Reflections on Internal Medicine and Family Medicine

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The manner in which U.S. medical care is organized and paid for is rapidly changing. These political and financial changes have created an environment that favors collaboration and cooperation among the primary care specialties. Although their relationship was once that of referring physician and consultant, the family physician and general internist are becoming peers, and they increasingly have similar needs and interests. Improving collaboration between the practitioners in these two fields requires a respect for important differences in their respective cultures. All family physicians work closely with internists during residency, but many general internists have had little or no experience working with family physicians. This essay reviews the practice style and philosophy of the family physician and suggests ways to improve communication and collaboration between the two disciplines.

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Although government-mandated health care reform has failed to materialize, market forces are causing unprecedented changes in the way medical care is delivered and paid for in the United States. No medical specialty has been more affected by these changes than internal medicine. Recently, the future of internal medicine has been discussed frequently at meetings and has been written about in the medical literature (1–11). The leaders of internal medicine have increasingly sought out the leaders of other generalist disciplines to collaborate in the training of generalist physicians. The American Board of Internal Medicine and the American Board of Family Practice have issued two joint statements on the generalist physician (12, 13). In the spring and summer of 1994, the executive committees of these organizations met to discuss areas of similarity and difference between general internal medicine and family medicine and to identify areas for collaboration. Program directors from each discipline were invited to the first of these meetings.

From the perspective of a family physician who has participated in some of these discussions, internists and family physicians appear to view the world differently in several areas. The purpose of this paper is to explain some of these differences and, ultimately, to facilitate collaboration between the two disciplines. Such collaboration may be crucial in deciding whether ongoing changes in health care will result in improved or worsened care for the U.S. people.

Family Medicine from a Developmental Perspective

The history of family practice as a specialty can be traced to political forces that led to the formation of the American Academy of General Practice in 1947 (14). The number of general practitioners in the United States had begun to decline in the 1930s. This decline threatened the general practitioner with loss of status and loss of such professional credentials as hospital privileges. In response, the American Academy of General Practice promoted continuing education and functioned as a political voice for general practitioners. Two-year general practice residencies were started in the 1950s, but these were unpopular with students and had no standardized curriculum. No system to accredit these programs or certify their graduates was available.

In 1966, three influential commissions issued reports that addressed the decline of general practice as a health policy concern. These reports are now referred to by the names of the men who chaired the commissions: the Folsom report (15), the Millis report (16), and the Willard report (17). These reports gave legitimacy to the recently incorporated American Board of Family Practice. The American Academy of General Practice initially opposed the formation of a certifying board. Some members of the Academy believed that "specializing" in generalism was oxymoronic, and they opposed any process to certify generalists. Nevertheless, a new specialty was recognized in 1969 and given the name "family practice." The practitioner of the specialty is called a family physician. Family medicine is the academic discipline that lies at the heart of the practice philosophy, clinical values, and core content of the specialty. In 1970, the American Academy of General Practice changed its name to the American Academy of Family Physicians. Additional details about the history of the specialty can be found in the excellent book by Doherty and coworkers (14).

By 1979, graduate medical education in family practice had grown from 15 in 1969 to more than 300 residencies. During this period, family medicine as an academic discipline depended intellectually on

the other specialties of medicine, which provided most of the teaching to family practice residents. This dependence was nowhere more apparent than in the relation between family medicine and internal medicine. Even today, family practice residents spend 8 to 12 months of their 36-month curriculum working on internal medicine services and caring for internal medicine patients under the supervision of internists. Much of the family physician's clinical training and practice style with adult patients is shaped by this experience.

The second decade in the history of family practice can be characterized as a transition from childhood to adolescence. As an adolescent discipline, family medicine began to desire greater independence from, and was intermittently resentful of, its parent disciplines. Physicians and educators unaware of this desire for independence may mistake it for arrogance and isolationism.

Now halfway through its third decade, family medicine is maturing as a discipline and stands both ready and able to function as an equal partner in interdisciplinary collaboration. Family practice faculty have much to offer in the areas of family systems medicine, practice management, and office-based care of common problems. Currently, internal medicine programs infrequently use this resource.

The Clinical Content of Family Practice

Many physicians overestimate the similarity in the content of the practices of general internists and family physicians. Most family physicians work in practices in which at least 15% of the enrolled patients are younger than 21 years of age. The percentage is even higher in residency teaching practices. The number of children cared for in each practice is, of course, greatly influenced by whether or not maternity care is included in the practice. More than one quarter of family physicians continue to provide maternity care, and younger family physicians are more likely than their older colleagues to include obstetrics in their practices. In some regions of the United States, more than half of family physicians continue to deliver babies (18).

Family physicians also care independently for a broader range of problems in such areas as urology, otolaryngology, and orthopedics (19). According to most studies of primary care practice, common musculoskeletal injuries are among the 10 most common problems seen in practice. This has become a focus of practice for many family physicians, especially those who care for young patients. As internal medicine training pays more attention to areas of primary care competence that lie outside of the traditional boundaries of the discipline, these differences may decrease. For now, they represent substantial differences.

Generalizing about the scope of a family physician's practice is difficult. Family physicians are trained to model their clinical competencies on the needs of the populations they serve. A family physician in an isolated rural practice has a powerful social need to develop clinical skills that accurately mirror the needs of the community, whereas physicians practicing in large groups or in urban settings have a less apparent need to do so. Thus, the content of clinical practice may vary more from one family physician to the next than in any other specialty in medicine.

Some internists believe that patients who see general internists are sicker and have more complicated problems than do patients who see family physicians. Although this may have been true in the past, two features of medical practice in the 1990s have eliminated most of this difference. First, fewer patients are referred to general internists now that medical subspecialists are generally available in most parts of the United States. Second, the evolution of managed care systems creates powerful financial incentives for primary care providers to care for patients with a broader range of disease severity. The patients of general internists now more closely resemble the adult patients of family physicians in terms of disease severity and acuity than at any time in the past (20–23). Remaining differences are likely to decrease further in a market based on managed care.

Nearly every graduate of a family practice residency in the past 25 years has spent 8 to 12 months of structured training on an internal medicine service after completing medical school. A traditional 36-month family practice residency also includes 2 to 3 months of general surgery; 1 to 2 months of emergency medicine; 4 to 5 months of pediatrics; 3 to 6 months of obstetrics and gynecology; 1 to 2 months of orthopedics; and required experience in urology, otolaryngology, dermatology, cardiology, ophthalmology, community medicine, and practice management. This rotation curriculum supplements continuity training, which entails at least 1 to 2 half-days per week in the first year of residency, 2 to 4 half-days per week in the second year, and 3 to 5 half-days per week in the third year. Extensive training in behavior medicine is integrated into this continuity experience. The residency review committee's program requirements for family practice are now being revised and in the future will probably focus less on rotation-based training and more on this continuity experience.

Few graduates of internal medicine residencies have completed required training as a resident on a family practice service. Throughout this period

(1969 to the present), internal medicine training has been required in each U.S. medical school, but few internists have had experience in family medicine during medical school. Thus, family physicians and general internists differ substantially in their understanding of each other's practices. Misperceptions about the clinical content of practice represent the most substantial impediment to collaboration, both in practice and in medical education. The family physician and general internist who choose to practice together are likely to encounter some difficult barriers to functioning as partners. Can the general internist and the family physician cover each other's practices? To what extent does practicing together distort the patient population served by each discipline? Should a collaborative practice necessarily imply that the family physician treats more children and fewer adults, or should the general internist begin to take on the care of children? Is there a way to integrate the general pediatrician into the collaboration so that the three disciplines can be practiced together? Answering these questions requires a more sophisticated understanding of the clinical content and practice style of family physicians than is currently available to most internists.

Core Values of the Family Physician

Internists, especially those in academic medicine, may underestimate the degree of nonconformity and rebellion required of U.S. medical students who entered family medicine in the 1970s and 1980s. It is these students who now fill the faculty ranks of family practice programs around the country. Nowhere is this nonconformity more evident than in the ambivalence with which family physicians have integrated themselves into academic medicine. The importance of this counterculture mentality in the character of the family physician can best be understood by reading the works of Gayle Stephens, which are considered classics in family medicine. Stephens is one of the philosophical fathers of the family practice movement, and his book, *The Intellectual Basis of Family Practice* (24), has inspired a generation of family physicians (25). An understanding of the culture of family practice will help to explain much of the independence and cynicism that so often seem to characterize the family physician.

Family physicians attach a meaning to the phrase "continuity of care" that subtly differs from the meaning used by internists. To an internist, continuity of care implies an ongoing relationship between the physician and patient that allows the development of intimacy and a sense of consistency in the way the patient's illnesses are managed. To a family physician, however, continuity of care has an additional meaning; this difference is important. To the family physician, continuity of care is a multigenerational concept in which the physician cares for families as groups. All of the families in a given practice do not seek or value such family-based continuity. In fact, some families prefer a model of care in which different family members have different primary care providers. However, most patients who seek care from a family physician value the opportunity to have a single physician for the whole family. This family-based practice model is the ideal toward which family physicians aspire, and it forms the basis of family systems medicine (26–28). Because the concept of continuity of care is so central to the practice and training of generalist physicians, a difference in the underlying meaning of this principle between the two disciplines must be explicitly discussed.

Internists are trained in the classic deductive reasoning model of differential diagnosis. Family physicians are trained in this model of problem solving on internal medicine services, but, in practice, they often take a less structured and more empiric approach to clinical reasoning that is based in clinical epidemiology. This difference in approach may be partly responsible for data suggesting that family physicians spend less time per visit with patients in the office, see patients more frequently, order fewer diagnostic tests, and care for common problems more efficiently (19, 22, 23). It is important to note that decision making based on clinical epidemiology has been most frequently described in the literature not by family physicians but by general internists (29–31). This highlights the increasing intellectual common ground between general internal medicine and family medicine. This common ground is less apparent with the internal medicine subspecialist.

Conclusions

The changes now taking place in our health care system will equal in magnitude the changes that precipitated the Flexner Report in 1911. Although the need to adapt to these changes has placed particular pressure on internal medicine, none of the specialties in U.S. medicine are immune to the process of natural selection. It seems inescapable that part of this adaptation to environmental change will require family physicians and general internists to work more closely together in the future than they have in the past. The American Board of Internal Medicine and the American Board of Family Practice should be applauded for facilitating this process. The next step, however, requires a greater understanding of the similarities and differences between the two disciplines; this could be achieved by

increasing the degree to which internists are exposed to the clinical content and core values of family medicine. This increased exposure might be accomplished by establishing rotations in family medicine for internal medicine residents. Family practice faculty might be sought to teach internal medicine residents about areas of primary care that traditionally lie outside of internal medicine. Collaborative ambulatory practices can be developed that allow general internists and family physicians to work together as partners. Joint conferences could be sponsored by the two specialties. Although these collaborative efforts will improve understanding between the two disciplines, they will also foster the developmental growth of family medicine as a discipline. Such growth is necessary if family medicine and internal medicine are to truly collaborate in an interdependent rather than a dependent manner.

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