Special Communication

The Best Ideal In Family Practice

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Nature, poor stepdame, cannot slake my drouth;
—Francis Thompson

Lurching Toward Utopia

A geriatrically perspicacious correspondent writing to a popular advice columnist observed that when children walking behind you on the street make bets on which way you are going to lurch next, it's a sure sign that you have become old.

Unpredictable lurching, however, is not confined to the elderly; it also can be seen in other kinds of movements, such as the family practice movement—and it does not seem to be simply a function of aging. Among general practice, family practice, generic primary care, family medicine, and now community-oriented primary care, our discipline has staggered and groped for its way among other ways that have, from time to time, attracted our attention, perhaps even our legitimate enthusiasm.

Family physicians have carried a torch for a number of ideals in medical care, each of which has been more or less problematic for mainstream medicine. You might construct a shorter or longer list or use different words to describe them, but I include the following as representative of the genre:

- Generalism
- Universal access
- Comprehensiveness
- Continuity
- Family orientation
- Behavioral orientation
- Cost-effectiveness
- Personal medicine

These eight ideals are not the exclusive property of family physicians, and we have not been uniformly successful in attaining them; but taken together, they compose the essential nature of family practice, and the attenuation or absence of any is a serious deficiency. Whatever else family physicians include in their repertoire of services to patients, these ideals must be served if we are to maintain our species identity. Also, I am ready to acknowledge that any physician who serves these ideals, regardless of pedigree, is doing family practice.

Ironically, the most egregious casualty of our multiparous natalogy—the most fragile and elusive ideal that repeatedly slips through our fingers—is personal medicine, the best of our ideals.

Properly understood, personal medicine is the guiding light or red thread that illuminates and identifies our path amidst the many vocational diversions that allure and tantalize us. It can coexist alongside the many epiphenomena of family practice—primary care, preventive medicine, geriatric medicine, behavioral medicine, family medicine, sports medicine, procedural medicine, perhaps even emergency medicine—but when any one of these becomes such an obsession that it crowds out personal medicine, our identity as family physicians is compromised.

During stages of my professional life, I have functioned as surgeon, obstetrician, psychiatrist, general medical officer, preventive medicine officer, substance abuse clinic director, team physician, and medical administrator; none of these roles made me a family physician, and only the role of medical administrator made being a family physician impossible. In all the other roles, I thought of myself as a family physician, temporarily occupied with something else in addition to my true calling, personal medicine.

In my view, personal medicine entails a form of knowledge having cognitive, affective, and psychomotor domains. Personal medicine is not to be confused with what the popular media identify

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as the failures of modern physicians to be kind and considerate, to exhibit finesse in interpersonal relationships, to listen in a friendly way, to take more time with patients, to give prompt appointments—in short, to qualify for what *Modern Maturity* described as a "perfect doctor":

> Ever wish you had a doctor custom-tailored to your particular needs? One who was smart and caring and had a parking lot behind his or her office and a bus stop in front of it? One who was board-certified, really listened when you talked, and accepted Medicare as full payment? Sort of a dream doctor?[1]

All physicians should try to correct the perceived flaws in modern medical practice, but even if that Utopia were reached, it would not encompass all that I want to include in personal medicine. Mine is not merely counsel toward perfection in manners and efficiency. As good and desirable as that might be, it does not extract the elemental thorns of human experience that produce and perpetuate illnesses.

Our Quarrel with Mainstream Medicine

Despite our ideals, family practice attracted an extraordinary number of critics during its development, both from general practice and other specialties. It's hard to imagine the same acrimony and resistance to another specialty. I do not wish to perpetuate obsolete debates, but they are part of our history, and contempt, like racism, is hard to eradicate. Part of the conflict was merely political and has passed with the times, but some of the criticisms were substantial.

A Yale faculty member, whose name I no longer remember, referred to family practice as "romantic revisionism." An editor of *JAMA* identified family practice with a lamentable "rising tide of anti-intellectualism" that threatened to return the pure science of medicine to the swampland of superstition and religiosity.[2] A professor of medicine at the University of California, San Diego, included family practice among forces that threatened academic medicine. He wrote:

> Congress and federal incentives were pushing medical schools toward family practice training and the delivery of health services to underserved areas. Medical students began to spend summers in Appalachia, not in a laboratory. Medical school curricula introduced courses in social and environmental aspects of medicine and decreased time devoted to the biochemical basis of disease. Students were called to do something practical, helpful, noble.... The role model to emulate became more and more the family practitioner, not the academic scientist—that is, the deliverer of health care, not the dispassionate scholar.[3]

Clearly, family practice touched in the body of medicine a special nerve that evoked a distinctive response. Family physicians' great offenses were that we identified ourselves with critics of mainstream medicine and that we claimed to know some things that orthodoxy was in the process of throwing out—one of which was personal medicine.

Of course, we did a lot of things that were politically objectionable. We were opportunistic, we took on airs, we cast ourselves as reformers, and we appealed outside regular channels for funds from local, state, and federal governments. We mobilized pressure on medical schools to let us in the door.

We attracted a motley group of fellow-travelers—long hairs, firebrands, malcontents, and medical politicians. We took full advantage of the antiauthoritarian and decentralizing climate of the times. We pushed, wheedled, threatened, and manipulated—crammed ourselves down the throats of unwilling medical schools and shamed them into giving us a place in the sun.

We allied ourselves with nonphysicians—behavioral scientists, educators, nurse practitioners, physician's assistants, clergymen, and assorted other itinerant academics—and espoused a multitude of causes and groups. We offered our services to rural citizens, inner-city poor, minorities, runaway teenagers, drug and alcohol addicts, prisoners, and migrant workers. We ran emergency departments, staffed storefront clinics, set up satellite offices, and promised everything to everybody.

As Utopians, we inherited the mantle of unrealistic expectations that had previously invested psychiatry in the heyday of the mental health movement. In short, we bit off more than we could chew and made some enemies in the process.

In our defense, we did not create the problems, circumstances, and flaws in the medical care system of which we took advantage and to which our presence called attention. The passage of 20 years

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not only shows that we were not God's answer but also that almost every problem we addressed has become worse. Our severest critics must see by now that, even if we disappear, the problems remain.

Family Practice and Heresy

The oddness, the not-quite-orthodox, provocative, and contemptible quality of family practice is its murky identification with the subjective elements of medical practice—what I am calling personal medicine. To many of the brightest and best medical educators, family practice reeks of heterodoxy, even heresy, and seems subversive and dangerous to the pure science of medicine.

In the light of medicine's long nineteenth-century struggle to establish scientific orthodoxy, these judgments and fears are understandable. Mainstream medicine has a hard-won and legitimate contempt for dogmatic, ideological, sectarian, and irregular healers of any sort. The battle against homeopathy, naturopathy, eclecticism, empiricism, Christian Science, and snake oil salesmen was long and bitter. It was more than a political battle against external enemies; it was a passionate crusade within the House of Medicine to purify itself from superstition, religion, tradition, and any belief systems that throve on propaganda and secrecy in order to establish medicine based only on experimental discoveries.

Heresies within medicine do not rest entirely upon ignorance, greed, and other forms of human depravity. They are grounded, in part, in the double-stranded history of medicine since Hippocrates. The dominant strand since the seventeenth century is the history of objectivity in medicine—the great ideas that made medicine a natural science. Among these, I presume that there would be consensus about the following:

- Secularization (focus on the natural world)
- Somatification (focus on the body)
- Quantification (application of mathematics to biology)
- Instrumentation (use of machines in diagnosis and treatment)
- Classification (rational typologies of diseases)
- Experimentation (controlled and reproducible empiricism)
- Chemicalization (use of drugs as primary mode of treatment)

These ideas rescued medicine from its Dark Ages and gave modern society a fundamental understanding of protoplasm—its structures, energy transformations, homeostatic mechanisms, and defenses against injury—and allowed us to develop a more or less objective therapeutics. They received their greatest shot in the arm in our own century with the institution of reforms in medical education that established the "body as a machine" as the dominant model of medical understanding.

There is nothing in this model, however, that is distinctively human. What is unique about humans is not protoplasm, but speech, laughter, crying, making and interpreting symbols, and giving meaning to our lives. The spectacular achievements of protoplasmic medicine cannot be gainsaid, but there is a nagging feeling that something has been left out. In throwing out the bath water of tradition and superstition, we saved the baby from infectious diseases but not from child abuse and the rest of the litany of modern epidemiology. I am not making a case for saving bath water but for remembering what we might have lost and what we yet have to learn.

Mismatches in Medicine

Despite its convincing successes, medicine has developed serious mismatches between its splendid veterinarianism and its broader public mission—between what scientific medicine is good for and the range of problems over which it has extended its hegemony; between what physicians know best and what patients need most. Curative therapy and primary prevention are available only for a fraction of diseases. Noncurative therapy and secondary or tertiary prevention are available for more, but the largest fraction of diseases can only be palliated. Physicians have no cures for predatory and self-destructive behaviors—none for finitude and ultimate mortality. It is a paradox that no matter how much death rates for specific diseases improve and life expectancy lengthens, body counts are destined to increase in our growing and aging population.

Whitehorn[4] observed more than 30 years ago that even if scientific medicine had perfect knowledge and treatment for all known diseases, physicians would still be busy trying to manage a broad

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range of clinical problems that arise from the ways persons conduct their lives and live together in groups. I need mention only habits, accidents, violence, abuse, and stress to illustrate the genres of problems that demand redirection of scientific attention toward human behavior, living in community, and therapeutic leadership styles—toward nurture as well as nature.

Moreover, scientific medicine does not come with a package insert directing the uses to which it should be put, anymore than nuclear physics came with one saying, "Make the bomb," or "Drop two bombs in 1945." Even when we know what to do medically, there are problems in applying medical knowledge to individuals and in distributing medical care equitably among the population. We know a lot more about the health risks of groups and populations than about the risks of individuals. There is a mismatch—a gap—between epidemiological knowledge and the knowledge of persons.

There is a mismatch between the demography of physicians and patients. Baby boomer physicians are destined to preside over the deaths of their grandparents and parents. White physicians are destined to provide most of the medical care for racial minorities. Middle- and upper-class physicians must treat the poor. We have a young, white, and rich medical profession and a population that is aging, increasingly diverse ethnically, and by most estimates made up of 35–40 million persons who are poor enough to be uninsured. This demographic mismatch promises that more physician-patient encounters in the future will be cross-cultural, and that age, race, and social class will have to be addressed if medicine is to be personal rather than merely technological.

Physicians have no basis for hoping that the experience of being sick can ever be separated from the meaning of being sick. Science deals in information and significance, but not meaning, which is cultural and personal. Houston[5] said in the 1930s that physicians and patients do not believe the same things about illnesses, their causes and cures. There is a growing literacy gap between state-of-the-art medicine and the medical knowledge of the public. Contradictory as it seems, medicine has again taken on the aura of magic.

Physicians can never look forward to a time when it will be easy to separate organic from functional complaints because the mind-body split was never the truth about us. At most, it was a temporarily useful intellectual distinction that rapidly lost its explanatory power. Pain will never be the same as suffering.

Why Personal Medicine?

Because of these mismatches, personal medicine becomes a clinical imperative, not merely what a few physicians practice because they lack a proper grasp of scientific medicine. Personal medicine facilitates the practice of scientific medicine, but more than that, it goes where science cannot go. It is not heretical to recognize and criticize the limitations of science or to appropriate in modern form what physicians have always done for their patients while waiting for science to catch up.

T.F. Fox,[6] former editor of *The Lancet*, gave the clearest defense of personal medicine in 1961. It . . . "is the care of a person by a person—by someone who accepts real responsibility for looking after his patient in sickness and in health."

When this simple but profound idea is acted out, something remarkable happens. Both patient and physician cease to be ordinary to the other. Fox put it this way: ". . . if the physician is so good a doctor as not to be put off by weakness, folly, grief, sin, or even bad manners; if he places himself at the patient's side; if he puts the patient's interest before his own—the relationship can be something valuable."

Are Fox's assertions hopelessly sentimental and obsolete? Has anything happened in the last 20 years that makes family physicians no longer desire such relationships with patients, afraid of intimacy, or incapable of sustaining continuity of care? True, the circumstances of medical practice have changed a great deal, but circumstances have never been good. There never was a golden age in which personal medicine was easy. The safe, nonexploitive, and intimate encounter between physicians and patients has always been an achievement over and against circumstances.

Benefits of Personal Medicine

What are the consequences of practicing personal medicine? We know too well the consequences of not doing it—increasing alienation, adversariness, complaints, and litigation—what the media publicizes. What about the benefits?

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The first benefit to patients, no matter what their condition, status, or role, is support, i.e., acceptance without blame. They receive personal recognition, respect for their dignity and autonomy, and appreciation for whatever is normal about them. Many come with unspoken or unspeakable agendas—they are unhappy, worried, suspicious, conflicted, isolated, trapped, and unreconciled. They speak of headaches, pains, spells, indigestion, sleepless nights, and chronic fatigue. They mention allergies and vitamins and wonder about rare and mysterious diseases. They need support and encouragement to tell their stories without fear of being ignored, rebuffed, disbelieved, or humiliated. It is a fearful thing to become a patient.

Support engenders hope, which begins by putting symptoms into the perspective of common human experience. No matter how bad the problem, something can always be offered. What can be hoped for? Always the best, as that is mutually defined. It may be a cure, treatment, partial recovery, preservation of a function, participation in an important event, relief from suffering, courage to face the unknown, even a good death. There is always something that can be hoped for, if it can be defined. When the physician hopes, as well as works, the patient can hope too. Houston[6] wrote that faith heals more by contagion than by argument.

Support and hope can lead to reconciliation. Everyone's life has regrets, hurts, failures, conflicts, and broken relationships and promises; illnesses tend to bring these into bold relief. A personal relationship with a physician that is open, honest, safe, and trustworthy can be an example, a training ground, for other relationships that also have possibilities for reconciliation. It is a rare experience of illness that does not offer the benefit of rearranging one's priorities and reassessing one's style of being with others. Reconciliation has remarkable power to heal.

These three benefits sometimes create surprise, which is the appearance of unexpected benefit. Norman Cousins and Bernie Siegal have made careers out of encouraging patients to believe in surprise, a miracle, if one is not put off by that word. One cannot take a surprise by storm, by demanding it, but one can create the conditions in which surprise is possible. Even when surprise is not forthcoming, nothing has been lost by creating the conditions for it.

On the physician's side, the benefits of personal medicine go far beyond getting paid for services. They validate the humanity of the role and gratify the instincts that entice us into medicine. They confirm our calling and connect us to the longest tradition in medicine—the works of mercy that antedate the modern era by 1500 years, the time when medicine earned the capital of public trust upon which we all still draw interest. Who would not want to be the sort of physician described by Cushing?

> . . . the time inevitably comes to each and every one, now in the best of health, when he must needs cry out for some experienced and sensible doctor who can alleviate if not cure his particular ailments, be they physical or mental; and the kind of sagacity and resourcefulness he will expect and need is less laboratory-born than bred of long and sympathetic familiarity with the anxieties and complaints of ailing, damaged, and worn-out human beings.[7]

Conclusion

Almost by chance, it seems to me now, family practice came along at a propitious moment in medical history. It fell the lot of family practice to straddle the fence between a burgeoning medical technology and the human services that most patients need most of the time, and this awkward posture is hard to maintain, but we should not evade it. As we struggle to direct our own evolution, let us not be intimidated or enticed to give up our most indispensable ideal—personal medicine. The need for it will never become passé, although we must continue to learn what it means and how to do it.

I close with a return to T.F. Fox,[6] who ended his lecture with this following observation:

> In planning your development you may be tempted to follow the national genius and put all your money on technology. But, even in these United States, you have a population which is backward in that it consists of human beings with a long racial experience of life in circumstances quite different from those of Lower Manhattan. If people were ever industrial robots, they might need no more than technological medicine. But actually they are not (and I reckon never will be); and even in the most highly developed parts of the world they still need personal medicine too.

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It is because they are aware of this that older people look back wistfully to the horse and buggy doctor. I know that the horse has died; and the buggy has fallen to bits. But we still have the doctor. And adapted to modern conditions, he could often, if he wished, be the patient's own doctor—and much the more useful for that.

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