Is Where We Are Where We Were Going? A Dialogue of Two Generations

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This article provides the dialogue of a discussion between prominent family physicians from two generations. One, from the first generation of family physicians, was a founder of the specialty who provides insights into the origins of the specialty, its goals and aspirations, and possible future directions. The other, from a younger generation, has been a leader in managed care and its effects on family medicine; this physician discusses future changes in the health care systems and reflects on whether or not family practice will be able to adapt to those changes.

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Lynn: Relatively few family physicians remember how all of this started. Let me start there. Around the time of World War II, most physicians were generalists, and there were few specialist training programs. In fact, ophthalmology was probably the most well-developed specialty in the 1920s and 1930s. The American Medical Association (AMA) was all-powerful, and AMA membership was required for licensure in some states. There was a worldwide economic depression, and there was little change or progress in medicine until the war started.

Physicians, like most healthy males, were drafted into the military services and were assigned particular tasks based on what was needed, rather than based on talent. General practitioners became surgeons, anesthesiologists, orthopedists, etc, overnight. Most generalists worked in aid stations and similar settings, and those in hospitals served as specialists. Physicians who went into military service as general practitioners came out as specialists.

In the post-war period, the specialist had hospital privileges, rising incomes, and increasing prestige. The remaining physicians were "just GPs" and were expected to die off (and "good riddance"). But a sense of pride and birthright began to emerge. General practitioners needed a change, and the notion of family medicine as a respectable and needed medical discipline began to appear. However, there were no formal training programs, so, in 1947, the American Academy of General Practice (AAGP) recommended that the rotating internship be continued and that a second year be provided with clinical experience in surgery, medicine, obstetrics, and pediatrics. By 1950, there were 94 general practice residencies at 32 different hospitals, though most trainees still entered practice after the first year.

During the late 1950s and early 1960s, a need was perceived for 3 years of training, with a medical board examination. The goal for training was ongoing study of family medicine with repeated examination and accreditation, but there was little movement toward this goal in the early 1960s. Nobody was listening.

In 1962, my wife Joan and I attended a medical conference in Boston and met Bob Haggerty, a pediatrician who developed the Family Health Care Program at Harvard Medical School. He invited us to spend a year with him in what was a child health research and education program. There were two other fellows, Joel Alpert and Evan Charney, both pediatricians.

What a wonderful experience! In addition to study and discussion, I was able to visit a number of medical schools. I met Kerr White, MD, at the University of Vermont and Nick Pisacano, MD, and Joe Hambuerger, MD, at the University of Kentucky. While in Boston, I authored a paper on "Training for Family Medicine," which was published in January, and yet another paper on the topic that was ultimately published in the *Journal of Medical Education*.

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I resumed my clinical family practice in 1964, and the dean of the University of Miami School of Medicine gave me a part-time faculty appointment and secured funding for family practice training from the University of Miami Women's Cancer Association. In July 1965, we had five rotating interns at Jackson Memorial Hospital and initiated a family practice residency program in 1966. In 1966, we were also involved in the development of family health centers in Boston and Miami, which provided patients and supervision in an office setting.

The AMA's Council on Medical Education became an important influence in the development of family practice. William Ruhe, MD, a physician from Pittsburgh, was the director of the Council and was the driving force in the development of graduate education for family medicine. He recruited Leland Blanchard, MD, and myself in 1967 to stimulate graduate training in family practice in 20 nascent residences around the country. In 1968, Lee and I developed the first "Essentials for Residency Training in Family Practice." With that document in hand, in 1969, the American Board of Medical Specialties formally recognized the American Board of Family Practice, and in 1972, the AAGP formally changed its name to the American Academy of Family Physicians (AAFP). The Society of Teachers of Family Medicine (STFM) was organized in 1967; I was the founding president.

Susan: In 1968, I was graduating from high school. It was another decade before I even became aware of family medicine as a discipline. Those of us who came later took much for granted. But, I remember how awestruck I was that my teachers actually knew you, or Gayle Stephens, or Ian McWhinney. They had touched the hems of greatness, and I felt a strong sense of purpose, a mandate to reform health care, coming from that generation of pioneers.

That legacy was a source of inspiration and energy for me, and still is, but I don't think my current students feel that same sense of mission about their work or the legacy of family medicine as a reform movement. That may be a sign that we are fully interwoven into the fabric of health care. That was part of the design of our efforts, but I wonder if we have also lost something.

Looking back, I am sometimes surprised about where we are now. Most of us are now loosely connected to our patients. I see new family practice graduates switch practices like Hollywood stars switch mates, based on convenience or amenities. While my images during training came from reading Huygen, describing generations of families in a practice over time, the context of long-term relationships in a community that seemed so fundamental is now so rare.

Of the 20 or so family physicians whom I see on a daily basis, only one has been in the same practice for more than 10 years. This month is my 10th anniversary in my current position, but I have changed practice sites three times during that time. This year alone, I helped close one hospital that failed financially and watched its 25,000 patients, including mine, scatter. This month I am planning the transition of 12,000 more patients because we lost a Medicaid managed care contract. It wasn't supposed to be this way.

Lynn: I was starry-eyed when we started. I expected something different. Being in Boston with Haggerty, I was optimistic. It seemed to work well in the community. But, bringing generalist practice into academic health centers has been disappointing. I kept thinking we could change the academic centers, but we didn't. At this point, 33 years later, it's awful. I couldn't wait to leave.

We have come a long way, but we need to go further. I may have been naive to think that academic health centers would change. They are toxic environments for primary care education. I am now convinced that we need to move primary care out into separate primary care campuses. I'll say more about that later.

Some changes seem right. Family physicians have gradually stepped back from their roles in hospitals, for example. "Hospitalists" have taken on these roles, and they seem to be doing a good job. They tend to be internists. Hospital-based care seems to demand a degree of depth that is hard to achieve in broad generalist training. I was attracted to Edmund Pellegrino's recent essay in the *Journal of the American Board of Family Practice*,[1] in which he argues for the natural alliance between family practice and general internal medicine. He says we have more in common than not and that we ought to bring the disciplines together. I think that his ideas deserve serious consideration.

Also, women have come into their own. There are now more female physicians, female thinkers and writers, and female leaders. They have brought new perspectives to family medicine and to the profession generally.

Susan: In the 2 decades since I started practice, family medicine has made enormous gains. The numbers and distribution of family physicians have grown, the American Board of Family Practice examinees are sitting for the exam in record numbers, and the last bastions of academic ivory tower resistance are yielding to the formation of new family medicine departments. Medical student trainees are almost universally guaranteed a focused educational experience in family medicine. Family physicians are assuming leadership positions in organized medicine, academic medicine, health care industry organizations, and government. Political

and social influence, compensation levels, and respect have all increased.

Yet, the National Residency Matching Program shows that students have declining interest in entering family practice residencies. Surveys of practicing physicians find them to be disenchanted with their careers and thinking of getting out.

Is family medicine having a midlife crisis?

What we have gained in strength and security seems coupled with loss. Our scope of practice is being nibbled from multiple sides. We were once the Cinderella story of managed care, but it's all pumpkins and mice again. The promise of group practice has betrayed many, who have been sold, sold out, privatized, etc, by their sponsoring institutions in the wake of the Balanced Budget Act and other economic initiatives. Universal health care is hibernating for a long amoral winter. It is no surprise that there is a lack of passion in doing ambulatory-only care, in a milieu with a 2-to-1 ratio of bureaucracy to touch, a 1-800-SueYourDoc mentality, and abundant profiteers and scavengers. Should our dialogue be "Where are we?" or "How do we get out of here?"

Lynn: I think there are real reasons to be concerned. First, our for-profit medical health care industries, such as hospitals, health maintenance organizations (HMOs), home health agencies, nursing homes, and others are simply failing to do their job. Barbara Starfield's "Is US Health Really the Best in the World?" tells us we are not doing well at all and attributes that to lack of primary care.[1] The *US News and World Report* of July 17, 2000, reports on the "Best Hospitals" in America by medical specialties. The report does not mention family medicine or generalist physicians or any other nonphysician health care providers.

Second, the pharmaceutical industry has a perverse hold on our profession. Its accountability has been well documented by Marcia Angell, MD, who until the first of July 2000 was the editor-in-chief of the *New England Journal of Medicine*.[2] Similarly, Roger A. Rosenblatt, MD, a family physician from Seattle, in a letter to the *New York Times* on July 13, 2000, criticized "the illicit affair between the pharmaceutical industry and the medical profession," stating that:

> From the day a future doctor enters medical school, she is bombarded with gifts intended to create a sense of dependence on the drug companies. The doctor comes to depend on the unending flaw of inducements: meals, conferences, trips, drug samples, free journals, and even financial incentives for prescribing and promoting expensive new medicines. This unholy *pas de deux* leads to overprescription of costly drugs when cheaper alternatives would work as well. The entanglement serves the drug companies but undermines the integrity and independence of the medical profession.

For myself, I have long refused to see drug reps, have not accepted drug samples, write generic prescriptions only, and do not accept "throw away" publications.

Susan: For me, the early 1990s was a time of professional excitement and joy as a family physician. I was actually a managed care evangelist. I thought that the shift to reimbursement for the health care of populations was a sound idea. The opportunity to reorganize care based on improving the health status of a population was far better aligned with public health goals than fee-for-service medical practice. Waste, duplication, poor coordination, inattention to prevention, and greed were common characteristics of care, and managed care, in its ideal forms, had an opportunity to change that.

Further, primary care was being recognized as a foundation for good and effective managed care. Funding allowed creativity in reassigning health care roles, with increasing emphasis on care in the home and community by individuals with different training, such as nurses, educators, physician assistants, and nurse practitioners. The importance of the physician-patient relationship began to be recognized as important in recruiting patient cooperation, with risk reduction, prevention, and illness care, and the behavioral and cultural aspects of clinical care had support. Family physicians seemed to enjoy a brief moment in the sun.

But managed care as a financing reform was doomed. For-profit opportunists seized the cost-reduction motive and skimmed the cream off the changes. What was supposed to be rational reallocation of medical resources became seen as loss of control by physicians and loss of choice for patients. The benefits of managed care, which were real in theory, were far outweighed by its faults in practice, and the backlash is now pushing us back to an older form of health care organization and financing. Specialists have reclaimed preeminence in clinical reimbursement and are jockeying for preeminence in contests about quality of care. In the persistent wake of cost reductions, health plans and institutions are pushing the financial risk back to the providers of care, and the primary care physicians are getting the short straw again.

I'm not really as burned out or discouraged as I may sound. On a daily basis, I recognize positive impacts of my work in patients' lives. My knowledge is expanding (both the information kind and the wise kind). I work with people who want to make things better, and I see a thousand opportunities for improvement—and even an occasional miracle.

The prospects are still good for family medicine to position itself in the future to be even more effective in improving health, access to health care, and people's faith in the profession of medicine. Think of the possibilities that instant and global communication could bring to bear on practice, continuing professional edu-

cation, and the doctor-patient relationship. Think of how computerized information and databases could aid clinical decision making, resource management, and improvements in quality of care. Imagine having successful biotechnical interventions for the conditions we now feel so clinically helpless about. There are extraordinary times ahead of us.

Lynn: I would urge caution in looking to technology for improvements in health care. I believe that family physicians need to refer patients to specialists for technological interventions when needed, but family physicians will also need to assume responsibility for care provided by the specialist. The family physician will need to monitor the various technological developments used by the specialist. A careful review of the procedures used by specialists may well reveal that they are used not so much for patient benefit as much as financial benefit to the specialist. Published studies about technical usage may represent good advertising—not the best outcomes.

Susan: I worry about whether family physicians will continue to be comprehensive in their health care role. Knowledge and technology are exploding at a pace that far outstrips an individual's capacity to absorb the implications of the changes, let alone their application. New diagnostics, pharmacological therapeutics, procedural interventions, etc, for the most common conditions (such as coronary artery disease, breast cancer) are changing our understanding of "best practices" on an almost weekly basis. These changing care modalities are seldom in the hands of primary care providers, and unlike previous decades, seem unlikely to get into our hands. Although colposcopy diffused into my practice after graduation from residency, it seems unlikely that angioplasty and coronary artery stents or the like will do the same. The technical demands mean that these applications belong in the hands of technicians.

Even simple clinical conditions have been made complicated by new understanding and new technologies, and our epidemiology seems to be moving further from "lumping" toward "splitting." For example, we will find that patients who have deep venous thrombosis have less in common with one another as we discover the role of point mutations of Factor V and a host of other genetic predisposes to coagulopathies. Venous thrombosis is not a single disease but a panorama of conditions leading to a common symptom, with differing diagnostics and treatments, prognoses and complications, intergenerational implications, etc. Clinical care pathways have diverged accordingly. Anticoagulation management has proved to be superior in the hands of specialized nurses who work largely independent of physicians.

This phenomenon is not restricted to health care. It is a trend being observed throughout manufacturing, service industries, etc. Peter Drucker, the business management guru, speaks about the shift to the "Knowledge Age" as the foundation of the future. He is convinced that we are entering a world of essential specialization and states:

> Whatever the base, knowledge in application is specialized. It is always specific and, therefore, not applicable to anything else. Nothing the X-ray technician needs to know can be applied to market research, for instance, or to teaching medical history.

The central workforce in the knowledge society will, therefore, consist of highly specialized people. In fact, it is a mistake to speak of generalists. Those who we refer to by that term will increasingly be those who have learned how to acquire additional specialties and especially to acquire rapidly the specialized knowledge needed for them to move from one kind of work to another, such as from being a market researcher to being in general management or from being a nurse in the hospital to being a hospital administrator. But, generalists, in the sense in which we used to talk of them, are becoming dilettantes rather than educated people.

It requires that people learn—and preferably early—how to assimilate specialized knowledge from other areas and other disciplines into their own work. This is particularly important, as innovation in any one knowledge area tends to originate outside the area itself.[3]

Lynn: Before looking into the tasks of organized general practice for the next 50 years, I searched for connotative definitions of the generalist practitioner, finding none. I propose the following definition: "The generalist practitioner is a health care professional who is responsible to a defined constituency to assure them of appropriate health care for an optimal outcome."

If this is to be the definition of the generalist in the 21st century, it is necessary to define and evaluate the generalist's role and responsibilities in health care. I believe that efficient organizational institutions will look to the generalist physicians and to the specialty of family practice for overall leadership. The generalist will be responsible for the integration of all health care professionals practicing in the community. I think family physicians will need to develop more executive skills as they manage a host of other health care professionals in the community. The various community-based professionals (nurse, social worker, optometrist, physiatrist, podiatrist, counselors, etc) will develop a Wal-Mart approach to housing and coordinating the interplay between their roles with patients and families. The obvious success of Wal-Mart should work well for health care and do so at less cost than the current model of independent offices.

Research based in the community will become more and more prominent. The improvement in care for all will take prominence over laboratory-type clinical research. Dr Kerr White's paper[4] on "Fundamental Research at the Primary Care Level" is a jewel, with the intent to investigate, study, and perform research to improve the health and well-being of clients and patients. Kerr includes in his paper a list of 10 common clinical questions that he believes merit further investigation. These do not include doing strange things to small animals.

Academic organizations will need to evolve so that the education of physicians and other professionals will become more and more community based, with a smooth transition between training and practice. To support and prepare for this role, we need to develop primary health care campuses as the training ground, separate from academic health centers.

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and values, etc, still have more to do with health outcomes, I believe, than cells or DNA. (Although I guess I wouldn't be too surprised to eventually see us map a "compliance" gene, a "relationship," or their equivalent.)

So, I still believe family physicians will have a central role in the distribution of health care through their personal relationships with patients and their expertise in interpreting clinical options in the context of patients' lives. I have been intrigued by the redefinition of this role in terms of "network organizations," in which computer networks are the metaphor for the way we may work in the future. Here is how Harry S. Dent, Jr, talks about it:

> ". . . Computer networks, which coordinate access to this distributed data, have made it possible to achieve economies of scale in the processing of information, the most valuable commodity in the world today. It's called the client-server model, or in today's Intranet jargon, the browser-server model.
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> . . . Our human organizations need to evolve in the same way. Instead of typical top-down organizational charts that still govern most companies today, we must adopt the network organizational model. Employees on the front lines, in the field, drive the organization by making the critical decisions that serve their customers' needs. Employees on the back line, who specialize in particular kinds of products or knowledge, help those on the front line."[6]

And, referring specifically to applications in health care:

> ". . . General practitioners in a network organization become human browsers, monitoring health and providing information about preventive care and treatment options. Many will become practitioners for a specialized clientele such as the elderly, or young families, or high-stress professionals, and so on. As a result, they'll be able to answer most questions and foresee most problems. But, when an extraordinary situation does arise, your doctor will bring in experts from anywhere in the hospital, the city, or the world to address it, all via the Internet when necessary. Your doctor will be able to instantly and automatically send all pertinent files and test results to that expert for the consultation. In other words, your doctor will browse the medical system, the servers, to get you the best possible diagnosis or care."[6]

Lynn: In contrast to being tangible like a gene, Ian McWhinney characterizes the relationship with a patient as a covenant: "A covenant is an undertaking to do whatever is needed, even if it goes beyond the terms of the contract. Sticking with a person through thick and thin is hard work, an act of love."[7] As I look back over some 50-plus years in health care, I recall the definition of the family by Don Ransom and Herb Vanderwort as "a significant group of intimates with a history and a future." The other thing that has been most useful to me is the relational model between both patients and students, characterized as "affinity, continuity, intimacy, and reciprocity." These are enduring.

Susan: Our challenge is going to be how to preserve our values while evolving how we work in the service of what is best for people's care. Let me borrow from Harry Dent again:

> Front-line positions will be the first and fastest growing career path within network organizations for the coming decade. Just like a small niche business, these front-line employees must be entrepreneurs—creative generalists with cross-functional skills that can focus on and solve the unique needs of a distinct segment of customers. Since the smallest teams can be the most focused, innovative, and responsive, people in such front-line browser functions must have general knowledge and the ingenuity to apply it in unique ways. Furthermore, they must easily adapt to new situations and learn as they go. I call these people specialized generalists. Their specialty is customer knowledge, but they are generalists by being flexible in their skills.[6]

The application of this notion to family medicine, looking at family physicians as the front line, means that we need to explore some new ways of working. The implications include that the specialty knowledge of family physicians is the patient in context and the doctor-patient relationship. These are the health care equivalent of customization. We would assess individual disease and risk in both personal and epidemiological contexts and identify (and in many cases apply) interventions to improve health outcomes and reduce risk.

How is that different from what we do now? We have to imagine and prepare for the optimal interventions to be designed by computer analyses that take into consideration unfolding evidence of efficacy of varying interventions (in real time, from a global scientific community), modified by the particulars of a case, the specifics of which we provide to the computer. The analyses would even prescribe what involvement by other health care professionals would support optimal outcomes. Some of that involvement would be from members of the local health care team that we would work with daily, and some would indicate the need for other physician specialists to play a role.

Specialty consultation in the form of technical hands-on interventions currently seems to be increasing but might decrease again as biotechnology gains more control over tissue differentiation and genetic manipulation. In general, specialty consultation will become less

a matter of referral and more an encyclopedic extension of our cognitive scope. In other words, we won't send patients to specialists; we'll send questions and data.

Information about patients will be cumulative and universally accessible. Our freedom to make errors, or even suboptimal decisions, will be curtailed by electronic protections that analyze the implications of new interventions and their application. We will work in groups (for efficiency) but close to patients. We will grow accustomed to receiving reports that measure what we do in terms of quality (more and more in terms of compliance with standards and including variables that address costs of care) and patient satisfaction.

Our professional organizations will have to focus on disseminating standards for the discipline and on helping define the technology that will support application of those standards in various settings. Rural practitioners will be held to the same standards as academic centers, and the AAFP or its successors will need to serve as glue to bind the various practice settings together.

I wonder if the distinctions among the primary care disciplines (I am including family practice, primary care internal medicine, pediatrics, and general obstetrics-gynecology) have any real meaning in this new world. The things that now separate them, like patient age and gender, don't alter the expectations of what should comprise appropriate risk assessment and disease treatment or even the doctor-patient relationship. Physicians in these other disciplines will look and act more like us, especially in terms of behavioral medicine and training, and we will adopt characteristics of their disciplines, including practitioners defining some areas of more narrow focus within primary care.

Lynn: I've cared for some patients for more than 40 years. What patients need from us hasn't fundamentally changed: someone who knows them, whom they can trust, and who can help them navigate the uncertainties of illness or the health care system.

Susan: Knowing patients and being trustworthy to them demands the same from us now as before. Navigating the uncertainties of illness or dying is still full of the same old mysteries and depends on our growth as human beings. The rest of the navigation job faces a sea change. Let's ask: how does the sailor harness the sea? (*We Have Plowed the Seas* by Simon Bolivar)

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