last 2 decades must only be a beginning – let's not entrench ourselves into a chronic holding position. We "must mix with action, lest than [we] wither by despair" – Tennyson.

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Fin de Siècle: Four Modest Wishes for Family Practice

Except for a few centenarians, who happened to be born in the 1880s or 1890s, we have the once-in-a-lifetime chance to live in the last decade of a century; rarer still, that decade also concludes a millennium. Such times might not be more portentous than others, but they stir our sense of history and whatever proclivities we harbor for numerology and spawn a good deal of reflection and prediction – some of it apocalyptic. *The Timetables of History*[1] suggests that there was widespread fear of "The End of the World" and the "Last Judgment" in the 990s, but there are only two entries of consequence under the heading "Science, Technology, Growth." One is that Leif Ericson is given credit for discovering Nova Scotia, and the other is the recognition of the importance of zero in mathematics.

By contrast, the 1890s (The Gay Nineties a.k.a. The Gilded Age) showed no evidence of apocalyptic anxiety and were replete with discoveries and inventions, some of which, as they unfolded in the twentieth century, had more apocalyptic potentiality than anyone imagined. The discovery of radioactivity, radium, and polonium and the invention of quantum theory in physics and the principles of rocket propulsion led, indirectly, to "The Bomb." One can hardly avoid observing the irony that people were less afraid of the future when they had more reason to be.

Perhaps they were enamored of more promising inventions in aircraft design (Zeppelin), the Diesel engine, the automatic telephone switchboard, cinematography, wireless telegraphy, and the horizontal gramophone disc. In medicine, the 1890s gave us x-rays, antitoxins, the organisms responsible for plague and malaria, Freud's "Studies on Hysteria," and the first use of rubber gloves in surgery. Small wonder that the last *fin de siècle* was a time of optimism and that no one could foresee two world wars, the Holocaust, freeways, laser discs, man-made satellites, organ transplants, magnetic resonance imaging, and AIDS, even though all were nascent then.

I have no capability or intention to predict what the 1990s will bring in science and technology that might affect the twenty-first century in similarly amazing ways, but surely I cannot be blamed for indulging in lesser speculations about our small part of human experience, our vocation as family physicians. The beginning of a new year is a traditional time for resolutions and good wishes, so in this first month of the first year of a decade that will usher in a new millennium, I have the temerity to make four modest wishes. None has ominous implications for the world-at-large, but they could be important for the next step in the evolution of medical practice in the United States.

Four Wishes

A Family Physician for Every Citizen

Without quarreling about names and titles in primary care, I wish that every citizen could have easy access to the medical services of a family physician, services that were envisioned and described in 1966, in "Reports" that are now familiarly known as Millis, Folsom, and Willard. Our nation has not yet made good on their ideals, which are still valid and widely accepted in principle. Each citizen deserves to be known by name to an identified physician who will provide ordinary medical services of high quality in the citizen's community, who will obtain consultation and make referrals to the next level of expertise, and who will buffer the citizen against nonrational encounters with the medical bureaucracy and the medical supermarket.

Achieving this wish will require further efforts to value this role and to prevent its erosion by unconscionable debt, unreasonable liability, and absurd professional constraints and to make it as attractive and gratifying as its natural affinities have always allowed. The role itself needs no artificial "hyping" or sales ability, because it is rooted in human nature, tribal and civilized history, and moral sensibilities. Hippocrates is

its patron saint; Hygeia its goddess; caritas its ethos; and Jenner, Osler, Schweitzer, and Dooley its prophets.

Increasingly, it is becoming clear that all physicians who practice this role must bind themselves together to promote their common interests on behalf of all citizens. What unites them is greater than what separates them. Family physicians, general internists, general pediatricians, doctors of osteopathy, and others who are committed to primary medical care must find ways to beat the numbers game and to keep their issues highly visible on the nation's agenda. The decade next ahead is no time for party politics and internecine warfare within primary care; no single group can meet the needs of all the people. I do not propose the form that coalitions should take; but I am convinced that they are inevitably desirable and that continued adversariness, however necessary it might have seemed in the past, must be put away.

Family Practice Education for Every Medical Student

I wish that every medical student, in all the nation's schools of medicine, could have an easily accessible opportunity to be taught by family physicians and their like-minded colleagues. Surely, one class, about 17,000 students, can be accommodated annually in formal and informal educational settings to make this wish come true. How can students choose a vocation that they have never seen "up close and personal"?

The barriers are less quality control of the educational experience than apathy or outright resistance on the part of mainstream medical educators. Formal studies of reform in medical education are unanimous in recommending changes that could, in large part, be remedied by this wish, particularly if it could be implemented early enough in the curriculum.

Every Family Physician a Generalist

When the generalist role atrophies, patients are entirely at the mercy of experts, and neither is safe from the other. It is a paradox that specialism necessitates more control and regulation than generalism, which is not merely an issue for family physicians, but for all of medicine. I wish that family physicians will see the wisdom of keeping generalism alive; not recapitulating the dysfunctional ontogeny of medicine-as-a-whole by splitting its ranks into subspecialties.

This wish is neither romantic nor nostalgic. It does not deny the importance of special expertise or the reasonable division of labor among physicians; it asserts the importance of balance and proportion between generalists and subspecialists. Most patients need what generalists have to offer most of the time, and when they need more, it can be obtained through the normal processes of consultation and referral. This simple logic is in the best interests of both patients and subspecialists; it protects patients from the extravagances and risks of too much medical care and protects subspecialists from having to do general practice in order to identify the patients who need their unique services.

In the past, generalism was disvalued because of what it omitted or missed; now the other side of the coin is visible, the consequences of relatively unselected patients encountering the raw power of a Promethean technology, unbuffered by the modulating presence of a competent generalist who knows both the patient and the system. It is no accident, I think, that exorbitant costs, intimidating professional liability, iatrogenic harm, excruciating medico-ethical dilemmas, and strangling bureaucratic control have occurred concomitantly with the rise of untrammeled subspecialization. Patients are unqualified, less by lack of knowledge than lack of power, to defend themselves against an army of medical experts.

Generalism also has a role to play at the interface of medicine and politics, where health policies are being negotiated. It is hard to imagine that our present system of health care financing, which excludes so many and rewards procedures disproportionately, would have been created by generalists. This is not to attribute more generosity or moral superiority to generalists, but to recognize their broader perspectives and their natural position of closeness to the people. Increasingly, specialty organizations have superseded other components of organized medicine – hospital medical staffs, county and state medical societies, even the AMA – as the voices of American medicine. It is impossible that they should not function as special interest groups, competing with each other for a bigger piece of the economic pie. We cannot build a just system for the distribution of medical services from the top down, giving priority to the desiderata of medical elites, who serve a small fraction of the universe of needs.

My wish, then, is that family practice will stay on the side of generalism. It is an essential part of our professional identity; it is legitimate and necessary clinically; it is our duty to the whole profession and to society.

Our Executive Editor has been an eloquent spokesman for generalism. In a recent issue of JABFP, he wrote:

> In evaluating American medicine it can be shown that the allurement of subspecialism allowed comprehensive care to lapse into a decline. Captivated by technology and its costly results, American medicine has forgotten the object of its existence – the whole patient. . . . Family practice offers an agenda of strategies; some of these are new and some are such that they recapture the venerable qualities of the physician, all of which are practicable expedients that the public can appreciate and the family practice programs can implement, and even Deans can understand.[2]

Every Generalist Practicing Personal Medicine

Few characteristics of clinical work are less understood than personal medicine. I have never met physicians who did not believe that they practiced it, or patients who didn't want it; yet the weight of evidence is that modern medicine has become impersonal. Family physicians have a big stake in it because we have claimed so much about doing it. I wish that every family physician could become adept in personal medicine. It is the glue that holds together whatever else we do, clinically, and gives it meaning.

There is a tendency to make it both too much and too little. It is too little if it is identified merely with being personable, with style, with superficial intimacy. It is too much, and off the mark, if it is identified with formal counseling, family therapy, individual psychotherapy, and the varieties of behavioral sciences. Qualified family physicians might use all these techniques, but they are not necessarily less reductionistic than any other form of subject-object interaction, such as surgery or radiology.

It is the personal dimension that separates human medicine from veterinarianism. (No slight to the latter intended.) As even Engel has recently acknowledged:

> *Biopsychosocial* as a term by which to convey postmodern scientific thinking is clearly inadequate for medicine. . . . *(B)io, psycho-*, and *socio-* do not by themselves convey anything that is necessarily uniquely human; and what is more exquisitely human than medicine?[3]

What indeed! The personal (human) is what is biographical and relational. It is what physicians come to know about patients from hearing more than vision, from what each discloses to the other about themselves *after* a relationship of trust has been established. It belongs to the same category of cognitive and affective experience by which we come to know our friends, lovers, spouses, and children; a category in which the usual connections between "seeing" and believing are reversed.

Personal medicine entails continuity, dependability, promise keeping, and beneficence. It grows in depth and meaning, survives hard times and misunderstandings, and is essential to individualizing the often hard decisions that arise with increasing frequency in technological medicine. It is the kind of knowing that one wishes for oneself when one inevitably becomes a patient.

Conclusion

Perhaps I have erred in describing these four wishes as modest. The first two require systematic changes in medical practice and education, never easy in a powerful system but doable without radical overthrow of the system. The last two are entirely within our own grasp; they simply require that we make good on what we have already said we value. Baseball teams in the final stages of a tight pennant race sometimes say, "Our destiny is in our own hands." They mean that if they win their own games, they do not depend upon their rival's losing to another team. Family practice, in this final decade of the century, is in that enviable position – nobody else has to lose in order for us to win modest gains.

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