

# The Forest and the Trees

Sarina Schrager, MD, MS

**AUTHOR AFFILIATION:**

Department of Family Medicine and  
Community Health, School of Medicine and  
Public Health, University of Wisconsin,  
Madison, WI

**HOW TO CITE:** Schrager S. The Forest and  
the Trees. *Fam Med.* 2025;57(7):463–464.  
doi: [10.22454/FamMed.2025.758338](https://doi.org/10.22454/FamMed.2025.758338)

**PUBLISHED:** 2 July 2025

© Society of Teachers of Family Medicine

Family medicine is a generalist discipline. Family physicians see people of all ages, in the context of their families and communities at a variety of different locations. Family physicians work in the office, the hospital, the nursing home, the sports fields, and often at a person’s home. Generalism, by definition, implies that a family physician will be able to assess a broad range of medical and psychosocial complaints and determine whether a higher level of care is needed. The breadth of knowledge taught during a residency can be daunting. At its core, though, family medicine is a specialty of relationships and stories. We can assess medical complexities, triage the acutely ill, and provide a contextual approach to the care of a wide variety of patients and medical complaints. Teaching generalism to students and residents can be conceptualized with the “6 Cs” proposed by Dr Martina Ann Kelly and colleagues.<sup>1</sup>

**TABLE 1. The 6 Cs of Generalism**

|                      |
|----------------------|
| • Comprehensive care |
| • Complexity         |
| • Context            |
| • Continuity of care |
| • Communication      |
| • Collaboration      |

Within these six concepts of generalism, there are myriads of specific content areas to teach. For example, to effect comprehensive care, a clinician needs to know preventive care guidelines, immunization requirements, and evidence-based treatment strategies for many common medical complaints. The clinician will also need to know warning signs of acute illnesses that could decompensate. Frequency of colon cancer screening—*check!* Recommended levels of LDL in people with diabetes—*check!* Side effects of common medications to treat anxiety or depression—*check!* Hospital admission guidelines for children with severe asthma— *check!* The list goes on and on.

Three articles in this issue of *Family Medicine* discuss specific content areas taught in family medicine. Dr Klas et al<sup>2</sup> surveyed family medicine residency program directors to obtain a summary of education about trauma stabilization in residency programs. Many family medicine residency graduates work in rural areas and may be called upon as the first contact for a patient who experiences a trauma in an emergency department or the community. The family physician may need to assess and stabilize a patient for transfer to a higher level of trauma care. The survey used by Dr Klas and colleagues found that most residents spend on average 2–7 weeks in an emergency department, but do not graduate (on average) with the skills required to independently stabilize people who have experienced a trauma. Residents are exposed to management of trauma, but during most 3-year residency programs, they do not gain the skills needed to independently evaluate and stabilize someone who has been a victim of a severe trauma.

Dr Tina Halley led a team of pediatric hospitalists to survey pediatric associate program directors looking to define whether the inpatient pediatrics teams who train a lot of family medicine residents in inpatient settings had specific curriculum.<sup>3</sup> Family medicine residents may be called upon to manage pediatric patients in the inpatient setting, but rarely are they required to manage complex care situations after they graduate. The survey used by Dr Halley’s team sought to identify specific areas that pediatric hospitalists focus on when training family medicine residents. Most of the pediatric hospitalists trained family medicine residents but did not have any specific curriculum for family medicine residents when they rotated on inpatient pediatric units.

Lastly, Drs Kento Sonoda and Kelly Everard studied opioid use disorder education in family medicine undergraduate clerkships.<sup>4</sup> In their survey, 45% of clerkship directors stated that they did not include any specific education in their family medicine clerkship. Their study found that this education varied based on the availability of faculty who had expertise in medications for opioid use disorder.

The adage “sometimes you can’t see the forest for the trees” can certainly be applied in family medicine residency education. Generalism constitutes the forest, the context in which we take care of all patients. Each tree (or content area) is integrally important to the composition of the forest, yet care must be taken to avoid losing sight of generalism while focusing instead on each individual content area. Our goal in educating family medicine residents is to emphasize the importance of both the medical content and the tenets of generalism (ie, the “6Cs”). This laudable goal of teaching the forest *and* the trees is one that most family medicine educators strive to achieve.

## REFERENCES

1. Kelly MA, Wicklum S, Hubinette M, Power L. The praxis of generalism in family medicine: six concepts (6 Cs) to inform teaching. *Can Fam Physician*. 2021;67(10):786–788.
2. Klas J, Puffer C, Klas P, Hollander-Rodriguez JC, Carney PA. Assessment of emergency and trauma stabilization training in family medicine residency programs: a CERA study. *Fam Med*. 2025;57(7). <https://doi.org/10.22454/FamMed.2025.459247>.
3. Halley TV, Bhansali P, Clouser K. Inpatient pediatric training of family medicine residents: a pediatric perspective. *Fam Med*. 2025;57(7). <https://doi.org/10.22454/FamMed.2025.431942>.
4. Sonoda K, Everard KM. Opioid use disorder education in the family medicine clerkships: a CERA study. *Fam Med*. 2025;57(7). <https://doi.org/10.22454/FamMed.2025.301169>.