

# Advanced procedures in family medicine: The cutting edge or the lunatic fringe?

► *About: "Laparoscopic cholecystectomy in a rural family practice," pages 205-208*

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**O**n the surface, the previous article by Haynes et al<sup>1</sup> appears to be a simple descriptive study of a well-established technology. So why publish something that is not new? Simply because the study is an incredible technical and political achievement in a JCAHO-accredited hospital by a family physician educator. All family physicians—whether they view themselves as “procedural” or not—should recognize it for its symbolic and political value.

### **High-touch and high-tech**

If family physicians wish to provide more than “generic primary care,” they must provide clinical skills at the bedside, in addition to diagnostic and psychosocial expertise. No amount of the latter will compensate for the former at critical moments. For credibility in the community and in the life cycle of families, the provision of diagnostic and therapeutic procedures trumps prescription-writing every time.

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By providing surgical or diagnostic procedures that improve access to health care in their communities, physicians such as Haynes are not regressing to a surgical mentality at the expense of psychosocial sensitivity and therapeutic listening. Our closest relations with patients and their families are established at the bedside while performing or assisting with a diagnostic or therapeutic procedure. Procedures frequently provide the ultimate “teachable moment.” As said at Keystone III: “You can pretend to know; you can pretend to care; but you can’t pretend to be there.”<sup>2</sup>

Also, procedures distinguish family physicians from the other “primary care providers” who are hired with the assumption that they will provide referrals. Patients will seek out those physicians who can simultaneously provide high-touch and high-tech.

### **1960s-1970s: The growth of high-tech**

During the 1960s and 1970s, advances in technology were predominantly located in hospitals. The traditional office-based diagnostic and surgical skills of the general physician were

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gradually transferred to a more central place, namely the hospital. Many of these skills were then categorically assigned to more specialized physicians resulting in the withdrawal of the generalist physician in the participation of these skills.

Originally, family medicine educators thought the 3-year curriculum would be sufficient for procedural training, but they underestimated the political passion for control by opposing specialties with a need to maintain their training monopolies. Among 20 voting specialties, family medicine has only 1 vote. This is the democratic reality, which frames any potential turf struggle in a highly subspecialized environment. These environments include, but are not limited to, academic medical centers, most urban hospitals, and some rural hospitals.

The institutionalization of these interventions depersonalized the patient-doctor relationship, limited access, and escalated cost. Family practice as an emerging specialty willingly joined in this movement, resulting in the abandonment of many generalist-appropriate skills. During that time, studies of how tertiary-care technologies might transfer into the community were undertaken.<sup>3,4</sup>

It became increasingly evident that many diagnostic and interventional procedures (eg, diagnostic ultrasound, gastrointestinal endoscopy, and colposcopy) had multiple-specialty applications and were clearly linked with important preventive activities.<sup>5,6</sup> Some leaders suggested that technical skills combined with the unique biopsychosocial model of practice of family physicians was the right way to provide competent, personal care to patients. In other words, high-tech was most effective when blended with high-touch and vice-versa.<sup>7-9</sup>

### 1980s–1990s: The FP curriculum expands

In 1981, the first in a series of fourth-year fellowships emphasizing this expanded curriculum for family physicians was initiated.<sup>10-12</sup> Thereupon followed the development of CAQ experiences in Geriatric Medicine and Sports Medicine, which, while instructive, failed to create added market value to most rural and underserved communities. The American Academy of Family Physicians—through the Task Force on Obstetrics (1989–1993)<sup>13</sup> and then the Task Force on Procedures (1993–1995)—ratified and distributed performance-based learning and competency-based testing programs. Moreover, the Advanced Life Support in Obstetrics (ALSO) program had a major impact nationally and internationally.<sup>14</sup>

By 1991, our discipline was focused on credentialing for lightning rod issues such as colonoscopy,<sup>15</sup> esophagogastroduodenoscopy,<sup>16</sup> colposcopy,<sup>17</sup> obstetric ultrasound,<sup>18</sup> and cesarean section.<sup>19</sup> In Memphis, because of the political conflict associated with the teaching of diagnostic ultrasound, gastrointestinal endoscopy, and cesarean section, we chose not to “fan the flames” with development of office-based laparoscopy. But we were ready. We included laparoscopic tubal ligation in our FP/OB fellowship, but the resistance from specialties who felt family medicine was invading “their turf” was difficult and remains so.<sup>20-24</sup>

By 1995, the Residency Review Committee for Family Medicine had codified the rural training tracks<sup>25</sup> and reaffirmed OB-capable faculty as part of the accreditation process. These advanced family practice curriculum needs were acknowledged, and various educational innovations with an emphasis on skills needed for success in rural or urban underserved communities began to emerge.<sup>26,27</sup>

Nebraska,<sup>28</sup> Marshall University,<sup>29</sup> and the University of Tennessee–Memphis<sup>30</sup> have summarized their experiences with the accelerated residency program and rural training tracks have done the same. These programs have

recognized the need to train our future teachers and role models broadly, combating the "learned helplessness" that too often characterizes our training environments when we leave this teaching to subspecialists.

### Meeting the needs of a rural practice

Some physicians with a more limited scope of practice appear threatened by proceduralists. While there is room for everyone in the big tent of family medicine, if our specialty is to survive and be credible, we must seek to meet the needs of our patients and our students. In most urban areas, family medicine has abandoned large parts of our patients' care to the specialties of emergency medicine and obstetrics/gynecology.

From the rural perspective, it is impractical or fiscally impossible to recruit and maintain platoons of obstetricians and board-certified emergency medicine specialists to counties not located near a metropolitan area.<sup>31,32</sup> Family physicians, if properly trained, are the ideal physicians for nonmetropolitan practice.

Moreover, the current practice management curriculum in most family practice residencies is a do-it-yourself suicide kit where few physicians understand accountability measures for billing, collections, equipment, and human resources. They may have memorized the entire amino acid sequence for the human genome, but they don't have the time to understand billing for Medicaid or the impact of providing a full range of services to their patients. What's wrong with this picture?

### FPs must adapt to serve their patients

The net result of the production of our graduates lacking technical skills is an overstocked urban job pool and a shortage of rural physicians. There are few 9-to-5 family practice jobs available in urban areas like Nashville and Memphis for limited generalists. On the other hand, there are jobs for every family physician willing to work after 5 P.M. This includes continuing care, urgent care, and middle-of-the-night hospital care. Procedural skills and hospital service pre-

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dictably require "extra effort" and extra risk. Reimbursement policies continue to favor those physicians who assume these risks and provide these services.<sup>33,34</sup>

Another result of following the path of least resistance (as reflected in nonprocedural family medicine is the decreasing student interest in family medicine.<sup>35</sup>

Responsibility also rests with unskilled faculty who will not perform a broader scope of practice within the medical specialty of family medicine. There is personal risk for "being there" at the critical moment of procedural decisions. Students do not automatically shun this risk, but family medicine may be self-selecting for those who do.

Family physicians practicing in diverse geographic, social, and political environments will naturally adopt various diagnostic and therapeutic modalities in the service of their patients. It is not up to us to judge the appropriateness of those modalities except by the ultimate yardstick of the quality of the end result.

We are not advocating the addition of laparoscopic cholecystectomy to the "required" family medicine curriculum. However, we support the right of John Haynes to practice this skill and to teach it to others to the benefit of patients. The specialty that cannot provide training and credentials for its own members has been reproductively sterilized.<sup>36,37</sup> This is a unique market niche ideally suited for family medicine.<sup>38,39</sup> Procedurally trained family physicians represent the cutting edge of an emerging paradigm of care that includes ambulatory surgery, maternity care, cesarean section, and laparoscopy, particularly for patients in smaller communities and developing nations. We salute John Haynes and his co-authors for taking "the road less traveled."

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