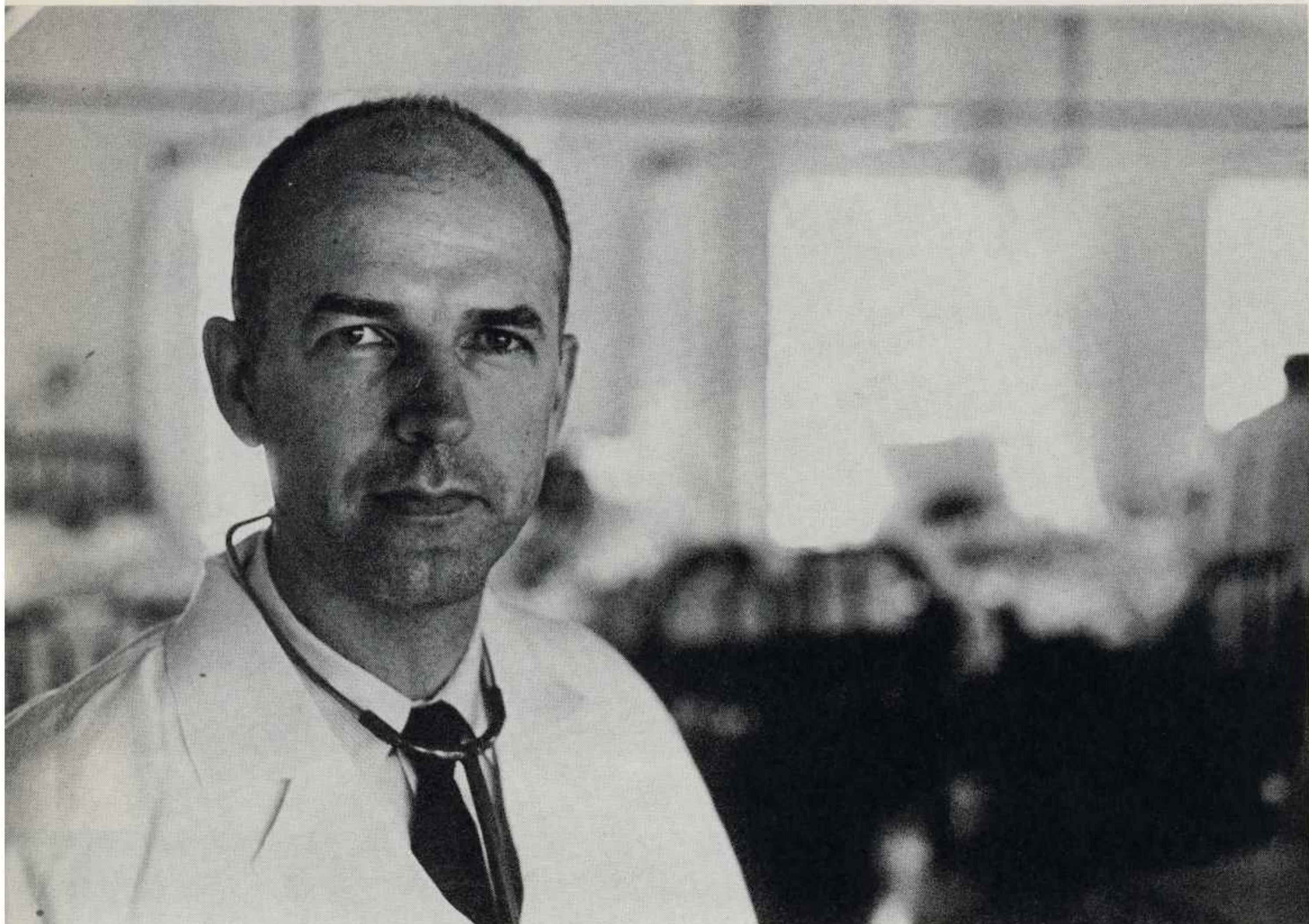

Dr. Roger I. Lienke, director of the division of family medicine

An Experiment in Family Medicine

The School of Medicine undertakes a unique new program with far-reaching implications

There are more families in the world today than ever in history; there will be more tomorrow. Families are made up of babies, children, adolescents, parents, and grandparents. Our society is comprised of families. The family is the core unit of society. Even in the primitive societies families need, want, expect, and will demand the security of access to some "doctor" or "medicine man" to whom they can turn, and with whom they can relate. In our country, the physician, who serves in this role, regardless of training, is to the family "their" family doctor. These are such basic facts it is difficult to envision responsible medical education evolving without planned programs devoted to a consideration of the needs of families. In fact, serious research into the medical problems of the family in our society (particulary in our society) is long overdue. Mental health, psychiatry, preventive medicine, prenatal care, pediatric care, adolescent care and geriatric care are evolving as fragmented specialties, yet, they intimately relate to and involve the total family units. Preventive aspects of each of these disciplines can be accomplished only from the perspective of family medicine, and prevention must remain the long term objective for the resolution of pathologic conditions that intimately affect the family millieu.

In the long run, society will provide the dominant force that determines the pattern of medical practice in this country. For this reason, there will be "family doctors" as long as there are families. The question and the challenge is what kind of doctor will this be. Should the family doctor be trained specifically and specially for this role? If so, how? Can we possibly train enough of them to meet the exploding needs of our people? Should all medical students emerge from medical school basically oriented toward service to the family, with later specialty training constructed on this foundation of orientation to family medicine? Can such basic training be accomplished by a core curriculum in medical school, with a continuing thread running all through the undergraduate years? Is family medicine an attitude? A sensitivity to the needs of families? Can a group of physicians who provide a balanced representation of specialty training comprise a "family clinic" and serve the role of family practice? Or, do family physicians require specialized training in organized programs that have yet to evolve?

I do not pretend to know the answers, but I intend to seek them. They pose questions to be resolved by planned experimentation. We have a unique opportunity in Oklahoma to develop meaningful programs in family medicine at a time most schools have abandoned it, even as a concept. Scrape the barnacles off your imagination, join us in exploring the world of the possible and share with us this thrust forward into the future. It will be what we make it—or what we let it be.—Dr. James L. Dennis, dean, OU School of Medicine.

Advances in medicine over the past half century and even in the last two decades have been extraordinary. The explosion of knowledge, the remarkable discoveries, the dramatic new surgical skills and techniques, the development of truly miraculous drugs, the relentless assault on disease have been overwhelming. But from this progress have come problems—problems which are of grave concern to both the medical profession and the public. Medicine is suffering from its own success. The growth of medical knowledge has necessarily led to specialization, and specialization is what is causing the problems.

Many people feel as if they have been chopped up and passed around. Patients complain that they are looked upon as organs and disease processes, not as persons. Many yearn for more doctors like the legendary general practitioner of the past with his magic black bag and his warm bedside manner, the physician who took an interest in his patient as a whole person, who knew him, was interested in him, and handled everything from a sore throat to major surgery.

The medical profession is also disturbed about the results of specialization. Three years ago the American Medical Association asked a group of twelve distinguished gentlemen to serve on a commission to examine graduate education in the nation's medical schools and to publish their findings and recommendations upon completion of their study. The report of the Millis Commission (its chairman is Dr. John S. Millis, president of Western Reserve University), composed of both laymen and physicians, was released in August. It is certain to have far-reaching effects on the way our physicians are trained.

In examining the internship and the residency, the constituent parts of graduate medical education, the Millis Commission writes: "Specialization with all its advantages has led to fragmentation and insufficiency of physicians who are competent and willing to offer comprehensive care. . . ."

The general practitioner is, in fact, disappearing. In 1931 84 percent (112,000) of all physicians in private practice reported themselves to be general practitioners. By 1960 the figure had dropped to 45 precent (75,000), and in 1960 only 37 percent (66,000) were general practitioners. Though these figures are not totally accurate because of the specialists who may be performing many of the functions of general practice (and some GP's who may be specializing), there is no doubt that the supply of doctors who are engaged in comprehensive medical care is dwindling. Writes the commission: "The general practitioner leaves behind him a vacuum that organized medicine has not decided how to fill."

The Millis Commission recommends that medical schools overcome "the very real barriers" to careers in comprehensive medicine through new educational concepts and approaches.

One of the barriers that must be overcome is what the commission calls a kind of arrogance in specialized medicine. "The first necessity is for organized medicine to recognize—not merely in a formal sense, but sincerely—that comprehensive health care is a high calling, different from specialization in thoracic surgery or hematology or something else, but not inferior—not inferior in training, in rewards, or in position with the house of medicine."

The way a medical school and teaching hospital is organized tends to lead its students into the specialties. Says the report: "There are exceptions, but in the typical medical school hospital, the student does not see a normal range of patients, but a highly selected and specialized sample. In practice, patients seek help for a wide range of ailments, from the merely inconvenient to the crippling and fatal. In practice, contact may continue over many years, allowing a full, rewarding experience of successful management of health problems over a considerable period of time. In the hospital, contact is likely to be restricted to a few days." The school and hospital are necessarily divided into the various specialties with no comprehensive, integrated program to pull all of them together. If students are to see comprehensive medicine practiced at its best, major changes in curricula and a major addition to teaching facilities must be made, starting with medical schools.

The University of Oklahoma School of Medicine has stepped out in front with a unique experiment in family medicine designed to train physicians in comprehensive medical care and at the same time gather hard data on the best ways to accomplish this end.

The program, the first and only of its kind in the nation, was conceived before the Millis Commission report was published, through the leadership of Dr. James L. Dennis, dean of the medical school. Dean Dennis' plans for establishing a division of family medicine were approved by the OU Board of Regents last spring, and in July the man to head the ambitious new project was named.

He is Dr. Roger I. Lienke, a tall, slender, 43-year-old physician who has been a teacher, a general practitioner, and a specialist. Under his direction the medical school has already embarked on an experiment that will have important implications for the nation's medical education.

Dr. Lienke believes in the value of the undertaking. "There are many sentimental opinions or contentious speculations about the future and training of the family doctor or the primary physician or the general practitioner, as he may be called. The custom has been for the controversy to rage unimpeded by facts. One side says general practice is no good, it's outdated, you can't teach it; the other says we need family doctors, they're the only ones who can give people the kind of care they need. What we need is solid educational research to give us some hard data on the best methods of providing comprehensive medical care and the training of physicians for that task. We want some answers and we want to get them through a controlled scientific experiment. Believe it or not, there's never been a program specifically for preparing physicians in family medicine."

He is convinced of its need and eventual success, and he is disturbed by and aware of the problems pointed to by the commission. "There are a lot of people looking for a doctor, and they can't find one because there isn't one. These are people in the rural areas. There are those in urban areas, too, who can't seem to find one either. That's because they don't know how to use specialists. They're looking for someone they call a family doctor, a general practitioner.

"Medical schools haven't been producing these physicians, and their interest for a program in training them has declined right along with the supply. The way a general practitioner is trained today is through a rotation method.

As an intern or resident he goes first to this specialty then to that one. A few weeks in obstetrics, a few in surgery, a few here, a few there. In the course of this round-robin he is expected to put all these things together and become a GP. Often the skills he picks up are of necessity semi-developed. We think there is a better way. We may be wrong, but at least we're going to try to find out."

The division of family medicine will try to find out by building a model clinic next to the hospital complex on NE 13th Street in Oklahoma City, establishing a residency program, and treating families and individuals over a long period of time. The post-graduate training will cover a minimum of three years—one as an intern and two as a resident. The resident will have continuous assignment in the Family Medicine Clinic, as it will be called, and will follow the same families throughout the period of his training. He will manage and coordinate all care that the patients require outside the clinic in, for example, University specialty out-patient clinics, in-patient services, house calls, and in nursing homes.

Family physicians on full- and part-time staffs will supervise and consult. "We're bringing family medicine to the medical center," says Dr. Lienke. "These families will come from every economic and social level, and we'll provide them with 24-hour care. It's a marvelous opportunity—and the first one—for family physicians to come to the medical school, hold their heads high, and practice and teach on the same level with the people involved in the specialties. And after the clinic is established we'll be able to have med students begin seeing families as early as the freshman year. This will be a conscious effort to preserve the concern for patients as people rather than disease processes."

Dr. Lienke likes to describe the family physician as a medical quarterback who can coordinate the care of his patient, calling for the proper medical facilities and personnel when they're required, the physician who calls signals for the entire family and who is able to handle about 80 percent of the treatment himself. "We've been concentrating on developing the kicking specialists, the expert flankers, and the big defensive linemen, and we've neglected the man who can put all these together into a cohesive unit.

"Health and disease in an individual are best understood by considering the whole person, functioning in a 'family' of environmental factors. Disease must be managed *in context*. The family doctor's special or unique approach lies in his ability to size up an illness in terms of its relationship to the total person and his life circumstances.

"It follows that the patient who tries to analyze and treat himself or match his symptoms directly with various specialists' offices often ends up with ineffective and expensive medical care. The family doctor can handle effectively most of the day-to-day health problems of a family in his own office. And he knows how to use specialized facilities and personnel in expediting the care of patients with complex problems.

"The family doctor's understanding of the influence of environment or culture allows him to recognize how the symptoms and management of a particular disease can vary remarkably from one family to another. The social meaning of a disease and the patient's attitude toward his problem may have much to do with the way the doctor goes about the analysis and treatment."

The undergraduates and residents will also have the assistance of a staff of specialists in understanding and administering to the medical problems of their families. They include a psychiatrist, clinical phychologist, medical sociologist, medical anthropologist, medical and psychiatric social workers, and medical and surgical specialists on the faculty.

The unified, non-rotational plan will give the family medicine resident a better understanding of environmental factors, and enable him to learn more skills than by seeing a wealth of pathology fragments on various in-patient rotations. The program hopefully will correct the deficiencies of the rotation plan: a view of medicine as fragmented disease processes, overemphasis on the more complicated, esoteric in-patient problems, and a feeling of being a second class citizen by the rotating resident.

"We'll evaluate the experiment in several ways," says Dr. Lienke. "If family physicians and trainees in family medicine can 'exist' in a university atmosphere, their role in private practice will be validated. If the model family practice activities can meet the standards of the institution, the value of such a unified training will be established. And we wish to take controlled studies in areas like the attitude of patients, students, residents, and faculty; cost studies; time and motion studies; morbidity studies and frequency of medical contact, and follow-up studies on resident careers.

"A real stumbling block to progress in family medicine has been a persistent tendency to divide medical practice into 'science' and 'art.' There is really nothing mysterious about humanistic mechanisms such as warmth, integrity, empathy, and intuition. These elements of medical practice can be definitely assessed and described with the regular techniques of the behavioral sciences. Further, the importance of the doctor's own subjectivity and style can, indeed, be brought into awareness and used in a scientific manner. In other words, it is now recognized that feelings and attitudes figure prominently in both the treatment and cause of disease. And there are standard methods to help a trainee in family medicine develop an understanding of the ways in which his own attitudes and emotions influence his work with patients as well as the ways in which the dynamics of his own family life may affect his understanding and therapeutic capability in dealing with families. It seems clear that the *application* of medical knowledge is a teachable science—not just an art.

"We've come to a point where our education has sidetracked the main question: How do you best prepare a doctor to go out and take care of somebody? Now we are in a very exciting, dynamic period in the medical profession when we are beginning to analyze ourselves and seek improvements, face some problems and seek solutions. The Millis Commission has made it clear that sweeping changes must be made. The medical profession must accept the leadership in effecting these changes, and I'm proud that our School of Medicine is already demonstrating such leadership. Planners of medical care and education through America will be watching the results of our experiment. I am confident we will make a very significant contribution to medicine." *END*