Considerations on Preparing to Enter Practice

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Throughout many years a criticism by the established practitioner has been that the new graduate from the medical school is not prepared to embark on practice. This is a truth with which any wise medical student approaching graduation must agree. The philosophy of medical education is that the four undergraduate years are no more than a period of basic training during a lifetime of learning. While the acquisition of the knowledge of the day and the practice of its technical skills are part of this basic training, by far the most important part is the cultivation of analytic ability and the improvement of critical judgement. In medicine, where the body of knowledge is doubling itself every ten years, and where half of today's information (and no one knows which half) may be no longer applicable in ten years, no other philosophy is tenable.

Application of this philosophy results in the development over a four year period of the best educated, most capable basic doctor ever graduated. But because in this highly technical and specialized age he is "undifferentiated", he is indeed unsuited without further special training, to practice or to embark on any of the many fields of endeavor open to today's medical graduate. Because today's student will be practicing tomorrow's medicine, and because tomorrow's patterns of practice are not yet known, the student must study trends as the best available basis for his preparatory training for practice. As the scope and complexity of medical knowledge increases, one trend is the introduction of technical components into more and more of patient care. The resultant "team practice" requires a "communicator" to deal with the patient and family, interpreting findings and supervising therapy. Growing numbers of groups and partnerships are a manifestation of this trend extending from complex technical procedures to the equal complexities of modern family practice.

Canada's medical schools graduate about 800 doctors annually. Subtracting emigrants to the United States, and adding immigrants from abroad, some 1,100 enter practice each year. However, only some 300 of the 800 new graduates enter practice at once. Some 900 doctors sit specialty examinations each Fall, after five years of graduate training. About 600 successful candidates and many of the unsuccessful ones enter practice. Thus the numbers of specialists in practice increase annually, to approach the number of general practitioners. Many specialists whose training fits them for consultant roles, although performing work in their chosen field in a highly competent manner, at the same time must engage in general practice for which their narrow training does not fit them. However, the doctor entering general practice directly from medical school, finds one year internship a most inadequate period of technical training with which to serve his patients alongside his specialist trained general practitioner confrere. Here are two adverse trends—too many specialists on the one hand and too few general practitioners (with too little training) on the other.

Corrective measures are already apparent. Specialist residency training standards are becoming more demanding and certification examinations more difficult. Residency training programs of rotating nature, in preparation for family practice, are now generally available and in all probability a two-year internship will become a requirement for licensure.

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Under the pressure of these and other trends, prominent among them being the formation of the College of General Practice of Canada, a new specialty is being created which promises to be the most interesting, challenging, and rewarding specialty of medicine. The specialist may be called a "specialist family physician" or "specialist personal physician". He will provide 80% of personal medical care, based on his residency training in internal medicine, psychiatry, paediatrics, non-operative gynaecology, normal obstetrics, and minor and emergency surgery. His residency training will be further adapted to family practice by the inclusion of preceptorship and locum tenans rotations in actual practices. He will be the communicator between his patient and the consultant specialist individuals and teams providing the remaining 20% of medical care.

How can today's graduate prepare to fill his role in such a future scheme of personal care?

The first step is to plan a second and possibly a third year of internship and residency training. This may appear financially impossible immediately following graduation, but can be returned to in five years or less if one does not become involved in the crushing family, property, and financial commitments of solo general practice or premature residency training for a specialty.

The second step, which may well precede the first in implementation, and which should be planned early in the interne year, is a period of two years as an assistant in an established general practice. With a known adequate income from the first, with a guaranteed patient load on which to maintain and extend one's clinical skills, and under a constantly available mentor who is intensely interested in your successful development because it is *his* practice that flourishes or declines, you learn both the practice and business of medicine in a way that no undergraduate clerkship or hospital residency can teach you. This has many advantages. One learns through personal experience the advantages and difficulties of general practice, the virtues of small group practice, the pressures of solo practice. It may become obvious that a specialty greatly interesting at the undergraduate level is not at all appealing in actual practice, or that another never considered as a student is your choice for a career. Two years general practice under these favorable circumstances provides a true understanding of the type of assistance required by the practitioner from his consultant. Thus, if a specialty is decided upon, the young doctor with this background is prepared to become a more efficient consultant. In addition, if the many advantages of a career as specialist personal physician have become apparent during the two years of general practice experience, one's actual needs in further residency training have become obvious, and step one (above) can be embarked on most effectively. Upon completion of this further residency training the young doctor will be as well trained for tomorrow's practice as it is possible to predict at this time.

In summary, certain trends in medical education both undergraduate and post-graduate, and in patterns of practice, have been presented. A prediction of the dominant future practice has been made, and a form of post-graduate training combining general practice assistantship and rotating residency suggested as the most adaptable basis for a career either as a specialist personal physician or as a consultant.