The Medical Home: Locus of Physician Formation

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Family medicine is currently undergoing a transformation and, amid such change, the medical home has emerged as the new polestar. This article examines the medical home through the lens of philosopher Alasdair MacIntyre and offers a perspective, informed by Hubert Dreyfus and Peter Senge, about medical homes as practical sites of formation for family physicians. The intellectual past of family medicine points to contextually sensitive patient care as a practice that is particular to the discipline, with the virtue of "placing patients within contexts over time" as a commonly held virtue. Dreyfus provides a model of knowledge and skill acquisition that is relevant to the training of family physicians in practical wisdom. In this model, there is a continuum from novice to more advanced stages of professional formation that is aided by rules that not only must be learned, but must be applied in greater contextually informed situations. Senge's emphasis on learning organizations—organizations where people are continually learning how to learn together—presents a framework for evaluating the extent to which future medical homes facilitate or retard the formation of family physicians. (J Am Board Fam Med 2008;21:451–457.)

Family medicine in the United States is currently undergoing a transformation. Roughly a decade ago there was marked optimism among family physicians, largely because of an anticipated, well-defined central role as care managers within emerging health care models.[1,2] Such optimism, however, quickly changed to frustration and disillusionment as family physicians and other primary care physicians found themselves depicted as administrative gatekeepers, rather than gateways, to care.[2,3] In recent years, organized family medicine has responded to such challenges by reassessing the status of the profession within the health care system,[4] by outlining a vision and brand identity of family medicine,[5] and by seeking to change the ways in which family physicians care for their patients, largely through the medical home model.[2,6]

The medical home has become the new polestar in contemporary family medicine. For example, a recent editorial in *American Family Physician* gushed that the medical home "captures the family physician's traditional spirit of caring and the contemporary spirit of innovation and integration that goes beyond the walls of a physical office. It is a philosophy that encompasses everything that family physicians do for their patients in their communities—in the office, in the hospital, in partnerships with other organizations, through communication with patients, and through patient advocacy."[7] How can the medical home live up to such promise?

In this article I examine the concept of medical home through the lens of philosopher Alasdair MacIntyre. I first introduce MacIntyre's idea of practice and provide a brief overview of several influential thinkers in family medicine, arguing that contextually sensitive patient care is a practice that is particular to the discipline. Then I discuss the market as a force that has strongly influenced how health care relationships are considered in the

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United States, contributing to the previous gatekeeper role for family physicians and the current appropriation of the medical home by the discipline. I conclude by offering a perspective, informed by Hubert Dreyfus and Peter Senge, about future medical homes as practical sites of formation for family physicians.

Practices Within the Medical Home

MacIntyre provides a useful framework for considering the medical home through his idea of practice. By "practice," MacIntyre refers to any coherent and complex form of social activity through which goods internal to that form of activity are realized.[8] A practice involves standards of excellence and guidelines, as well as the achievement of goods.[8] Medical care, or the provision of assistance to those in need of care or cure from disease, disability, or dysfunction, and the health education and prevention of disease by people who are knowledgeable and skillful in providing such assistance,[9] is representative of practice in this way of thinking. Internal goods are those goods that are realized in the course of trying to achieve excellence in, and cannot be held in any other way than through, that form of activity. In contrast, external goods involve property or possession, such as power, fame, and financial resources, and are characteristically objects of competition.[8] Hence, well-being, healing, and health have been identified as goods that are internal to medicine whereas income and prestige are considered external goods to the provision of medical care.[10]

The notion of goods is central to MacIntyre's concept of virtue, which is an acquired human quality that enables us to achieve those goods that are internal to a practice, and the lack of which effectively prevents us from achieving such goods.[8] For physicians, the internal goods of medicine—well-being, healing, and health—help determine what it is to be a good physician. However, physician virtues do not arise de novo, but flow from institutional sites of care, from practical wisdom, and from teaching that is rooted in a specific practice history.[11] Every practice has a history, which is greater than the progressive development of relevant technical skills, linking contemporary practitioners with their predecessors.[8] The predecessors of today's family physicians, and the ideas that influenced them, can be viewed in light of several 20th century historical and social forces that shaped how physicians conceptualized and understood their patients.

Influential Ideas About Family Medicine

Several ideas introduced by James Mackenzie and Will Pickles challenged the growing hegemony of laboratory science and encouraged a broader, more contextually rich view of the patient that was found in the daily practice of British general practitioners (GPs). Mackenzie's textbook on clinical diagnosis, *Symptoms and Their Interpretation*, attempted to reconcile the growing "laboratory methods of clinical diagnosis" with the established experiences of the GP.[12] Enactment of the National Insurance Act in 1911 provides some historical perspective to Mackenzie's ideas, because this legislation essentially underwrote general practice in Britain but also severed GPs from hospital and laboratory practice and from the ideas, attitudes, and professional identities found there.[13]

More than 20 years later Pickles embraced Mackenzie's thesis that it was "the family doctor who alone saw disease in its true perspective"[12] and expanded this notion by encouraging country doctors to widen their clinical gaze from individual patients to populations within a defined geographic area.[14] At a time when advances in bacteriology and public health were converging and shaping medical practice,[15] Pickles' text, *Epidemiology in Country Practice*, broadened the role of the country doctor to accommodate these advances.[14] Pickles seems to have envisioned an epidemiologically sensitive GP who appreciated the temporal nature of symptom, disease, and resolution, but who was also a keen observer of patients and of the social and physical environments in which they dwelt.[14]

It remains doubtful that Pickles' model of the country doctor-cum-epidemiologist ever came to fruition in Britain because of the events accompanying World War II. Yet the catastrophe brought about by war, and the reconstruction that followed, set the stage for general practitioners to gain a more comprehensive view—beyond the geographic location of their patients—of a wider range of contextual factors influencing health and illness. Most conspicuously, the meticulous and extensive family records of Dutch physician Frans Huygen advocated for an appreciation of social and historical influences in conceptualizing and understand-

ing illness.[16] Published in 1978, *Family Medicine: The Medical Life History of Families* compiled 30 years of family medicine case histories into a way of thinking about health and illness that was grounded within a family context while providing empirical support for a newly emerging theory of family systems.[16] More importantly, Huygen gave some intellectual ballast to the discipline of family medicine, setting out on its own course in the United States.

The Intellectual Basis of Family Practice is Gayle Stephens' widely cited treatise to establish family medicine's legitimacy as a scientific discipline within the United States.[17,18] The concept of patient management was central to Stephens' thesis and was operationalized as relating to patients in a personalized way that incorporated an almost Gnostic knowledge of the patient who had a unique identity and personal history. Stephens also defined the way in which family physicians went about acquiring this skill: "The critical factor is not academic background but, rather, the personal characteristics of the individual and his experience with sustained therapeutic relationships."[18]

Ian McWhinney's well-recognized principles of family medicine embraced a very broad clinical perspective that was committed to a person rather than to a body of knowledge, a group of diseases, or special techniques, and defined itself through relationships as well.[19] The intellectual contributions of Mackenzie, Pickles, and Huygen are self-evident in many of McWhinney's principles; the discipline seeks to understand the context of the illness because many illnesses cannot be fully understood unless seen in personal, family, and social contexts; it needs to think in terms of both individual patients and populations and participate in a community-wide network of agencies that foster health; family physicians should share the same habitat as their patients, and; physicians should see patients in their homes and use this knowledge of environment to foster a greater understanding of the context of illness.[19]

When considering these influential thinkers of family medicine, one interpretation is a practice history of an expanding clinical ontology, or the ways in which family physicians have progressively broadened their worldview and related to their patients when compared with their medical colleagues. If this is valid, then contextually sensitive patient care is a practice that is particular to family medicine, with "placing patients within contexts over time" as a commonly held virtue.[20] Indeed, this proffered virtue is a key attribute of family physicians espoused by the Future of Family Medicine Project; a talent for humanizing the health care experience.[2]

The virtue of "placing patients within contexts over time" requires clear definition. Context is the social milieu, physical environment, and historical events that surround and accompany each patient, influencing his or her health and illness experience.[21] Time here is thought of more broadly than just biological time, which marks the stages of human development. It also includes historical time—locating patients within environmental and social contexts—and social time, which reflects the timing and scheduling of life events and relationships.[22] Context and time are closely linked to relationships, which represent the ties that patients maintain within their local social world, such as family and friends, but also the active interface between patients and their physicians.

The Medical Market

Unlike its forebears across the Atlantic, family medicine in America has had to grapple with both the opportunities and challenges of market-based approaches to the delivery of health care.[23] The idea of the market influences how both organizational and interpersonal relationships are framed in health care contexts.[24] Although the medical marketplace has had a long and complex history,[23] managed care was a more recent focus as to how health care relationships were considered. George Annas, for example, saw the medical market as operating on several levels: "health plans and hospitals market products to consumers, who purchase them based on price. Medical care is a business that necessarily involves marketing through advertising and competition among suppliers who are primarily motivated by profit." Annas went further to comment that the physician's role was radically altered by the market, because physicians were no longer advocates for individual patients, but rather champions for populations of patients.[25]

It was the market, however, that pushed family medicine and primary care to center stage throughout the 1980s and 1990s because of the rise of managed care.[26] Yet at the time of this ascendancy there was evidence within family medicine of dis-

comfort with emerging health care models, mostly personified in the gatekeeper role.[27] Physician responsibilities as gatekeeper included coordination and control of access to medical care and ancillary services, as well as patient advocacy.[28] For many family physicians, however, the gatekeeper was ethically problematic. Stephens reflected on his clinical experience and concluded that gatekeeping was an untenable and hopelessly conflicted role that undermined the heart of the family physician's effectiveness by transforming an intimate, covenantal relationship into a contractual arrangement between strangers.[29]

Today, the idea of the gatekeeper has been supplanted by quality as the market watchword in health care.[30,31] According to the Institute of Medicine, quality has been defined as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."[30] The notion of quality is not new to family medicine because many family physicians have had previous experience with quality incentives through managed care.[32] Incentives exert a substantial influence on physician practice behavior, especially when financial incentives are aligned with professional values and focus on a common clinical interest, such as improving the quality of care.[33,34] An Institute of Medicine report called for the Centers for Medicare and Medicaid Services (CMS) to increase payments to providers who delivered high-quality care.[35] With an eye on rising health care costs, CMS subsequently offered its vision for Medicare as "the right care for every person every time" by "making care safe, effective, efficient, patient-centered, timely, and equitable."[36]

The CMS vision included a roadmap to improve care, such as working through partnerships to improve performance and achieve specific quality goals; developing and providing quality measures as a way to promote quality improvement efforts; and rapidly importing effective, evidence-based treatments into patient care.[36] The growing emphasis on these and other systems-based approaches to health care, coupled with the growing alignment of quality and incentive, has shifted the locus of care from the patient–provider level to the organizational level of the medical practice. In family medicine, this movement has contributed to the appropriation of the medical home.

Medical Homes and the Formation of Family Physicians

Although the American Academy of Pediatrics introduced the medical home concept in 1967, referring to a central location for a child's medical record, 4 national primary care organizations drafted and disseminated the Joint Principles of the Patient-Centered Medical Home, which is denoted by the hallmarks of safety and quality.[37] If we return to MacIntyre's way of thinking, the medical home can be considered an institution because it is characteristically and necessarily concerned with external goods, such as the acquisition and distribution of material and financial resources, power, and status.[8] For example, there has been a recent proliferation of Medicare and private payer demonstration projects and pilot programs that are seeking to facilitate reimbursement to clinical sites offering medical home services.[38]

According to MacIntyre, no practices can survive if they are unsustained by institutions.[8] As an institution, the medical home is necessarily concerned with external goods, such as reimbursement and a vital role in the health care delivery system. These external goods, in turn, sustain practices that contribute to the internal goods of health, healing, and well-being. However there is an intimate and inherent tension between practices and institutions because the ideals of the practice are vulnerable to the competitiveness of the institution.[8] It is here where the virtues provide an essential function because they empower practices to offset the potentially corrupting influence of institutions.[8] If "placing patients within contexts over time" is a virtue particular to family medicine, as I have argued earlier, how can future medical homes contribute to the acquisition and maintenance of such a virtue? This is a key question as the discipline moves forward with emerging educational innovations centered around the medical home.[39]

I noted earlier that physician virtues do not arise de novo, but flow from institutional sites of care and practical wisdom.[11] Hubert Dreyfus provides a model of knowledge and skill acquisition that is relevant to the training of family physicians in practical wisdom.[40,41] In this model there is a continuum from novice to more advanced stages of professional formation that is aided by rules that not only must be learned, but must be applied in increasingly complex situations.[40,41] The movement

from rule-based to context-based ways of thinking and relating trains those in formation to select which details are significant and relevant within specific clinical moments; in doing so, learners also select a perspective from which to view the patient.[40,41] For example, when encountering a patient with metastatic breast cancer who discloses hopelessness, family medicine learners would use their contextual understanding of the patient to consider the symptom more broadly and comprehensively, beyond the traditional medical model, as perhaps the revelation of an underlying existential or spiritual concern.

The acquisition of practical wisdom is not solipsistic for individual family physicians but is interdependent with sites of care, such as hospitals, long-term care facilities, offices, and eventually, medical homes. These sites of care may be considered local and particular types of community that contribute to the formation of individual physician virtues; in turn, the individual virtues of the physician contribute to the sustenance of the community.[41,42] Peter Senge provides an organizational way of thinking about the medical home in an interdependent perspective that complements both MacIntyre and Dreyfus. Senge's emphasis is on learning organizations (organizations in which people are continually learning how to learn together).[43] There are 5 disciplines, or developmental pathways, for skill or competency acquisition in the learning organization: systems thinking, personal mastery, mental models, building shared vision, and team learning.[43] Rather than elaborating on each of these disciplines, I would like to focus on the 3 levels of the learning organization: practices, principles, and essences, as a framework for considering future medical homes as sites for family physician formation.

According to Senge, practices are the most conspicuous aspect of any discipline because they are the tasks that occupy the primary focus and work of both individuals and groups within the organization.[43] What are the particular practices of contextually sensitive patient care that are specific to each unique medical home? The practices of an urban community health center in the Southeast, for example, would be necessarily different from that of a solo practice in the rural Midwest. Principles represent points of reference for members of learning organizations, helping individuals make sense of, and through which they are continually refining, their practices.[43] How do medical homes embed the virtue of "placing patients within contexts over time" within their guiding principles and practices? In health care settings that are strongly influenced by the market, reconciling patient-centered and evidence-based medicine will be a considerable challenge in the ongoing development of principles. Finally, essences are states of being or self-perceptions that come to be experienced spontaneously and naturally by individuals or groups with high levels of mastery in the disciplines.[43] How do all members of the medical home become formed in practices of contextually sensitive patient care and come to embody essences that contribute to the health and well-being of every member, both patient and provider?

Conclusion

The medical home has the potential to become a distinctive and specific locus of formation in which family physicians practice and habituate contextually sensitive patient care. However, the market will variably impact not only the ways in which family physicians embody the practices of caring for patients within context over time, but also how family medicine comes to represent particular activities that contribute to health and healing. Whether in present-day health care settings or in medical homes of the future, it is still during clinical moments, when patients seek help from physicians, that the actions of the individual physician and the institutional care system converge.[44] Here lies the normative and moral work of family medicine, an activity that has historically provided the foundation for sustained therapeutic activity between patients and physicians.[4] The extent to which future medical homes contribute to the formation of family physicians, who embody a time-honored virtue that promotes health, healing, and well-being, will determine whether the medical home will live up to its promise.

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