and coordinating comprehensive health services. The challenges to the office-only family physician doing this may be just as great as for any family physician along the spectrum of practice models.

My purpose here is not only to describe the current diversity that exists in family practice today, but also to suggest that we more fully embrace our differences as a specialty. The Intermountain Family Practice physicians, today's version of the able-to-do-it-all generalists, could feel forgotten by the rest of us. Office-only family physicians, particularly those not in private practice, might not feel respected by more traditional family physicians, who have generally been leaders in organized medicine. Disrespect of practice models within our specialty only divides us and limits the important contributions each model of family practice makes to our specialty.

This essay does not discuss other areas of variance among family physicians, such as special interest areas. Many family physicians focus heavily on such specific clinical areas as geriatrics or sports medicine. Others focus primarily on teaching, research, or administration. Fortunately for our specialty, most family physicians with special interests and expertise continue to practice broad family medicine and are resisting full subspecialization, as has occurred in internal medicine.

All family physicians, regardless of their practice models, have much to contribute to patient care and to the specialty. Family physicians who limit their practice to the office have an opportunity to develop a more sophisticated model of primary care. They have the time to develop state-of-the-art practices focusing on health promotion and disease prevention, those aspects of practice for which rural family physicians might simply not have enough time. Office-only family physicians might also have time to provide regular individual and family counseling and might more rapidly develop their skills in new office procedures, such as colposcopy and flexible sigmoidoscopy. Rural family physicians preserve the role of the true generalist in community care. Such family physicians are very busy providing the needed services to their community, do a wonderful job of teaching students and residents, and are grateful for the new developments brought to them from their regional referral centers. Intermediate family physicians like myself work to find a balance along the spectrum of practice models.

The different models of family practice have important implications for residency training, medical student interest, reimbursement, continuing education, and medical organizations.

Residency Training

The Residency Review Committee for family practice has a singular list of essentials to which all residencies must comply. These essentials are broad and flexible enough to allow for training all models of family physician. The limiting factors are the resources of the residency programs. Should all residency programs be expected to train family physicians for the full spectrum of practice models? I suggest that for many programs, this approach is not possible. Are these programs inferior? Medical students coming from university medical centers are often surprised to learn that some family practice residency programs do an excellent job of training family physicians for remote rural areas. These programs are usually in community hospitals, where family practice is the only residency, and the residents are expected to provide a wide range of major surgical procedures. Graduates of these programs who choose to practice in an office-only setting will not use many of their skills. In contrast, as part of an effort to increase the number of family physicians, there is an effort to have health maintenance organizations (HMOs), such as Kaiser, develop residency programs. Should an HMO, which uses family physicians exclusively in

an office, be expected to train residents for another model of family physician?

These issues and questions speak for a greater clarity of and appreciation for the various models of family practice and the nature and resources of training sites. It is hoped that most residency programs will be able to offer a sufficiently diverse training to allow the graduates the broadest range of practice options.

Medical Student Interest

The medical student interested in becoming a rural family physician is likely to be very different from the student interested in an office-only practice. Most students interested in family practice appropriately do not know which model they will practice, but they do have inclinations when the spectrum is discussed. Matching a student inclined toward a rural model with an office-only practice for preceptorship could turn the student away from family practice and vice versa. I suspect more medical students would choose family practice if they were aware of the rich diversity of practice models. Their choice of role models, preceptorship sites, and application to residency programs should reflect their interests.

Organized Medicine

I have seen leaders of family practice organizations on the local and national level, who come from either a rural or intermediate practice, speak disparagingly of family physicians who limit their practice to the office of an HMO. The platform of candidates running for offices in organized medicine has been the preservation of traditional private practice and competition with office-only family physicians. In California, for the first time, a family physician who works for Kaiser Health Plan has been elected to the board of directors of the state academy chapter. With a large number of residency graduates choosing this practice option, to stay unified as a specialty, organized family practice should embrace these physicians.

Reimbursement

One of the ironies of present-day practice is the lack of fairness in how physicians are paid. Rural family physicians probably work hardest and place themselves in situations of much higher risk, but they could be paid the least among the practice models. Family physicians in private practice typically have incomes that reflect only what they earn, rather than what they are worth to the health care system. Family physicians in a large multispecialty group might work fewer hours and remain in the office, but they might well be paid much higher, reflecting their worth as case managers in an organized health system that financially rewards cost-conscious practice. These income imbalances could contribute to the animosity among family physicians in different practice models. Somehow we must work toward a system of physician reimbursement in which all family physicians, regardless of practice model, are paid according to their worth.

Continuing Education

Planning a conference to meet the needs of all family physicians is increasingly difficult. Rural family physicians might want to be updated on providing thrombolytic therapy for acute myocardial infarction, whereas office-only family physicians are interested in only primary care skills. Continuing education courses will be successful only if they address the diversity in their audience.

Conclusions

Family practice must have a clear and attractive image to motivate medical students to select the specialty and to encourage payers and insurers of health care to value family physicians for their worth. A goal for the United States would be a base of family physicians providing primary care in an organized health system with fair and equitable reimbursement for all physicians. The diversity of family practice models, demanded by different locations and community needs, clouds the picture unless all models of family practice are recognized and appreciated by teachers of family medicine and by leaders of our medical organizations. We have much work to do within our specialty toward this end before we can expect the outside world to understand and appreciate us.

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