OPEN HOSPITAL DOORS TO FAMILY DOCTORS

If we are going to produce a good family doctor who will remain content to *be* a family doctor, we cannot make him endure the ignominy of following a patient's case meticulously up to the point of requiring hospital care, then shut the hospital doors in his face. We must give him hospital privileges so that he can have parity of status with his peers and be back in the mainstream of medicine, rather than inferior to it or on the periphery. One of the seldom-admitted reasons medical graduates today do not enter general practice is that hospital privileges are denied them and that their status, overall, is considered "second-rate."

The D.C.M. would not teach in the hospital. He would not engage in research. He would, instead, investigate his patient's problems in the broader hospital setting with its expanded resources. He would understand that his work would always be under the review of the hospital-based consultant specialist in charge of the department. But it would not be difficult for the D.C.M. to accept these concessions for the privilege of caring for his own patients in the hospital setting, knowing the handsome dividends it would pay: (1) his patients would remain, basically, his patients, even though specialists would temporarily supervise their regimen; (2) he, himself, would constantly be receiving graduate education as he watched how specialists handle patients whose needs exceed the skills the D.C.M. can provide; (3) he would keep abreast of the giant steps medicine takes every day by being in the hospital atmosphere where they occur, and the absorption of this knowledge would be a vital backdrop to his major function of being an aware, broadly-informed family doctor.

THE PRESCRIPTION CONTAINS "SAFEGUARDS"

We have prepared our new-type primary physician superbly in high school and later in the new-type medical school. Chronologically, he is ready to begin serving the public at 22 years of age. But, some may ask, is he ready to practice at that age? Has he learned enough to blithely hang out his shingle and supervise all the help from social agencies, as well as to handle the ill patients who would soon find their way to his door? Wouldn't we all be uneasy about the qualifications of so young a physician—unless he had passed some decisive examinations? For these reasons, certain safeguards are built into the prescription.

The young man would not be permitted to practice by himself as soon as he graduates. He would be required to practice at least a year under the watchful aegis of superiors—a group of G.P.s would be ideal. In this setting he would build his confidence, add to his maturity, sharpen his judgment, and steadily increase his knowledge. As a final test of readiness to practice alone, *his competence would have to be certified by the same state and national boards of medical examiners that accredit traditionally-trained M.D.s.* If he failed to pass at first try, he would be required to extend his preceptorship as long as was necessary. But at no time would he practice alone *without* certification. With such safeguards, neither the medical profession nor the public need to have any qualms about the competence of the D.C.M., despite his obvious youth.

ONCE A D.C.M., ALWAYS A D.C.M.?

Not necessarily. It is possible that the person who decided to be a primary physician in his youth and enjoyed its pursuit for most of his life may wish to alter his status in later years. His family has grown and assumed its own responsibilities. He himself is older and less elastic. The demands of a general practice can begin to be wearing when one has passed the zenith of youth. We all know dedicated general practitioners who enter specialties in their later years.

The D.C.M. status need not be considered permanent, a trap without an exit. At any time this doctor decides to pursue some special facet of medicine that has intrigued him, the sturdy basic education he has received makes specialization possible. He need only take the courses necessary to qualify him for the field of his choice. He may well appreciate the shorter hours and circumscription of problems afforded by a specialty when his steps begin to flag. Even though he then becomes a specialist, however, for many years he has served the public as a "personal physician"—the capacity it so badly needs.

AFTER LOCAL FIELD-TESTING—WHAT?

After the plan has been field-tested locally and its merits proven, it could then be implemented in the more than 50 centers like the Albert Einstein Medical