GP to FP to GP?

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The founders of family medicine understood that language was powerfully symbolic as they reconfigured general practice into the specialty of family practice. "Family" was a compelling term, central to American values, and had nothing but positive connotations related to medical practice. But, while the family—the social group most widely experienced throughout human history—will continue, the name of the 20th century specialty—family practice—may not.

Since it was used by Lynn Carmichael, MD, and others in the mid-1960s as both an intellectual principle and a political tactic, the term "family medicine" has continued to create some discomfort for its teachers and its practitioners. This discomfort has been expressed through recurrent analyses that find "family" lacking in the research and education carried out by family medicine educators. It shouldn't surprise anyone, therefore, that Goldschmidt and Willard, in this issue of Family Medicine, report a small percentage of family-oriented perspectives in clinical research published in the field.¹ Not much has changed from Schmidt's editorial in the late 1980s, which lamented the paucity of "family" in the literature of family medicine.²

The larger question is: should we ever expect more?

The Institute of Medicine’s report on “Health and Behavior” is a compilation of the extensive research on social systems and societies.³ Weilh, Fisher, and Baird’s work in the subsection of that report, titled “Families, Health, and Behavior” discussed the research from the social sciences, behavioral sciences, and epidemiology. They found that the literature in all of those fields had studied and demonstrated the interaction of individuals and families around prevention, chronic illness, and cost of health care.⁴ So, indeed, families are important—in many ways more important to understanding health care issues than ever. But, for family medicine to claim special status in the issues affecting health and families may be an unnecessary and self-imposed burden in a world in which engineers, social scientists, and geneticists are all studying families from their own biological, psychological, and social perspectives. Family medicine is not the sole possessor of the educational and intellectual copyright for families. Rather, it is but one of many disciplines to look at family systems in medicine.

Goldschmidt and Willard¹ acknowledge that there is no “correct” percentage of clinical articles that should contain references to families. They also acknowledge that other medical disciplines are likely to include references to families in their clinical literature. Further, it would be a mistake to suggest that the literature in family medicine should use “family” as frequently as the pediatric literature includes “children” or the literature in obstetrics and gynecology mentions “women.” Family has never been, nor should ever be, the sole or even chief defining intellectual concept in our discipline.

McWhinney described four essential elements for an academic discipline,⁵ and family medicine has successfully met most of them: a unique field of action, a defined body of knowledge, an active area of research, and training that is intellectually rigorous. Our educators have developed methods of assessing families,⁶,⁷ and a great deal of research has examined the effects of families on health and illness. We have created intellectually rigorous educational programs that brought educational reform into the world of community practice. But, by McWhinney’s definition, the uniqueness of family medicine’s field of action is what trips us up if we insist on “family” as defining that uniqueness within medicine. Instead, family medicine must extend far beyond families and interact with much larger systems if the discipline is to define its field of action more clearly. The space between individual care and public health requires clinicians who will work with teams on the contextual issues of families but, more importantly, who will work within the context of communities and populations. Those clinicians must be family physicians.

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“Family” has served the discipline and those in it well by creating an identity. But, that identification with families cannot and should not restrict us from other options if family practice is to add value to health systems. Otherwise, our “identity” works against us. For example, 20 years ago, Ted Phillips, MD, one of the discipline’s founders, examined the unanticipated consequences of the political decisions that created family medicine. In looking at the decision to become “family practice,” he mentioned the confusion in the minds of the public about the differences between general practice and family practice and the “historic expectation (of society) that the medical profession will provide general practitioners.” I recently was talking with one of our state legislators about our department, and he asked “So are you a specialist?” to which I answered “Yes, I am a specialist in family practice.” He said “How can you be a specialist as a GP?” I am not sure I answered the question any more convincingly than the answer I got the first time I asked it myself 33 years ago. The terms “primary care” or “PCP” as a designation for a polyglot of providers hasn’t met either the public’s expectations or those of the medical profession either and certainly has not provided an adequate identify for family doctors.

One reason why many of the community-based generalists in other parts of the world still call themselves general practitioners is that they provide a much broader foundation for their country’s health system than family practice does in this country. While those general practitioners are involved with families, and researchers in those countries use family to define the starting point for social inquiry, they are not limited by the identification with families. If we have learned nothing else from our current world political and social situation, it is that the community-based physician must be alert to developing epidemics or threats and that they must do so through the thoughtful care of individuals while always looking for clusters, trends, and other long-standing epidemiologic principles for uncovering patterns of illness. Our gaze must always extend beyond family. Engebretsen wrote that “The health of environmental systems and their impact on human health will become the most important health concern for the rest of this century.” He wrote that in the last century, but we have seen his concerns come true in this one. What family practice in this country shares with general practice in the rest of the world is the central role of the generalist in managing care for populations, both large and small. While general practice as a term has been vilified in this country, it remains the best descriptor of not only what we do but what we offer to a health system. It is unlikely at this point that we will see 40 years of logos, academies and societies, academic departments, Boards, and journals change back from family practice to general practice. Too much individual and collective energy has gone into making the terms “family medicine” and “family practice” visible in health care and academic institutions. (For starters, though, we should settle on one of those terms or the other). But, I don’t believe it would be a loss if, at the end of this century, our discipline were to be called general medical practice as long as our role as the center of a system of care for individuals, families, and communities were assured and clearly framed. “Family” has been a great place to start, but what we do cannot end there.

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