Family Practice
Part III--the problems

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News
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* * * * * *Family practice doesn't promise med students a rose garden.

DALLAS--The family practitioner is the tribal medicine man of our society.

"The public wants us; they need us; they use us. And if we did not exist, they would invent us," said Dr. Seth Cowan, immediate past president of the Texas Academy of Family Practice, when he addressed the association at their state meeting in Dallas this year.

Bill Ross agrees. A family practice doctor from San Benito, Tex., the physician left his patients three years ago to take over the family practice program at The University of Texas Health Science Center at Dallas. Since he joined the school, four new residencies in family medicine have been added to the program, the largest in the state, at John Peter Smith Hospital in Fort Worth. All in all, there is a total of 14 active family-practice residency programs in the state today.

Ross himself talks about the practice of family medicine in almost mystical terms. He speaks of many an individual he has known throughout the years through his medical practices in East and South Texas as "my patient, my friend, my reason for being." He sees the role of the family physician as confidant, helper and neighbor, in short, the tribal medicine man.

The physician says that even though the practice of medicine has evolved from the old "horse-and-buggy days"of the family doc to the more modern methods of care in these days of high technology, the continuity of care will remain the same. The family physician will continue treating families--from babies to grandmothers--over a number of years in a community setting. The differences are in the quality and quantity of training the family doctor receives.

In the past the family doc generally did an internship after graduating from medical school and then went out and hung up his shingle. Today, however, few young physicians begin practice after only one year of graduate training. Usually toward the end of the junior year, the medical student must make the decision as to what kind of medical specialty training program he or she wants to enter.

The traditional medical specialties and subspecialties--from allergy to urology--are research-based. Family practice is service-based. Ross believes this important difference leads to one of the major problems faced by practitioners of family medicine today: the disparagement of many of their peers.

It is a problem that raises its ugly head in the "halls of ivy" where family-practice physicians share the same faculty ranks with researchers. It is also a problem the family practitioner in private practice, especially in the cities, faces in dealing with colleagues. And it spreads like an infection to the medical students.

One family-practice doctor asked a new resident how he survived the pressure from his teachers at the medical school to enter one of their specialties instead of family practice. "It wasn't easy," was his reply. Students agree this type of situation is typical.

No one wants to feel like a second-class citizen. Or a second-class member of his or her profession. Unfortunately, too often that's the way it is. However, Ross says, there's a bright side to this problem of professional snobbery: these pressures may act as a "weeding-out" process. "If medical students are dissuaded by others to enter family practice, then we don't want them. We only want residents who know family practice is what they want to do."

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Ross himself, who is president-elect of the Texas Medical Association, does not feel the least bit inferior. "I know more about family practice than your best neurosurgeon or pathologist here. But I do not pretend to know more than they in their fields."

In informal conversation with students, the administrator is interested in exploring the work and lifestyle of a family practitioner. The man exhibits pride in his profession. First, he tells them they are exceptional people: otherwise, they would never have made it into med school. Then he asks them to appreciate the fact that they are in the best position of anyone in medicine. As private physicians, the only people they will work for will be their patients.

"When you get out into practice," he says, "the first professional phone call you'll get won't be from one of the other family docs--it will be from some specialist who'll be asking you politely how you expect to handle your referrals. The specialist has the referring physician to satisfy as well as the patient."

An important part of the role of the family doctor is provider of access to the medical-care system for his patients. The family doctor has to see that his or her patients are sent to the very finest specialist possible.

"When you're doing your residency," he tells them, "if you're on third assist, don't waste your energy being perturbed because you're not operating. Use that time to watch the tissue handling, watch the conversation during the operation, watch the attitudes--and, for God's sake, watch the patient afterwards. See who you'd like to take out your own daughter's appendix at three in the morning!"

Another problem in family practice today centers around the question of just who should take out your daughter's appendix. A small furor surrounds the issue of hospital privileges, that is, which medical and/or surgical procedures a physician may be granted permission to perform on his patients in a given hospital. The question of privilege has become so controversial that the American Academy of Family Physicians has offered legal assistance to any physician--not just family practitioners--who is denied what is essentially "due process," that is, the opportunity to prove he has the academic training and professional skills to perform the procedure he is requesting.

The privilege question is tougher for the family practitioner in other parts of the country. Texas, however, is not immune to the problem, even in its smaller cities. While several major hospitals in Fort Worth traditionally have family-practice doctors on their staffs. Thirty miles away in Dallas, though, these doctors are relegated to small and suburban hospitals.

Yet it isn't just the size of the city, says Dr. Bruce Jacobson, head of the John Peter Smith family-practice residency in Fort Worth, part of Southwestern's program. Many smaller cities, and, ironically enough, many that need more family-practice doctors in their communities, are tougher. The economics of medicine may well play a part in these situations.

Jacobson, whose JPS program includes an unusually large amount of surgical and ob/gyn training compared to other programs, says the privilege issue may well frighten off some medical students who are considering family practice as a career. If this is not the case, then the situation certainly does influence the new family-practice doctor's decision about where to begin practice.

One former resident chose a smaller Central Texas practice over a more affluent city in the western part of the state because he wanted to utilize the skills he learned at John Peter Smith.

Another left East Texas to practice in another state. Because of the privilege problem in his new location, he decided to move back.

There is one positive side to the privilege problem, says Jacobson. "It does help push out graduates to the small towns where they are needed the most. That's where they can practice medicine to the full extent of their abilities."

Another squabble inside the profession centers around who the best teachers are for future family practitioners, whether they be residents or medical students. At the fall meeting of the Texas Academy of Family Practice, a call was issued to members to consider teaching in their field.

Ross believes family-practice doctors are needed as role models and administrators. But he wants the teaching of the medical students and residents left to the specialists.

"My concept is that I want every student to have the very best training possible. I don't want my students just to have my experience. I want them to have exposure to the best of medical knowledge in each field from the experts who live it, breathe it, drink it, sleep it. I wouldn't swap Donald Seldin (head of UTHSCD's powerful internal medicine department) for any other doctor I know to teach my students internal medicine."

Jacobson, whose residency program has graduated about 86 family-practice doctors since 1972, agrees. In fact, he follows the same philosophy for his residency program. Top specialists in departments such as pediatrics, psychiatry, surgery, internal medicine and ob/gyn train family-practice residents, along with those who are taking residencies in these other specialties.

One of the things that has made the process of turning out family doctors more difficult has been the cutback of federal funds. Many of the programs, such as the preceptorships in the small towns, which were being used to encourage the spread of new family doctors across the state, have been dropped. Hospitals like those in Snyder and Sulphur Springs have voluntarily supplied room and board and even small stipends to students so they can afford to take advantage of the preceptorship period. Also, since the cutback of the federal monies, it has become even more important for the state to continue the support to fulfill its mandate for more doctors for the people of Texas in the areas of greatest need.

Jacobson is proud of John Peter Smith's record of turning out a large number of family-practice doctors, and especially the high numbers (75 percent last year) that are going to towns under 15,000 population. However, little has been accomplished through the health science center's residency programs--or any of the others in the state about meeting the needs of the medically underserved in the cities. That's a nice way of saying no doctors are setting up practices in the ghettos. Ghetto people, in most cases, are even worse off than people in remote rural areas. Most are dependent on large county charity hospital emergency rooms for any care at all. But you can't dictate to a physician where he practices, so this problem is even harder to solve.

Ross expresses concern about these citizens. He is working with several groups on the state level, looking for answers to this problem.

Even with the increasing interest in the calmer lifestyle of small-town living--for everyone, not just doctors--today's medical students may approach the possibility of a rural practice with some personal fears. One is being away from a major hospital, a natural question since so much of their training has been in such a setting.

Medical students Mike Parchman and James Fisher, now a resident in Arizona, came away from their experiences working with family-practice physicians in Sulphur Springs and Snyder, respectively, with a new attitude about small hospitals, however. Both were impressed with the facilities available.

In addition, the increasing application of technology to medicine through such devices as telephone EEG's and telemetry X-rays, will bring the small town "doc" into instant communication with major medical schools around the state. There is also the possibility of "hooking into" a medical school library's computer bank for the newest in medical research.

These advances, along with the opportunities for continuing education offered by various medical schools and both the national and state organizations of family-practice physicians are at least partial answers to the young doctors' fears of "professional isolation." Also, consultant help from a major medical center is only a phone call away.

Dr. Charles Baxter, professor of surgery at the Dallas health science center and one of the top authorities on thermal injuries in the country, agrees. He is the first to point out that one of the most valuable services of the burn "hotline" at UTHSCD is not just consulting on burn cases. It's helping spread the word that the doctors there are eager to help their colleagues whenever they feel in need of consultation on a particular case in any medical or surgical area.

Another concern of medical students considering family practice is whether their lives would be like that of the old stereotype country doctor slowly working himself into the grave, day after day, week after week, year after year. Or in the words of third-year student Parchman, "Is there life after medical school?"

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Both Parchman and Fisher were pleasantly surprised to see that this situation has changed. Physicians in Snyder rotate weekends and nights on call, so that everyone has a chance to get out of town--or just have some uninterrupted time with hobbies or family.

Carl Dillaha, the family practitioner with whom Fisher worked, has a piece of land out of town, hunting dogs and a motor home which heads for nearby New Mexico almost by itself. Max Latham, Parchman's preceptor, also loves to hunt and to fish. Both have time with their families, which they enjoy.

Parchman says that a physician must value his or her lifestyle enough to demand a life of his own. The student, who is not married, says he enjoys reading not just medicine but English literature and history. "I also like being able to take a week off and go skiing, backpacking and camping. These things are important to me."

The day of the solo practitioner is gone. Today doctors realize that they must cooperate with each other to physically make it. Also, they need the intellectual stimulation of their colleagues.

It just isn't realistic to think that every little town is going to have a doctor," says Ross. "It's not. But we're doing our best to see that there's one nearby."

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