THE LONDON UNIVERSITY LECTURE IN GENERAL PRACTICE

Doing better, feeling worse: family medicine in an academic setting*

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Introduction

MY title is taken from a collection of essays published in 1977 by The American Academy of Arts and Sciences (Knowles, 1977). In the introduction, the editor noted the existence of a profound national concern that, despite a massive increase in health expenditure and a marked expansion in health workers over the past decade, the health of the American nation had improved less than was promised or expected.

In this paper I shall describe what I believe to be some of the philosophies shared by general practice in the United Kingdom and family medicine in the United States, but viewed from an American perspective. In the university setting, there are problems common to both countries that need to be addressed. These problems lead me to believe that while, with increasing experience, academic departments of general practice and family medicine are "doing better", as we face present-day reality and attempt to see ourselves as others see us, we are "feeling worse".

Problems with specialization

Several explanations have been advanced to account for the fact that Americans are doing better and feeling worse. While they are aware that medical knowledge and scientific technologies have increased enormously, patients are also concerned about the quality of health care, the accessibility of services and the impersonality and frequent discontinuity often associated with the medical encounter.

The development of specialization in medicine has in many ways been an accident of history. It appears to be a response to the initial advances of knowledge about the causes of disease and to increased understanding of how the human body works. Further, the trend towards specialization has been accelerated by new and, in many cases, highly complicated technologies. The development of this specialized knowledge and these technologies influence the climate of opinion both in practice and in medical schools. Almost universally, medical schools have been associated with highly specialized tertiary-care hospitals. In 1959, White (1961) indicated that generations of medical students were being trained in hospitals where not more than 1 per cent of diseases were being treated.

Little has changed since then. In almost any teaching hospital, conscientious house officers, registrars, interns and residents daily bring to bear any available piece of diagnostic machinery on difficult cases in an effort "not to take any chances" and "to find out for sure". This deeply rooted behaviour has arisen from the notion that we must expect scientific accuracy in medicine. Doctors have been conditioned to become afraid of uncertainty. They are not being taught to deal with what has been termed the resources of ambiguity, or to be comfortable in dealing with uncertainty. Rather, what we find is the equating of uncertainty with personal incompetence. When faced with uncertainty we become anxious. One of the ways of retreating from the anxiety of uncertainty has been to seek assurance from technology. Thus a doctor may come to rely too much on laboratory readings in place of clinical judgement. Currently, however, scientific attitudes are changing. For exam , physicists are now talking about a 'probabilistic paradigm' for research, which departs from the idea that we can always have certainty in science.

Using generalists

Living with uncertainty has been one of the hallmarks of family medicine or general practice. In an academic situation, this ability of generalists to accept that they do not know everything, and to apply this principle to problems of patient care, has been widely criticized. The recognition that it is impossible to know everything has been interpreted as a lowering of academic standards. Is

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this a legitimate criticism? In my own university setting, I maintain that it is not. On the contrary, I assert that a generalist has an academic function which a specialist cannot possibly hope to have. This is an integrative function: integrating ideas and technologies, and maintaining the integrity of the patient as a person.

If this is true of the trained academic generalist in medicine, are there any inferences which can be drawn for the trainee, at either undergraduate or graduate levels? It is clear that the academic and intellectual demands made on the generalist are enormous. In my own institution, because of the high expectations that specialists have of generalists, my students must be excellent problem-solvers. Above and beyond intellectual abilities, potential generalists must also possess the ability to understand themselves and humankind in general. The remaining students can be adequately trained for the specialties, where the personal demands for integrative learning are less and where there is more opportunity to concentrate on a narrow area.

These theoretical concepts help us to understand some of the differences in practice between a generalist and a specialist in medicine. Specialist care, by its essential nature, tends to be episodic. The specialist is consulted for a particular problem. It is true that occasionally the problem may become chronic, and in that situation the specialist sometimes provides ongoing care, and shares some of the features of continuity of care with the generalist. But this is not the most usual arrangement. Thus it is appropriate for the specialist to seek to know as much as possible, if not everything, about the patient in relation to the presenting problem. This necessarily implies full study and investigation. The patient thus tends to be subjected to a series of investigations which may be both uncomfortable and invasive and, simultaneously, costly. This process is essential to satisfy the physician's "need to know".

The alternative approach, that of generalists, practising in the area increasingly inappropriately termed 'primary care', recognizes that at any given time the doctor is not going to be able to know everything about his or her patient. These generalists will investigate appropriately, using technologies that are available to them and to their specialist colleagues by consultation, but their criteria for determining the appropriateness of any investigation at any particular moment will depend on an assessment of the urgency of the condition from a medical point of view. Time can be used very effectively, in that what is not known today may be known tomorrow, either by the patient revealing it as a part of the doctor–patient relationship or by the natural genesis of the disease process. Alternatively, more effective technologies may become available which will yield even greater information in the future. This attitude stems from more than the notion of continuity of care. The ability to practise as a generalist is also academically sound, and demonstrates at least as much intellectual integrity as the specialist's urgent need to know now.

General practice in the academic setting

But, one might ask, does the British counterpart face the same demands as an American academic department of family medicine? To begin to understand the answer to this question, it seems necessary to outline the history of the renaissance of family medicine.

I have lived through a part of what might be termed the renaissance of general practice in Great Britain. The College, now the Royal College, of General Practitioners, was formed in my professional lifetime. I was able to applaud the formation of the first university department of general practice at Manchester. I was actively involved in the transformation of the trainee assistantship scheme in general practice into vocational training schemes, and I later became one of the regional advisers in general practice at London University. I moved to the United States in 1976 because I wanted to do research in what I still term general practice in an academic setting and because I believed that it would become increasingly difficult in this country to get funding for such research.

At that stage I perceived that if general practice and/or family medicine were to survive in an academic setting, its credibility amongst peers in other branches of academic medicine could be assured only by demonstrating clinical competence and by high quality scholarly activity, including research. Others, based on their own experience and surveys of the literature, have reached a similar conclusion (Howie, 1979; Knopke and Anderson, 1981; McWhinney, 1981).

When I arrived in the United States, the American Board of Family Practice was only seven years old. The first family practice residencies had begun in the same year (1969) that the Board had formed. While this rethinking was going on within the ranks of the medical profession, public pressure, partly mobilized by physicians themselves, was growing to restore the family doctor to the American medical scene. Ultimately, state and federal monies were appropriated specifically for the training of primary care physicians, which led to the burgeoning of departments of family medicine. The immediate result of this movement was an acute shortage of doctors prepared to make the transition from active family practice in the community to the more highly competitive academic world.

Because of its relatively brief history as an academic discipline, family medicine lacks the heritage possessed by other specialties, a situation which continues to cause concern and problems of identity among its membership. As Kurfeys (1981) has stated, there has been increasing pressure on our departments to specialize our activities. Academic recognition is highly correlated with specialization in a particular area. In informal discussions with faculty members from other depart-

ments, it is not unusual to be asked to participate in some interdisciplinary discussion, but then they say: "It would be good to have your participation, but what's your special line?"

Identity crisis

Here we begin to see another aspect of the problem that faces us. Is either family medicine or general practice a specialty? There is a tension here, both within the discipline and between disciplines, which leads to an identity crisis. Should the generalists call themselves specialists? That family medicine or general practice requires 'special' integrative or interdisciplinary training is clear, but it seems to be the only true sense in which it can be regarded as a specialty. In the United States, the discipline of family practice is entitled to this description of a specialty by the existence of its certifying specialty board, the American Board of Family Practice.

Our training must remain broad and be as general as possible; failure in this respect will result in declining interest and enrolment of undergraduate students and residents. There is some evidence to suggest that even in well-established departments, this trend already exists. Perhaps one of the most alarming trends is that university-based training programmes for residencies in family practice are frequently viewed by students as inherently weak. They feel that they have to get away from the university environment in order to get a good family practice education. These attitudes are undoubtedly fostered by the students' frequent contacts with faculty members outside the department who do not really understand and support family medicine concepts. These attitudes have been reinforced by medical schools, under financial and political pressure from legislatures, having appointed chiefs of family medicine or departmental chairpersons whose primary skills are in administration or the exercise of political power (Smith, 1981). Geyman (1978), the editor of the *Journal of Family Practice,* has summarized this problem: "The great majority of family practice faculties so far have beeen drawn from the ranks of practicing physicians . . . [who] have been well qualified by clinical experience and expertise for teaching, but have usually lacked experience or formal training in teaching, research or related academic areas."

The response to these at least partially legitimate criticisms is almost as worrying as the criticisms themselves. The academic family physician begins to look around and attempt to discover areas in which he or she can gain a special expertise. If it were possible to do so, acceptance by faculty in other departments would be much more readily gained. I view this development with alarm because of the basic philosophy of family medicine and the need for generalists within medicine which I have outlined above. The trend towards re-creating specialists within its ranks could well destroy family medicine. Numerous otherwise neglected areas of medicine have suddenly become attractive to academic family medicine. Federal funding patterns have acted as an attractive bait, especially for university departments that are seeking to augment their depleted funds by research projects. For example, in this search for a 'special' content area, family medicine has begun to pay particular attention to families. I do not believe, as some have suggested, that all family physicians should necessarily become experts in family therapy. Our prime function is to treat the patient as a whole person and to seek to heal and maintain the integrity of that personality. Only when aspects of that whole person's problem are affected by the family do they become of concern to us both from a diagnostic and therapeutic viewpoint.

Acceptable specialization for the generalist

As I have indicated, I am very sensitive to the pressures and tendencies which urge the family physician to specialize. Yet while maintaining this healthy suspicion I believe that there are some areas where, at least for the academic in family medicine, a degree of specialization may be helpful.

Such an area is behavioural science. In this I would want to include clinical psychology, ethics and sociology and, particularly in the American setting, health planning and economics. Of these, I believe clinical psychology is the most significant because, while some understanding of it is necessary for all doctors, the family physician needs to be particularly aware of the dynamics of interpersonal interaction.

Another area for the generalist to specialize in is medical education. Constructing educational objectives which can be regarded as relevant and attainable by both teacher and learner remains amongst the most difficult problems to be faced by the academic family physician. The fact is that it probably still takes a lifetime to train a good generalist. This difficulty is aggravated by the fact that many of us desire to opt out of the learning process before we complete our professional careers. These drop-outs may include many of those who have given general practice, and who will eventually give family medicine, its bad name in academic circles. At least in America this issue has been addressed squarely in that Board-certified family physicians must now be recertified every seven years.

An effective curriculum

I believe that family medicine belongs in the medical school. While the introduction of primary care physicians into the tertiary care setting produces practical difficulties, the enormous academic advantages outweigh the disadvantages. I am fortunate in that I and my department are regarded as integral parts of both the medical school and its associated hospital. Some of my

colleagues are not so fortunate in that both the Chair and its associated family practice unit are frequently located off the main campus, sometimes several miles away. In that setting, they are able to construct a more supportive local environment, but the physical distance frequently leads to the department being intellectually distanced from the mainstream of academic thought in the medical centre.

Being established within the main centre enables the department to play an active role in teaching, not only in the clinical years but also in the basic science years. My department has mandated curriculum time in each of the four years of medical school. Our participation in courses such as an introduction to patient care, physical diagnosis, epidemiology and ambulatory medicine provide an on-going generalist approach to medicine throughout these years. In addition, we are developing clinical electives and a family medicine subinternship which will be taken away from the main university hospital in one of our affiliated community hospitals. After graduation, the department is responsible for the two largest family practice residencies in the state of Massachusetts.

Faculty development: we are the experts

To support all these teaching activities, we have concentrated on teacher training. We have now had two years' experience with regional faculty development courses. Each year we have enrolled a number of participants who have committed themselves to attending a series of three-day workshops held throughout the year (Catlin and Quirk, 1981; Quirk *et al.*, 1981). Our efforts in these first two years, which were federally funded by a grant (Catlin, 1978), are necessarily concentrated on educational theory and practice.

One of the tendencies that we have noted is that generalists, especially family physicians, want to bow out from teaching experiences, especially if there are specialists available. This tendency to abdicate the role of teacher by an otherwise experienced physician is, I believe, conditioned by the way in which the same physician is treated in his own academic community. We therefore resolved to learn from each other and to avoid calling in an outside expert, underscoring the notion that, in family medicine, we are the experts. This attitude and approach has produced greater confidence in tackling educational problems and activities by practising family physicians, whether employed within the university setting or outside it in the community.

Academic survival

The emphasis of the faculty development programme is now beginning to change from concentration on educational theory and practice to research and other scholarly activity. This shift is in response to our participants' needs as they become acutely aware that survival in the academic community depends upon promotion and, ultimately, tenure in a senior academic rank. In my own university, the standards which have to be considered for promotion at any level are assessed in three areas: teaching, service (which for a doctor includes clinical work as well as serving on university and community committees and so on) and research or scholarly activity. For promotion from one rank to another, there has to be significant progress in each of these areas.

It is commonly accepted in university settings that the best research workers do not necessarily make the best lecturers. It is interesting that at the University of Massachusetts, at least an element of generalization is expected of faculty who are promoted to senior ranks. In other words, an excellent researcher must also be excellent in teaching or service if he or she is to be promoted. This is perhaps one of the few concessions made to generalization.

So apart from a pure desire to expand our area of knowledge, it becomes imperative for the academic family physician to begin to ask him or herself if it is possible to do effective and useful research. I firmly believe that many opportunities for research remain which need neither expensive equipment nor peculiar circumstances in order for them to be carried out effectively. In these days of relative economic crisis, let me assure you that your colleagues across the Atlantic are not basking in the surfeit of money, staff and equipment that certainly used to exist. Pressure is inevitably and rightly being maintained on departments to prove their usefulness, not only in clinical work and in educational activities, but also in research and/or scholarly activity. The resources that the university is prepared to devote to a department will depend upon its assessment of that department's effectiveness in these areas.

Doing better, feeling worse

It is apparent that it is not enough to establish departments of family medicine and to espouse the idea of generalization within the medical school. That such departments can be established in universities on both sides of the Atlantic has now been clearly demonstrated. In that sense, we are clearly "doing better". But the big question of our overall effectiveness and usefulness in the university setting remains. Our present state of growth could, I think, be well described as adolescence, and like many adolescents, while we recognize that we are doing better, we are simultaneously feeling worse. This is probably a good thing in that it encourages continued intellectual and academic growth.

One of my mentors at London University frequently said to me that I had to earn the right to be heard. In an academic setting, family medicine has not yet, in my estimation, fully achieved that distinction. Universities and other departments are beginning to listen to us, but

we have not yet fully earned the right to be heard. Our continuation and our acceptance depends upon the quality of our work. Wherever we are currently putting most of our energies, we need to strive for excellence. Whether our prime emphasis is on the quality of our clinical work, our educational or our scholarly activity, we need that excellence. Our future, I believe, is essential for the welfare of our patients and for the maintenance of cost-effective health care, not only in high-technology, civilized centres of the West, but also in socially and educationally deprived parts of the world. I am not discontented with my own diagnosis of "doing better and feeling worse", but I am looking forward to the day when you and I and our successors are able to feel more comfortable about our achievements in an academic setting.

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Pharmaceutical services

As a proportion of all NHS costs, pharmaceutical services dropped to 9.4 per cent in 1980, compared with 10.1 per cent in 1979, 10.4 per cent in 1969 and 10.2 per cent in 1959. The number of prescriptions dispensed rose from 224 million in 1949 to 374 million in 1980. The Office of Health Economics estimates that 75 per cent of all prescriptions will have been exempt from charges in 1981, compared with 54 per cent in 1970.

Source: Office of Health Economics. *Compendium of Health Statistics.* 4th edition. London: OHE.