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Continuing Education for Family Practice

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A few years ago, while I was Dean of the Marquette University School of Medicine, one of our recent graduates, an intelligent, sensitive, and dedicated young man with an attractive personality and excellent character, came to my office with tears in his eyes. This young physician had entered medical school with the goal of becoming a country doctor. He was steadfast in holding to his goal and shortly after his internship was fortunate to become associated in practice with a general practitioner in a town with a population of approximately 2,000. The nearest hospital was 20 miles away. The senior physician had developed a medical service program of good quality for the people whom he served. He, too, felt fortunate in having our young graduate associate with him because it would relieve him of some of the pressures of solo practice and his responsibility as the only physician in town. Eight months passed, and the two physicians developed a fine working relationship with each other. Everything seemed to be going well, and the senior man decided to take a much needed vacation and went to Florida with his wife for six weeks while his young partner took care of the practice. A few days after the senior partner returned from his vacation he died suddenly, leaving the young ician with the total responsibili or the community's medical ca Weariness from six weeks of h work, and the shock of his pa r's death left him shaken and pressed. It was then that he s t my advice about what he s ld do. As a young physician t ed to appreciate the advantages modern medical science he f woefully inadequate trying to s e the people of his community hout the support of colleagues. it had not been for his sense of igation to the people in the com nity, he would have immediately cepted an appointment as a re nt in anesthesiology. I encourage im to persevere, and he returned the community and did the best could with the help of the other hysicians who staffed the regiona hospital. Eventually he found a her young man to associate wit him. He is now the busy and po ular leader of a three-man group ractice. He is satisfied with his pr ssional and financial success, and, although the medical care which he and his colleagues provide for their patients is limited by the available resources, he is proud that he is serving ably as a family physician.

Stories similar to this are common in a medical school dean's office today. In some schools more than 50% of the entering class expresses an interest in becoming family doctors, and yet the number who eventually enter and remain in family practice becomes less each year. The medical schools are criticized for allowing this trend to progress. "Why don't you train more general practitioners?" is one of the most common questions asked of medical school deans. If family physicians are greatly needed, why is society confronted with an ever-increasing shortage? Are family doctors really needed, or are they merely *wanted?* All of us know patients who want to have the doctor call at their home every day, and, if they are affluent and well known, they may very well demand and receive this service. On the other hand, these daily calls may not be needed at all. The people of our nation are urged, by way of Madison Avenue, through press and television to want thousands of attractive articles and services, many of which are not really needed. I suppose there are some people who want a famliy doctor because they assume that he will be constantly at their call. Others may want a family doctor because they think his services may be cheaper. At this point it may be appropriate to ask do people really need family doctors? Do they need a "jack of all trades"? Do they need a sociologist to study family interactions? Do they need a counselor? Certainly they need a physician to call upon, but what kind? Since the role of the family physician is not clearly defined, and since family doctor and general practitioner are terms which have many meanings within the medical profession, it is understandable why the public and the medical profession are unable to gree on an answer to t question "Why don't you train more general practitioners?"

My remarks up to this point may have conveyed the impression that I am pessimistic about family practice because I have emphasized the decreasing number of physicians who, in the traditional meaning of the word, are called general practitioners. My outlook, however, is genuinely optimistic because I consider family practice to be one of the important functions of contemporary medicine.

The complexity of medical science and practice has made the segregation of medicine into sub-specialties necessary. No one person can practice all of medicine and surgery. All of us are specialists, including the family doctors.

Medical practice is diverging into two functional branches. This divergence is most evident in the medical schools and large institutional medical centers. The growth, development, and refinement of the technical side of medicine, with its dependence upon instrumentation and complicated scientific modalities, has commanded the exclusive interest and attention of specialists who work with these things. This is good because society needs more technology and specialization for the rapid application of new discoveries. On the other hand, society needs medical care which is comprehensive in scope, patient centered in orientation, and related to the family or social group. The values inherent in physical and biological science and technology polarize around the first divergent

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trend; wh[illegible]s the values inherent in the con[illegible]t of the person as revealed by [illegible] social and behavioral sciences, polarize around the second diverging trend. Although the two poles have opposing charges, they, nevertheless, are parts of the same magnet. Although they diverge, they, nevertheless, are inseparable because together they are the essential elements of modern medicine. Some medical specialties cluster around the technical pole. These are the task oriented specialties such as ophthalmology, otolaryngology, orthopedic surgery, plastic surgery, neurosurgery, radiology, and pathology. Other specialties such as pediatrics, internal medicine, and psychiatry, because they deal less with tasks and tissues and more with personality, interpretations, and guidance, cluster around the opposite pole which I will call comprehensive medicine. In other words, medical practice is diverging in one direction toward specialized and technological perfection, and in the other toward a comprehensive focus upon the patient as a person in a social environment.

There are some specialties which, although task oriented, are able at times to assume broad medical responsibility. General surgery, obstetrics and gynecology, and urology often require a continuum of long-term care and hence may take on some of the comprehensive attributes of family practice. It is the referral specialties which are identified mainly with tasks and tissues, whereas the referring specialties are identified more with comprehensive and continu[illegible]care of individuals or families.

What doe[illegible]of this have to do with contin[illegible]education for family practice? [illegible]ny experience many of the con[illegible]ng education programs desig[illegible]for general practitioners and [illegible]mily doctors have been built u[illegible]f lectures and demonstrations [illegible]n by task oriented specialists w[illegible]ttempt to teach the general prac[illegible]ner how to care for minor or co[illegible]n ailments included in his disci[illegible]e. The usual program is desig[illegible]to present practical information. [illegible]dom, except perhaps in lectures [illegible]ch deal with psychiatry or p[illegible]trics, does one hear anything abo[illegible]amilies or the management of [illegible]prehensive medical care for a fa[illegible]y. If family physicians are to [illegible]able to provide the very latest [illegible]the best medical discoveries o[illegible]dvances, they must know what is [illegible]ailable. One would hope, therefo[illegible]that family physicians would [illegible]exposed to survey programs wh[illegible]outline the latest developments [illegible]n medical science and technolo[illegible]. Continuing education for fa[illegible]ily practice should also attempt t[illegible]chieve the following goals:

1. Courses of studies in the humanities, sciences, and the arts can, through their broadening effect, be of great benefit both professionally and recreationally.
2. The family physician who assumes the responsibility for managing the medical care of patients and their families should become acquainted with the latest developments in diagnosis and treatment. Even though he may use only a small part of this knowledge in his day-to-day practice, it, nevertheless, is necessary for him to understand these developments in medicine in order to make them available to his patients through proper referral.
3. The family physician should be provided with courses which deal with the application of behavioral science knowledge. The scientific study of communication principles, learning techniques, and psychology can enhance the skills and techniques used by physicians in family practice.
4. New developments in preventive medicine, environmental medicine, occupational medicine, and rehabilitation should be presented in a manner which emphasizes their importance to family practice and the continuity of patient centered medical care.
5. Courses for leader role development for interprofessional collaboration.
6. Courses on the interaction of religion and medical practice.

Continuing education courses for family practice should be open to all of those who specialize in comprehensive medical care. By whom should this continuing education be conducted? The universities are, perhaps, the best equipped to do the job. Universities not only have medical schools but they have other departments well equipped to convey the knowledge which is developing in other areas and which relate to the function of comprehensive medicine. The specialty societies, and I include in this the Academy of General Practice, are, perhaps, not well equipped to conduct such courses because of their traditional use of task oriented programs.

There is a special place for the continuing study of the interaction of religion and medical practice, particularly by personal and family physicians. A number of medical schools have developed programs in pastoral medicine designed to provide "internships" for hospital chaplains and also to establish a resource for medical students and faculty to draw upon for professional support in dealing with those problems in which religion and medicine interact. The American Medical Association has established a Department of Religion and Medicine, and the Academy of Religion and Mental Health has conducted well-planned symposia on the subject for over ten years.

It is regrettable that Catholics have lagged in sponsoring such programs. It should be a challenge to the Federation of Catholic Physicians' Guilds to sponsor continuing education programs for the clergy and physicians in the general area of the interaction of religion and medicine. There has been a dearth of discussion of these matters in Catholic circles. Those programs which have been sponsored usually have centered around what has glibly been called pelvic moral-

ity, where the psychological and behavioral science aspects have barely been touched upon.

Our patient comes to us with a value system which he has created out of his family background, his schooling, his social environment, his church, his employment, and his conscience. This value system may be rigorous or lax, religious or secularist. It has become a part of his personality and, as such, enters into his behavior and into his judgments. If a physician is to be an expert diagnostician and therapist, he must be aware of its presence and its meaning.

It has been said that the physician-patient relationship is most productive when the value systems of the physician and the patient are in resonance, or, in other words, when physician and patient understand and are familiar with each others moral and religious principles. As Catholics we know the value of religion in our lives. Its meaning to each of us may be different in degree or even in kind. The same is true of our patients.

As personal or family physicians we easily become involved in the moral and religious problems of our patients, sometimes even more so than the clergy, particularly when our patients will not talk to a priest. Most of us handle these problems intuitively or with "just plain common sense." In the meantime, the behavioral sciences and theology are adding greatly to our knowledge and are providing principles and techniques which could be used to improve our management of these patients who are sick in body and spirit. I suggest, therefore, that one of the great opportunities for continuing education of the family doctor is a development of a program, hopefully under the auspices of the Federation of Catholic Physicians' Guilds, on integration in the practice of medicine. It will be difficult to assemble a faculty for such a course, and we may have to draw heavily upon our non-Catholic brethren who have taken the lead in this field. The psychiatrist and physician have more in common than either has been willing to recognize and explore.

I have touched upon several areas during this brief presentation, and, although I referred to it earlier, I have not attempted to answer directly that frequently asked question "Why don't medical schools turn out more general practitioners?"

I have used the term family doctor in preference to general practitioner, and stated that family practice is a specialty which, if properly practiced in terms of providing comprehensive personalized medical direction and service, can be a very important branch of medicine. I have attempted to outline those areas of knowledge which should be renewed and improved for the family physician through postgraduate programs. Finally, I have emphasized the need to develop research and educational programs which focus on the interaction of religion and medicine, and I present this as a challenge to the Federation of Catholic Physicians' Guilds.