

SPECIAL COMMUNICATION

Holding On and Letting Go: A Perspective from the Keystone IV Conference

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This commentary examines what it might look like to be countercultural in the current era of health care change, and asks what we should hold onto and what we should let go of as we reinvent an ideal that gives meaning to family physicians and value to patients and populations – that primary health care is a relationship to be nurtured and supported, not just a commodity to be delivered and optimized, measured and incentivized, bought and sold. (J Am Board Fam Med 2016;29:S32–S39.)

Guest editors' note: This paper captures ideas presented in reaction to the initial presentations at the G. Gayle Stephens Keystone IV Conference. It goes further to reflect on the purpose of the conference and the opportunities for family medicine during this transitional time in health care, as discerned by an exceptionally well-informed journal editor and thought leader for primary care and personal doctoring.

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From the moment of birth, we have the instinctual ability to grasp objects. By 5 months the grasping becomes purposeful—we grab and hold onto what we want.

Letting go is harder. For a few months, when holding onto a rattle, an infant will look longingly at a new, shinier rattle—then look back at the dull rattle in hand, and then back to the shiny rattle, unable to let go of the old to grasp the new.¹

Not much later, we learn to let go to grasp. But letting go remains the more difficult action.

I relearned that lesson this fall. Reaching to put garden hoses into my garage attic for the winter, the ladder wavered, then toppled. Despite feeling the fall, I kept holding on to the hoses, rather than

reaching out to grab something to disrupt the tumble.

Fortunately, the cement floor broke my fall, and I was roughly OK. Still, the bruises reminded me for weeks of the strength of the instinctual drive to keep hold of what is in hand.

Holding on and letting go were among the challenges of the fourth G. Gayle Stephens Keystone Conference in Colorado, as participants strove to answer the question, “What promises will a personal physician make to her/his patients going forward in the evolving health care system of the United States, particularly in terms of when and where they will be there for their patients?”²

At many points, the conference felt like a revival meeting, as the collective tried to revive the central but assaulted notion^{3–6} that relationship is at the center of healing.^{7–15} At the center of what patients want, need, and increasingly do not think is available in a fragmented, depersonalized, often depersonalizing health care system. At the center of quality health care. At the center of family medicine.

Shiny new rattles enticed: newly won bobbles of prestige, enticements of lifestyle, being paid to “perform” on the sparse commodities of care that

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can be measured,¹⁶ “transformation” to a way of practicing that would finally garner respect, acceptance, and payment reform.^{17–22} But we desperately tried to hold onto the ideal—the way of being that gives meaning to family physicians and value to patients and populations—that primary health care is a relationship to be nurtured, not just a commodity to be delivered and optimized, measured and incentivized, bought and sold.

What Might Being Countercultural Mean Today?

Brought to the fore by Rosemary Stevens’s²³ historic witness to changes in US health care was Gayle Stephens’s²⁴ notion of family medicine as counterculture. When Dr. Stephens wrote of this, a tidal wave of countercultural revolution had already fomented family medicine into existence, as our forbearers willed a new mode of doctoring out of a timeless way of healing.^{25–39}

But what about now? Is it ever more important to counter a culture that increasingly separates the haves and have nots? In which polarizing sound bites too often replace neighborly dialogue? In which greed, anger, and fear are fomented to gain or maintain power? In which the still, small, but powerful voices of generosity, kindness, and courage cry out unheard amid the churning hubbub?

Now that family medicine has achieved some measure of marginalized centrality,⁴⁰ of acknowledgment without respect,⁴¹ of valuing without understanding,⁴² what might it mean to be countercultural in the current era? How much of being countercultural now involves letting go? How much involves holding on?

What if being countercultural now means:

- Getting over ourselves; vaporizing the dewdrops of self-regarding identity to merge into larger tides of change of which we can be a vital part—but only a part of a team, system, and community lurching toward an emerging, imperfectly seen collective good
- Recognizing, influencing, and riding the waves of larger interrelated change. Stephens,²⁴ quoting Revel,⁴³ recognized 5 interdependent revolutions that needed to happen simultaneously or not at all: political, social, cultural, technological/scientific, international/interracial.

- Working on multiple levels toward equitable treatment and environments that give everyone a fair shot
- Using every private and public opportunity to make space for real communication about real issues, rather than what currently passes for civil dialogue: sound bites designed to elicit an immediate visceral reaction that forces us into warring camps
- Teaching students the enduring values of family medicine, but freeing them to fulfill them in their own new way. Dr. Stephens wrote: “I would now rather be identified with student discontent than with the authority that imposes requirements on them.”²⁴
- Building learning communities⁴⁴ and communities of solution^{45,46} that combine Big Data with deep, on-the-ground relationships to reinvent community-oriented primary care^{47–49}
- Fighting against the widespread adoption of a line-worker approach to mass production that has largely been discredited in manufacturing but that is being applied full bore to public education and to delivering fragmented, depersonalized commodities of health care^{50–56}
- Standardizing what is common but not mistaking this for what is important: making room to take time with the particulars³¹ of person and place, family, and community
- Conducting research not as something that is done to rats, or to people treated like rats, or to subparts of people, and calling that “precision medicine,” but as generating relevant new knowledge in partnership with practices, patients, and communities; adding stories to the statistics, narratives to the numbers^{57,58}—personalized medicine that requires knowing the person
- Integrated care^{59–61}
- Embracing the measurement culture at arm’s length¹⁶; working to assess what is important, empowering those on the front lines to move beyond metrics of central tendency toward personalized care, and making space and time for the important wonders that are beyond measurement
- Being the change we want to see⁶²

I do not know if being countercultural is the proper political stance now. I do know that every day family physicians fly in the face of the fragmenting pressures of greed, anger, and fear, trying to do the right thing for individuals, families, and

communities. Family medicine has been the buffer for a disjointed, depersonalizing, avaricious health care system for so long that the buffering capacity is nearly expended. We risk being the dead canaries in the mine of the unsustainable health care system.

But family medicine is more than the early warning system; it is the bedrock of any functional system.⁶³ Rather than dying to let the miners escape, a dying family medicine risks collapsing the whole mine. In this situation it is important not only to be countercultural only in opposing the dysfunction, it is vital to champion viable alternatives—planting the kernels that, even if they do not thrive immediately, become part of the seed bank from which new life emerges when the current dysfunctional environment has burned itself out. And like new growth burgeoning from a scorched field,¹⁸ new alternatives are emerging, from personalized micropractices^{64–67} to large, single-specialty practices functioning as accountable care organizations⁶⁸ to direct primary care⁶⁹ to high-functioning community health centers and family practices that have found a way to coexist amid the dysfunction while showing a better way.⁷⁰

Stories

At Keystone IV, many stories were told, and many more were held in participants' hearts as they attempted to discern features of family medicine that are too rich, complexly related, and personal to be reduced to inventories or averages. These are the attributes that defy easy metrics that can be centrally commanded and controlled.¹⁶ But these are also the elements that make primary care the cornerstone of an effective, equitable, sustainable health care system^{63,71} and that are the system's and society's best hope for achieving the quadruple aim of improved population health, patient experience, sustainable cost, and clinician/staff work life.^{72,73}

On the first evening of the conference I told 1 of these stories. Here is one of the several others that I held in my heart.

The moment I walked into the examination room, I was wildly impressed by my 17-year-old new patient. She was drop-dead gorgeous. Movie star striking. Blonde, shoulder-length hair framed a perfectly featured face with impeccable skin, sitting on a body that could sell magazines in either the men's or the women's section of the newsstand.

I moved to learn why she was here. She'd given birth to at the county hospital, and since her 6-week postpartum visit nearly a year ago at Planned Parenthood, she hadn't been out of the house where she lived with her son, her fiancé, and her father. She'd been feeling down. Crying spells. Not sleeping well. Not suicidal. Still able to attend to her son, but it took every ounce of her energy, and she felt dried up. She still was breastfeeding but starting to wean.

As she told her story, I was even more impressed by her articulate maturity. I learned that she was watching and waiting to see whether her fiancé really was husband material. He grew up rough; did not have a loving father like she did. But he was working night shifts and odd jobs to support them. He treated her OK despite his porn addiction. She never felt unsafe at home. Still, she was waiting to see whether he would be enough of a standup guy to stick with. It would be tough if she kicked him out. He did not have anywhere else to go. The medical assistant already had done the depression screening questionnaire, and the patient scored high. I commended her for breastfeeding so long and found that she wanted to continue at least the nightly feedings for a while. I looked up the antidepressant medication option with the least crossover into breast milk and electronically sent the prescription to the pharmacy next door. She agreed that counseling would be a good idea, and I told her about the counselors in our office and recommended the particular person I thought would be a good fit for her after the antidepressant medication kicked in and made it easier to get out of the house.

Her son was in the next room with his father. They were worried he had a tapeworm. No travel or well water; he's eating fine, growing and developing normally. I asked what, from our visit, I could share with her fiancé. Nothing? Everything? Something in between? She chose everything.

Exiting the room with her behind me, I exhaled slowly, letting the breath distribute to the Universe my feelings and thoughts about the visit, but keeping the essence with me. With the next slow breath, I considered my strategy for the visit to the room next door:

check on the tapeworm concern, of course; assess the son's overall health and start a health promotion plan. The medical assistant had already cued up the immunization order for me to sign. But what about the fiancé? The last place a 17-year-old man wants to be is the doctor's office. But he's critically important to my 2 patients: his fiancé and son. OK. I will look for a little opportunity to connect with him. Maybe sports. Anything outside of medicine, an investment in a relationship that could become important. Maybe someday he'll even become my patient.

None of this nonmedical talk or thinking is billable of course. None of it gives any points on the quality or productivity measures. In fact, it often makes us look bad on the crude measures that misunderstand what is important about family medicine.⁷⁴ But it is what family physicians do every day as they invest in developing relationships while being paid for delivering commodities.

I opened the door and stopped. The fiancé was drop-dead gorgeous. Movie star striking. A home-grown haircut framed a perfect face with just enough ruggedness to keep it from being pretty. A body honed not by workouts at a fancy gym, but from loading trucks night after night.

The young woman screamed and rushed around me to grab her son, who was trying to climb into the drawer he'd opened on the front of the examination table. Several cellophane-wrapped plastic speculums were on the floor around him.

"You cannot just let him do whatever he wants! You have to watch him!"

"Bitch," he said under his breath. The "ch" struck a staccato note.

OK, change in plans, I thought to myself. I do not have the luxury of trying to connect through small talk. What I just witnessed has to be dealt with, now. But first, establish some credibility by dealing with the shared concern they both have about their son.

His cherub face, blonde hair, and chubby body could sell baby magazines. He obviously had good gross motor development to be standing and trying to climb into the drawer. He was not at all distressed by his mother's screech and swoop into her arms; he smiled disarmingly.

My examination revealed a healthy, well-developing boy. A look at the tapeworm in the glass jar, confirmed by a peek under the microscope, showed a pale, segmented, fibrous filament.

"What are you feeding him?"

The list included carrots, precut from a bag, julienne-style—just the size of a tapeworm.

"Great idea to get him used to eating a lot of vegetables at an early age. It looks like his body is telling us it is not quite ready to digest a whole piece of carrot yet. His stomach juices can bleach the color out, but not break it down. So it comes out looking like a worm. Until he's a bit older, try grinding up his veggies, or you can buy them already ground up in little jars." While holding their son on my lap and handing him tongue depressors on which I'd drawn funny faces, I asked the couple to sit down together.

I spoke first to the fiancé. "Boys learn how to treat women by watching their fathers. Even though your son cannot say many words yet, he already is listening. He's learning what to say to his mother. Fathers have a lot of power to show their children how to do things right—even if that is different from how the father was treated growing up."

I told him that some of how his son's mother was acting was from depression, the kind that happens after you put your body through a lot by having a baby. But we had a plan to help her to be more like herself over the next few months. And he could help.

To both of them, I described the research showing that, in marriages that last, communication involves at least 5 times as many positive statements as negative ones. That is a big task when you are both stressed out, tired, working hard, and worried about the future. But before there are words, there are thoughts.

"I want you to both pay attention to every little thought you have about your partner. Look at whether it is a positive thought or a negative one. When it is a negative one, remember instead all the little things your partner has done for you. Remember the reasons you got together in the first place. Think about the new family you are trying to build together."

I leaned back and bounced their son on my knee as he smiled at all us. "Over time, you may find that the number of negative thoughts goes

down, and the number of positive ones goes up. Thoughts lead to words and actions. Pay attention to your own thoughts, and words, and actions. Do not worry about the other person's reactions. When you do not like how they act, try to give them the benefit of the doubt. I have confidence that you can build the kind of relationship you want, and let your son witness that, and make it part of who he is."

Separately, they looked at me and nodded. They glanced at each other, held the gaze for a second, and then lowered their heads.

Over the next year, the woman's depression lifted, the son continued to develop beautifully, and the fiancé continued to work hard at night. He cared for the son during the day while the mother got a job driving a truck on local routes. The fiancé became the husband.

I saw them recently, together in a room, the father attending to the son drawing with crayons, the mother on the examination table as the patient. She'd gained 30 pounds and was in pain from a chronic back strain from hoisting heavy cartons off her truck. Her face looked at least a decade older. It made me think of my 40-year-old patients from disadvantaged backgrounds who look like they are in their 60s and have the medical profiles to match. This is how it starts, I thought.

I felt good about my first visit with this family. Someone auditing the medical records would give my team a decent quality score for treating postpartum depression and a fair score for a somewhat incomplete well-care visit of a 1-year-old. And I took too long to meet my "productivity" goals. The record is unseeing, and the quality metrics totally blind, to what was most valuable in that first visit—to a subtle intervention focused on fostering self-reflection about thoughts that lead to words and actions that cross generations. These are the things that family physicians are desperately trying to hold on to, even as we let go of our need to do everything ourselves and let the patient benefit from the full engagement of a diverse team.

We also are struggling to both let go of and hold on to our family and community focus. My practice gave up its family charts because all the electronic medical record vendors told us there was no business model for putting genograms in the electronic

medical record. But we still try to keep the family focus. Research done in this practice and others in our network found that 18% of visits to family physicians involve care of a family member other than the identified patient.⁷⁵ Half the time the other family member is not even in the room. Most of the time, this care is never billed for.⁷⁶ We work to build new systems that will support us in face-to-face, electronic, and asynchronous care of families.

The Rockefeller Plaza-based branding company that did the research for the Future of Family Medicine Project that emerged from the prior Keystone III conference called the community focus of family medicine "its best kept secret."⁷⁷ As the scope and geographic span of our care diminishes and as pressures for so-called productivity increase, we struggle to carry forward this community contextualization of our care, even as we try to advance it with technology that brings aggregate and personal information on the social determinants of health—the larger forces that continue to disadvantage our patients from generation to generation, making them old before their time.

And so we continue to spend unpaid time trying to do what is important, even if it is not measured as quality or productivity. We continue to diagnose and treat and try to prevent diseases. We work to periodically raise our gaze from the disease to the person, from illness to health, and from individual to family to community to society. And more and more, we spend our thoughts, words, and actions on the community and society, trying to create space for all of us to see and act on our commonality.

What to Let Go of, What to Hang on to

Keystone IV, and the present moment, put before us the challenge to be clear and resolute about what to carry forward and what to let go of, what to fight for against all odds, what shackles to shed.

What if we give up:

- Our personal attachment to the hard-won bobbles of prestige
- Family medicine's apparently deep need to be found credible by powerful others
- The false dichotomy between systematically generating new knowledge and caring about, and

pragmatically caring for, individuals, families, and communities

- Ways of acting that imply that if we just get the approach and messaging right, then the next generation, and the many partners we need to succeed, will get in line behind us
- The mainstream platforms that, like a waterski-er's tow rope, have kept us above water, but in the fallen health care system, are now just dragging us under
- The notion that the needed changes are more about us and what we need than about partnership with others to change the environment that constrains and enables our working toward the collective good

What if we decide to retain but *reinvent* in a new information age:

- The commitment to a fair chance at health for everyone
- Our pledge to provide and promote health care that is integrated, personalized, prioritized, and sustainable
- The notions of community-oriented primary care, using data on the collective to inform and empower the individual, family, and community^{78,79}
- Our fundamental understanding that good health care is not just a commodity but a relationship based on the tenets of^{26,63,71,80–82}:
 - being an accessible entry point with the health care system
 - focusing on the whole person and what they need
 - coordinating care that otherwise would be fragmented across settings and integrating care across acute and chronic illnesses, mental health, and prevention
 - sustaining partnership by deeply knowing individuals, families, and community
 - What if a new generation retains and reinvents the idea of being countercultural, not just as a reaction to the evil that we see around us, but as a wellspring of the potential we see in others and in ourselves?⁸³

The natural impulse is to hold on to what has sustained you. It takes reflexivity to overcome the primitive grasping reflex. In moving toward the new ways that are needed in health care, it is vital to

take time to consider what should be carried forward, and then to partner with others to reinvent health care on a robust and evolving foundation.

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