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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 physician with the total responsibility for the community's medical care. Weariness from six weeks of hard work, and the shock of his partner's death left him shaken and depressed. It was then that he sought my advice about what he should do. As a young physician trained to appreciate the advantages of modern medical science he felt woefully inadequate trying to serve the people of his community without the support of colleagues. It had not been for his sense of obligation to the people in the community, he would have immediately accepted an appointment as a resident in anesthesiology.

I encouraged him to persevere, and he returned to the community and did the best he could with the help of the other physicians who staffed the regional hospital. Eventually he found another young man to associate with him. He is now the busy and popular leader of a three-man group practice. He is satisfied with his professional 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. Suppose there are some people who want a family 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 agree on an answer to the 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 divergencie
trend; whereas the values inherent in the concept of the person as revealed by the 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 care of individuals or families.

What does all of this have to do with continuing education for family practice? My experience may suggest that education programs designed for general practitioners and family doctors have been built up of lectures and demonstrations given by task oriented specialists who attempt to teach the general practitioner how to care for minor or common ailments included in his discipline. The usual program is designed to present practical information. Sometimes, except perhaps in lectures which deal with psychiatry or pediatrics, does one hear anything about families or the management of comprehensive medical care for a family. If family physicians are to be able to provide the very latest and the best medical discoveries or advances, they must know what is available. One would hope, therefore, that family physicians would be exposed to survey programs which outline the latest developments in medical science and technology. Continuing education for family practice should also attempt to achieve the following goals:

1. Courses of studies in the humanities, sciences, and the arts, so that 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 conduct 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-
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The position of the doctor in society has always been one of special importance and from time immemorial has been surrounded with a peculiar respect and even mystery. His profession has never been looked upon as a mere means of gaining a livelihood. Men have regarded the doctor as one apart, in whose hands they have to place the important matter of their bodily well-being. Generally, through the ages, men have done so with confidence. Whether in our own time the ideal and moral standard of doctors is lower than I history will be able to tell. The Catholic doctor can have no excuse for not living up to the requirements of the Hippocratic Oath and indeed of an even more perfect professional ideal.

The basic role of the physician in the care of the family unit now and in the foreseeable future will not change from a moral point of view. His first obligation now and in the future will be to acquire a reasonably full and competent knowledge of the science and art of medicine. Following this medical knowledge, the physician must be continually aware of the need to keep abreast of the advance of medical research and practice, especially if he finds that a good bedside manner ensures him a sufficiency of patients and perhaps even a very busy and lucrative connection. Besides this medical knowledge the physician must now and in the foreseeable future see to it that he knows the correct ruling on the ethical points that may be involved in practice. This is a really grave obligation.

Another serious responsibility of the physician is to give to each case the full attention which is due to the patient by the implicit contract entered into when he undertakes the case. He should know when it is necessary to call in a consultant but his own knowledge should be such that it should not be necessary to get the help of a consultant in the treatment of what we may call normal difficulties. If his incompetence makes consultation necessary in such circumstances, he is guilty of injustice to his patient.

This noble profession has as its first object, the giving of its services to humanity. Now and in the future, our material recompense or honorarium should be reasonable, so that we may live well, personally, but it should always be proportionate to the treatments, the economic and social conditions of the patient and the accepted custom. Gratuitous services which are sometimes necessary, can never be an excuse for negligence. It behooves all of us involved in the sublime work of healing ills, to promote true morality and to aid in the healing of ills of the soul as well, thereby pointing the way to eternal salvation.

Medicine now and in the future must emphasize the sense of nobil-