The View From 2020: How Family Practice Failed

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"It's dangerous to make predictions, especially if it's about the future." (Kerr L. White, MD)

It was the widespread recognition that family medicine had failed that provoked Keystone V, convened in Colorado in 2020. The conference was attended by a couple of dozen "residual believers," as they called themselves, all of whom had attended Keystone IV in 2012. There was not even a trace of dissent to the assertion of failure among this small congregation. The tone of the meeting was captured by a quote from Toni Morrison in *Meditations for Women Who Do Too Much*:[1] "The clouds gathered together, stood still, and watched the river scuttle around the forest floor, crash headlong into haunches of hills with no notion of where it was going, until exhausted, ill and grieving, it slowed to a stop just 20 leagues short of the sea."

The residual believers, not surprisingly, disagreed about why, after establishing incumbency at the end of the 20th century, family medicine persisted as a thin shadow of the strapping adolescent it had been such a few years ago. They began their dialogue by characterizing the milieu in which they lived.

The World in 2020

The division of wealth among the citizenry had not just persisted but widened, and there were proportionately and in actual number many more very wealthy individuals and many more very poor individuals. Similar situations existed globally in virtually all nation-states, if that was what they could be called. More people lived in "low-population density areas," retaining connectivity globally through ever more rapid and complete information technologies. Rural, always hard to define, was considered nearly an obsolete term.

Family was widely recognized to be a term naming that collection of persons and pets that an individual chose to designate as "my family." Children seemed comfortable with identifying themselves as having been "born" or "birthed," depending on how they were conceived and gestated, and surveys of all sorts asked about both genetic parents and real parents.

Medicine was still politics on a grand scale. Hospitals were thought of almost entirely as capitalization schemes. Those that survived were the ones able to amass enough capital to have the latest version of whatever technologies could be applied to generate revenue out of the medico-information complex, by far the largest single sector of the US economy. This sector was constantly applauded for being such an economic engine. Physicians, however, despite collective bargaining, had lost control of most of the technologies, although not entirely, as some subspecialties thrived on the basis of their ownership of a particular gadget or device.

There had been no accurate medical workforce predictions other than that there would be growth. The eruption of all sorts of additional and alternative health care providers had continued for the first decade of the 21st century, with one person in four now making their livelihood by providing some sort of healthcare. (Yes, healthcare was in the dictionary as a single word.) All the Keystone V attendees concurred with major workforce and organizational themes that had emerged.

The general surgeons had reversed decades of decline and become the centerpiece of personal, face-to-face healthcare *outside* of the major cities. They were robust physicians able to deal with what came in and, aligned with their cousins, the emergency physicians whose ranks had continued to grow, comprised some 20% of all physicians.

The rural hospitals of old had survived as the economic centerpiece of commercial service areas, and they typically served as the organizing and monopolistic hub of healthcare for most people within, on average, a 90-km radius. In the facilities aligned with these rural health agencies, the surgeons and emergency medicine physicians were joined by midwives who managed most maternity care, nurse practitioners doing some 80% of technical procedures and virtually all genetic counseling, and pharmacists who were the first point of contact for the care of all the chronic conditions amenable to drug treatment (these conditions were the descendents

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of what were previously known as priority or ambulatory care sensitive conditions).

Patients with chronic conditions, no matter where they lived, could maintain daily access to their own medical measurements and the world's knowledge base about their condition. Indeed, the latest research from the comprehensive data warehouses had just announced that for the first time a majority of people with arthritis had actually used their personal health "information-net" on a given day.

Things were quite different in the crowded cities. Healthcare boutiques were all the rage, each jockeying for a more enticing image than its competitors, spending twice as much on advertising as on quality improvement. These boutiques had largely replaced the hospitals of old that had physically devolved into multiple "Best Service Centers," while economically emerging as huge umbrella corporations. There was a mutual dependence between each boutique and its doctors, the heirs of medical subspecialization.

The offspring of the 20th century internists were clearly in charge of treating organ failure, almost always in free-standing biointensive units. The psychiatrists had largely disappeared, their prescribing done by a host of others, including psychologists who finally had drilled into the inner sanctum of insurance-based revenues. No one knew how many spiritual counselor types existed, as this service was protected by new privacy legislation that had resulted in counseling services going underground. Pediatricians were widely perceived as child healthcare advocates, and no one was opposed to children. Thus, the pediatricians continued remarkably the same as 20 years before, still pointing out that they were severely underpaid, except for those aligned with a boutique for a particular childhood problem. The obstetrician-gynecologists, after winning the skirmish with family medicine concerning maternity care, had abandoned obstetrics as not worthy of their training and expertise. They were in the midst of a national advertising campaign designed to explain just what a gynecologic physician did, with the intent of cornering the urban market for biotechnical and surgical applications relevant to the female genital tract. Some of the Keystone attendees marveled at how little had come of independent nurse practice, and no one doubted that the hottest contest in medicine was being waged by what was previously called interventional radiology and transplant surgery. Most were betting on the radiologists.

The public continued to aspire for more healthcare and openly fantasized about immortality, but despite so much "progress," the public remained as dissatisfied as any time since the daily, national satisfaction poll had been established. There were constant complaints at the cyberbars and in the e-Press about healthcare price gouging. A virtual cacophony of advice darted about any gathering with individuals attempting to discover the locus and access rules for what they presently viewed as their most important healthcare want. A decade after universal inclusion was finally, technically achieved in the United States, it didn't seem like everyone was guaranteed much of anything. If there was any single source of dissent that united the society, it was a disregard for re-insurance companies. These megacorporations were the only entities large enough to take on the actuarial risk of healthcare, and they were widely perceived as a self-serving elite in the corporate world. They were, in fact, able to dictate healthcare pricing and access by virtue of their grip on the huge healthcare data warehouses and overwhelming amounts of capital.

If there was a significant pocket of public dissent, it was probably among the most wealthy of the poor, struggling to break into the "good life" so apparent via the media but elusive, seemingly always just out of reach. The poorest poor, on the other hand, at least for the moment, were apparently reconciled to being the poorest people in the richest nation on earth. Indeed, school children often chanted the mantra, "Better to be poor in America than rich someplace else." No one was asking for, much less demanding, a return to the good old days "when we had a family doctor," usually citing Norman Rockwell's "Doctor and Doll" as a nice metaphorical rendering of the family doctor that was no long relevant. The absence of another metaphor for the family doctor in the society confirmed its obsolescence. Yet, every Keystone V attendee reported anecdotes about individuals who reported their frustrations about being treated as an unknown object by the healthcare enterprise and not feeling understood by anyone. The message was, "How can there be so much known about me, while there is no one in the healthcare system who knows me?"

Why Had Family Medicine Failed?

This review undertaken, the residual believers of Keystone V turned their attention to why family medicine had proved insufficient, lost power, and failed the test of public opinion. They first agreed that the steady decline in the proportion of the health dollar, and eventually total dollars going to family physicians, was a fact that reflected other factors and would not be considered an adequate explanation in and of itself. They also agreed that failure doesn't really exist as a thing. It is not like an underground aquifer or a vein of silver buried beneath some mountain waiting to be discovered. Failure only exists from a position of judgement. To make the judgement, one must have a viewpoint, and thus, the residual believers organized their thoughts from different viewpoints.

Viewpoint #1: Family Medicine Didn't Really Fail. It Abdicated

Given their breadth of training, multiple opportunities, and unsurpassed versatility, family doctors had been able to "switch, rather than fight." By relinquishing more and more services to other providers, family physicians garnered immediate benefits, such as apparent peace and relief from accusations of "not being a team player." In the specifics of specific places, it made sense to turn over the care of the dying, the newborn, the adolescent, the athlete, the discouraged, the pregnant, the bed-bound, the post-operative person—to someone else. It had also made sense to abandon the old model practice center idea in family practice residencies in favor of training in many different settings providing best care for something.

But, the ultimate result of these adaptations was erosion of the functional domain until it lost its coherence, that essential totality that made it what it was. Instead of a doctor of the domain, a doctor of miscellaneous things emerged, temporarily, and then when miscellaneous services were viewed as especially important or lucrative, they were taken elsewhere, to be done or overseen by subspecialists. This progressive dilution of role was quite all right for many family physicians who were pleased to avoid unpleasant interruptions at dinner, welcomed a predictable work week, and yearned for a balanced life of their own with considerable privacy, if not anonymity.

Then, the problem with role models and the name erupted. In the major teaching programs in the cities, where was one to find an example, much less an exemplar, of the old idea of a comprehensive, personal, primary physician? And what was the name of what this physician did, and what was this physician to be called? Was it, or was it not, general practice? Was the family the defining focus of care, and if not, what was? Was there a distinction between family medicine and family practice? Was the graduate of a family medicine residency and a family practice residency the same thing? Should they be called a family practice physician, a family doctor, a family physician, a generalist, or a second-rate pediatrician or internist? Thus, without a name recognized and understood by all, and without a place to hold forth, it was easy for family medicine to go out not with a bang, but with T.S. Eliot's whimper.

Viewpoint #2: Family Medicine Went Down as Part of the Old Paradigm

The implosion of the American Medical Association (AMA) didn't stop in the early 2000s. It, and the grip that traditional physicians had on the American psyche, diminished below a threshold of dominance to being one of several organizations representing the various healthcare professions. A decade of confusion had left physicians not so much with a tarnished image as no image at all. Most folks believed that a shift in power and authority was overdue, and they put family doctors into the mix with all the other physicians who had lost their moral authority. A few were even quantitative in their assessment, reminding the family physicians during the past few years that the American Academy of Family Physicians held a dominant position in the AMA as it "went down."

There was parallel play at the academic health centers (AHC) where family medicine managed to get aboard, just in time to be insufficient to shore up academic concoctions of various sorts that had outgrown their supply lines and lost their social contract with their communities. In effect, family medicine gave its birthright and its dreams to the AHC of the 20th century, and the AHC, having never really valued family medicine, was looking elsewhere as it decayed.

The now nearly absent local family doctors were not held blameless in the demise of family medicine. Many suggested that their near worship of their independence, lack of curiosity and solid contributions to better medicine, and focus on payment systems, resulted in their getting lost in their administrative methods and being "out-competed" by others in the best execution of specific tasks. In short, when the old order began to collapse, most of the public, based on their own experience, either had no notion of a family doctor or identified their own family physicians with the profession as a guild, not with themselves, and accepted looking elsewhere for best medicine. The idea of a healer-person was, at least for now, replaced by a healer-virtual, residing somewhere in the healthcare system as a whole.

Viewpoint #3: Family Medicine Failed Because It Chose the Wrong Tasks

There was a buffet of possibilities used to illustrate this viewpoint, but most fell into three categories having to do with the nature of the work, maturation of the discipline, and intellectual advancement.

Nature of the Work. Instead of developing and claiming therapeutic relationships and being there for their patients, family physicians spent more and more of their time managing things while others actually delivered services. Linked to but discrete from a complex array of daily administrative tasks were the tasks associated with unionizing and bargaining and lobbying that succeeded in sustaining jobs but left too many family physicians without genuine work. Someone remarked that family physicians woke up one morning about 2010 and couldn't remember what their particular clinical task was. Little wonder that the best and brightest no longer aspired to become doctors doing the tasks family physicians did each day. Indeed, an MBA was much more cost-efficient than an MD degree, and possessing an MBA was more lucrative and prestigious.

Maturation of the Discipline. Another perspective was that family medicine had experienced a developmental arrest in adolescence. Someone recalled Gayle Stephens, MD, having remarked that family medicine decided to spend itself on constructing its mind, instead of its place. This resulted in selecting the tasks required to hail family practice as the true primary care discipline instead of the tasks required to establish first-rate, frontline services for most of the problems that most people had, most of the time. A cardinal example was a protracted emphasis on producing more and more family physicians, rather than the best family physicians.

Staying stuck in adolescence left noise or silence in the policy arena, where an authorized and mature voice should have been heard. Most agreed that family medicine preferred to closely hold resentments for past wrongs and rehash old hurts, rather than forgive and forge critical partnerships with public health, mental health, genetics, immunology, space medicine, the social sciences, computer science, physics, and other disciplines that might have resulted in a different and better story for the public and for family medicine. A few held forth with vigor that this arrest in adolescence prevented doing the tasks of full integration into both the scientific and local communities from whence family medicine would have been bilaterally nurtured. Yet again, someone thought that it was Gayle who captured this situation by saying, "Family medicine never filled an empty space in the hearts of people."

Intellectual Advancement. A persistent focus on the discipline instead of the population's unmet needs inadvertently resulted in family medicine surviving, while things didn't get better for the people receiving their care from family physicians. As the years passed, with family practice separated from curiosity and a vigorous quest for discovery, there was widespread recognition that breakthroughs always occurred somewhere else, followed by agonizing about how the family physicians just weren't doing the best things anymore, again.

There was another viewpoint about research that held that the failure of family medicine research was actually a result of self-selection of unimportant questions, addressed almost exclusively within a biomechanical model, restricted to reductionistic methods. This resulted in huge expenditures of time and money on tasks that, in the end, could have been done by many others and in fact were. The tragedy was the failure to select the tasks of discovering the socially based life conditions necessary for health and exploring the largely unknown terrain of the mind-body-environment system in which family doctors had dwelled with their patients for centuries.[2]

This situation left family physicians proclaiming the superiority of their theory without empirical evidence to support their claim and unable to explain the anomalies they saw in their own daily practice. Family medicine was left in a chasm between the powerful truth of biomedicine and a more adequate medicine. Family physicians seemed to have never found the time to stop, think, reflect, and cultivate habits of curiosity and introspection. Thus, it was left to others to discover that meaning could override biology and discover how to break free of linear models and engage the complexity thriving in what was once known as family practice.

Viewpoint #4: Family Medicine Failed Because It Never Became Part of the Culture

Family medicine never became part of the culture of the United States, and it wasn't radical enough to merit the opportunities in being counterculture. This line of thought held that family medicine was doomed from its beginning, like a blighted ovum, because the culture of the United States emphasized consumption and had a fascination with, perhaps the worship of, the biological and physical sciences. This viewpoint revealed how poorly family medicine shaped up next to scientism and unbridled self-interests exercised through a medical marketplace.

The environment of the United States was supportive of lone individuals, doing largely as they pleased within fragmented systems, with insatiable appetites for more of something. Prioritized, integrated, "good-enough" healthcare was no match for the country's cultural dynamo, supercharged by sequential economic expansions.

There was a certain disingenuity in family medicine's public display of its ambivalence about specialization while the populace was totally preoccupied with consuming the fruits of specialization. Everyone remembered the embarrassment of family practice being associated not with the best of modern medicine but with beer commercials and denigrated as "Medicine-lite." Looking back, it should have been recognized that it would be NASA, not family medicine, that led the way to superior rural medicine; Americans expected innovation from the space program, not family medicine.

Being located outside the mainstream of culturally sanctioned medicine, while welcoming huge challenges, was a primary reason why family practice's revenues were never greater than its expenses, always leaving the discipline short on capital in a capitalistic society and market-based medicine. In short, the United States' medico-information complex completely overshadowed family practice and absconded with the sanctioned engines of progress, often in search of economic profit. Instead of differentiating, family medicine played the chameleon, fitting in with the flow instead of going against the current. Looking back, the residual believers uniformly regretted not speaking out more forcefully and effectively in the academic centers, practice

organizations, media, and government for the core concepts of family practice and primary care.

Conclusions

Keystone V concluded without consensus as to why family practice had failed or for that matter that there was any single reason for its precipitous decline. The participants were comfortable with their four answers: (1) abdication, (2) going down with the old medical paradigm, (3) choosing the wrong tasks, and (4) being a cultural mutant.

The residual believers also agreed that if another group were collected to repeat the exercise, there would likely be other proposed explanations that had eluded their conversations at Keystone V. They were still discussing their belief of a pervasive unhappiness with healthcare that spanned the nation as they departed and were quite surprised and not a bit amused the next morning by the front-page story in the *Wall Street Journal* headlined: "Citizens' Commission and Corporate Roundtable Propose a New Medical Specialty: Primary Medicine."

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References

1. Schaef AW. Meditations for women who do too much. New York: Harper Collins Publisher, 1990.
2. Pauli HG, White KL, McWhinney IR. Medical education, research, and scientific thinking in the 21st century (part one of three). Education for Health 2000;13:15-25.