

The Second Generation

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The 1960s and 1970s marked the establishment of family practice as a specialty. In the beginning, we were clinicians and teachers. Family practice rose on a tide of social unrest to represent a counterculture movement in medicine,¹ a movement dedicated to longitudinal and preventive care rather than episodic, disease/problem-oriented care and a movement involving patients and families in shared decision making, rather than insisting on compliance within the dictates of an omnipotent, paternalistic physician.

We valued continuity within relationships. We offered comprehensive care and acted as care coordinators, first in multispecialty and hospital settings and later in managed care.

Creating the Second Generation of Family Physician Educators

Our fathers, and a few mothers, were visionary and often amazing clinicians. As our residency programs grew, these clinicians grew in importance as teachers and role models. But, it wasn't enough. We needed to know what to provide to our patients and how best to serve them. We needed information relevant to our practices. To generate

the research needed to develop this information, we created a second generation of family physicians—the academicians. With this new group of academic family medicine researchers, we entered our next 20 years, the 1980s and 1990s—our adolescence. Our paradigm was the three-legged stool, the “triple threat,” the clinician-teacher-researcher.

It was from this group of individuals that I selected the authors of the research classic articles reprinted in this edition of *Family Medicine*.

Classic Research Articles in This Issue

The articles, all published in the early 1980s, represent our discipline's initial foray into the research arena. Each article is accompanied in this issue of *Family Medicine* by a brief commentary, written by the author of the original classic article. The classic articles and current commentaries tell a story about who and what we wanted to become as scholars within our discipline in the next generation and what we have become.

Peter Curtis, MD

The first paper, by Peter Curtis, MD, raises the question of what we should study.² He noted the uncharted areas of the natural history of disease and early symptom patterns, the need to give practicing physicians a loud voice in posing relevant research questions, the potential benefits of research to our

students and ourselves, the likely “laboratories” in which to conduct research, and the training needs of our young researchers. Peter's commentary about his initial vision and our current reality notes both the accomplishments of the 20 years since he wrote his editorial and their consequences in the form of an ever-growing rift between clinician-researcher and clinician-educator.

Larry Green, MD

With clinical practice being perhaps the most promising laboratory for conducting family practice research, the article by Larry Green, MD, on sentinel practices, published in 1982, was timely indeed.³ He introduced the family medicine audience to this concept, already in existence in England, Canada, Australia, and Finland, and discussed the growing interest and planning for such a reality. Larry's commentary on what we have learned from our 20 years' experience with practice-based research networks (PBRNs) offers insight and hope for the future. The body of information already provided by these network investigators, practitioners, and their staffs, now numbering 16 networks and including approximately 4,000 (10%) of all practicing family physicians in the United States, is impressive.⁴ The support that PBRNs are now receiving from the American Academy of Family Physicians (AAFP) and the Agency for Healthcare Research and Quality (AHRQ) will likely ensure their success in the future.

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John Frey, MD

In many ways, the heart and soul of who we are as clinicians, teachers, and scholars is reflected in our literature. The literature analysis by John Frey, MD, and Julianne Frey, MLS, published in 1981, helped us see ourselves in light of our own work and that of our British counterparts.⁵ John and Julianne highlighted the closer ties of the British investigators publishing in the *Journal of the Royal College of General Practitioners* to practicing clinicians in the evolution of knowledge, a finding that spurred the then-fledgling efforts of our own PBRNs. In contrast, they also noted the large percentage of educational-related articles in the *Journal of Family Practice*. These articles, however, were primarily descriptive or position papers. The Freys challenged family medicine investigators to apply the same rigor to educational research as in clinical investigations. In addition, they called for more evidence of our long-term effectiveness as family physicians.

This call to action still rings true. In fact, even in *Family Medicine*, a journal devoted in large part to educational research, we are seeing fewer educational articles submitted, despite our tremendous innovations and years of experience in ambulatory teaching. There are still few studies that demonstrate the effectiveness of our teaching methods or of such central principles to our discipline as continuity of care. Yet, we have taken tremendous strides toward describing who we are and what we do, blending qualitative and quantitative measures, to demonstrate high rates of the delivery of preventive services and patient satisfaction.⁶ We are developing a culture of scholarship among our residents and fellows through an emphasis on evidence-based medicine, as reflected in the POEMS (Patient-oriented Evidence That Matters) published monthly in the *Journal of Family Practice*. Our literature is changing, and, yet, as

John so poignantly summarized in his commentary, still missing from both our clinical research and educational publications are answers to key questions about our effectiveness on important outcomes for our patients and students.

Larry Culpepper, MD

The final paper in the series of classics is about funding for our research endeavors. In 1984, when Larry Culpepper, MD, introduced us to the National Institutes of Health,⁷ we dreamed of the day that we would sit at the Institute's table. Now, we find that we are at least eating at the table, albeit with plastic silverware. In Larry's commentary, we see the opportunities afforded to us through the AHRQ and the AAFP to support research.

What do we need to fulfill our promise and these researchers' visions for our future? I believe that the answer is clear: we need each other. We can no longer ignore the rift that our early success has created within our ranks between clinician-educators and clinician-researchers. Our very foundation was built on counterculture and once again we must come forward with a new model of academic scholarship. Within our departments, we must forge new ways of working together. Patients and clinicians must raise their questions, and researchers must respond with methods to answer these questions. Clinicians must refine these methods, based on the realities of practice, and work collaboratively with researchers on data collection, analysis, and writing. We must forge new relationships with our communities—with businesses and third-party payors—to fund these research efforts because these research investigations answer *their* questions. If we take a step back from that three-legged stool, we can see the original tree, a tree where no root is unnecessary, and all are valued if we are to bear fruit.

I Need a Family Physician

This week, as I sat at my mother's bedside in the surgical intensive care unit, trying to effect small changes that might speed her recovery, I needed a family physician. I needed a clinician to hold my hand and help me understand what was happening, a teacher to help the residents caring for her consider the evidence (or lack thereof) of the treatments being wrought on her, and a researcher to find answers to my many questions. If we are to improve care for our patients and ourselves, we must be all of those things. But, we can only be all of those things if we combine our talents and skills.

My thanks for this series of original articles and commentaries to Dr Curtis, for his high-touch research in obstetrics and his teaching and direction of an outstanding fellowship program; to Dr Green, for his incredible leadership in developing and sustaining PBRNs; to Dr Frey for his shepherding our nascent literature into a more sophisticated body of work and for so eloquently telling our stories; and to Dr Culpepper for his outstanding research, writing, and mentoring.

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REFERENCES

1. Stephens GG. Family medicine as counterculture. *Family Medicine Teacher* 1979; 11(5):14-8. Reprinted in *Fam Med* 1989; 21(2):103-9 and *Fam Med* 1998;30(9):629-36.
2. Curtis P. What kind of research in family medicine—further reflections. *Family Medicine Teacher* 1980;12(6):8-11.
3. Green LA. Sentinel practices. *Fam Med* 1982;14(1):22-3.
4. Nutting PA, Beasley JW, Werner JJ. Practice-based research networks answer primary care questions. *JAMA* 1999;281(8):686-8.
5. Frey JJ, Frey J. A literature analysis in family medicine and general practice. *Fam Med* 1981;13(6):7-10.
6. Stange KC, Jaen CR, Flocke SA, et al. The value of a family physician. *J Fam Pract* 1998;46:363-8.
7. Culpepper L. An introduction to the national institutes of health. *Fam Med* 1984;16(2): 63-8.