that most often are implicated in drug-related patient events: systemic corticosteroids, digoxin, nonsteroidal anti-inflammatory agents, β-blockers, furosemide, theophylline, thiazide diuretics, sympathomimetic agents, and other benzodiazepines.[6] Ideally, such a process would include face-to-face educational interventions for nurses[7] and would be a cooperative effort among the facility medical director, nursing director, and consultant pharmacist. Iatrogenesis occurs often in this population, and the overall costs of medications being taken (whether inappropriate or not), some of which have an adverse effect on health care financing in this setting, are enormous.

A goal of simply reducing medications is not enough, however. Many nursing home residents, like my patient, would not be alive had it not been for medication. Thus, medication reduction must be judicious and not nihilistic.

It is in these areas that good medical practice must go beyond the recommendations of Ackerman and von Bremen. For example, relief of depression and the application of nursing care are paramount in seeking to manage chronic pain without nonsteroidal anti-inflammatory agents. Admittedly, depressive symptoms are often situational, and frequently medications are not indicated. Nevertheless, management of chronic pain should often include attention to depression through counseling or a trial of a medication with a low risk of adverse drug events in an older population. Furthermore, such physical measures as frequent repositioning, range-of-motion exercises, active exercises, massage, and the use of such devices as recliner chairs are far better than an attitude that the patient should be left alone to "suffer a little." In these areas the physical therapist can be helpful in resident evaluation, in initiating treatment, and in applying special technologies; however, physical therapy alone will rarely be successful in providing pain relief; it must be coupled with attentive nursing care.

Thus, medication reduction is a secondary goal in nursing home practice. The primary goal should be to maximize resident well-being. Here barriers exist that dwarf the issue of polypharmacy: the high occurrence of chronic, disabling conditions; inability of the resident to advocate for himself or herself; low wages and lack of professional status for nursing assistants; poor preparation and minimal supervision for many licensed nurses; inadequate reimbursement for physician services; and difficulty knowing which treatments really provide benefit for a patient. Such obstacles to ideal nursing home care often seem so insurmountable that in times of cynicism the nursing home physician might yearn for the simplicity of, for example, managing cystitis in a young patient or a well-child visit.

Nursing home residents remain an underserved medical population, and their complex needs require some of the best that medical science and humanism can provide. As Ackerman and von Bremen recommend, family physicians should seek to serve as activists in bettering the care of older persons in nursing facilities.

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A Hiker's Guide To General Practice

There is no cogent argument for promoting primary care vocations that do not remain true to the primary care role.

The hiker metaphor comes easily to mind when one resides in the Colorado mountains, but I like

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it for additional reasons. It suggests intimate, physical, step-by-step commitment to walk a trail but does not imply authoritative knowledge of the entire trail or even the accurate identification of what is seen. Hikers experience the details of weather, fatigue, and curiosity and sometimes surprises and exquisite panoramic views, but they are not necessarily experts on geology or botany and might not know exactly where they are. Their experience is personal, real, and true enough to be of value to other hikers, but it is limited and relative and is not a substitute for a well-drawn map and a compass. I fancy myself a hiker on the long trail of general practice writing to other hikers who also are along the way. I cannot see the end of the trail from here, but so far, there have been enticing views, cold water, and lively companions with good instincts for the main path.

Stages of Change

Four stages in the evolution of general medical practice have occurred during my professional lifetime. When I began in the 1950s, general practice was in the midst of accelerating *attrition* since about 1935. The numbers of general practitioners were declining absolutely and proportionately; the scope of practice, especially hospital privileges, was under attack; and within medicine the vocation was held in contempt. A spectacular reversal in the specialty composition of US practicing physicians occurred in the 38 years from 1931 to 1969, a time when physician-population ratios were relatively constant. The relative ratios of general practitioners and specialists changed from 83:17 at the beginning of the period to 23:77 at the end.[1] Two factors were at work — the irresistible appeal of specialization and a flight from general practice, which lacked organizational power and academic and practice definition.

Despite this bleakness the vocation was reborn in the 1960s as family practice. I think of this occurrence as a stage of *professionalization*, because its main achievements were the creation of the necessary infrastructures for a specialty — a certifying board, training programs, accrediting bodies, and sponsoring professional organizations. This transformation was an unprecedented achievement, both quantitatively and qualitatively, but it did not correct all the problems arising from the stage of attrition.

The third stage was a *utopian revision* of the second stage, occurring concurrently, and aimed at expanding and refining the theory and content of traditional general practice around academic social sciences, behavioral medicine, family therapy, and epidemiology. This stage retained vitality, but it did not fully capture the mainstream of family practice. Pellegrino,[2] a friendly critic, described it as a mutation, because it went beyond what the public understood and wanted from general practice. Nevertheless, professionalization could not have succeeded as well as it did without the energy it derived from reform and new ideals. The trajectory of medical professionalism was deflected toward wholism, humanism, and social justice by the utopians among us.

Now, we are in a stage of *generic primary care* wherein family practice, general internal medicine, and general pediatrics — along with others — are eyeing each other, cautiously trying to decide whether they are more alike than different and whether their interests would be served best by some sort of amalgamation of generalists. The lack of appropriate generalism is now seen as a glaring deficiency of US medicine, contributing as it does to relentless fragmentation of care and exorbitant costs.

Each evolutionary stage has been experienced by general practitioners as an identity crisis, containing both threats and opportunities that in some respects are uniquely problematic and controversial among medical vocations. In ways not shared with other medical and surgical specialties, general practice has been challenged to redefine and relegitimize itself as a condition of its existence. Its role, scope, focus, and position in the medical care system seem always to be under judgment and subject to external forces over which it has no direct control. In some respects, generalist practitioners are like members of a Western tribe whose hereditary land was in the path of a transcontinental railroad, which disrupted their orderly development and flooded them with agents and entrepreneurs who pretended to know what was good for them.

The present is no exception. The challenge now is widely perceived to be a surfeit of opportunity to play a strategic role in health care reform, but it also contains threats and risks. The public has become less sanguine about managed care and suspicious of the gatekeeping role. Other special-

ties cannot be expected to give up their powers, privileges, and wealth and to concede to generalists what some are already calling, cynically, the "driver's seat." Entrepreneurs are everywhere making deals, buying practices, creating new commercial entities, trying to outguess the future. Other health professionals are eyeing the marketplace hungrily, asserting their competence to provide medical services better and cheaper. The future appears uncertain, ambiguous, even chaotic.

Moral Credibility — A Dependable Trail Marker

In looking back at the last 45 years of our roller-coaster history, I believe that our evolution has been steadied, guided, and empowered more by our moral credibility than by our cleverness, power, knowledge, and competence. We were believable when we raised our hands in response to the Millis Commission's call for more primary physicians, the Folsom Committee's call for more community-based medical practices, and the Willard Committee's call for a new breed of family physicians.

We were believable to the Liaison Committee on Medical Specialties when we submitted our application for a board of family practice, to agencies of government who agreed to fund our training programs, and even to most of the nation's medical schools when we said we could teach and model primary, comprehensive, continuing, and family-oriented care to medical students and residents.

We were believable to ourselves when we said we wanted to improve access to care, especially among underserved populations in rural and inner city areas, to become patients' advocates, and to work for distributive justice in medical care.

Moral credibility is the most distinctive feature of our history and ought to be our continuing guide into the future. In claiming moral credibility I am *not* also claiming moral superiority. The former is more characteristic of groups than individuals; it is attributed by various publics to groups that have served them well. We inherited a legacy of moral credibility from our forebears, a capital resource earned in the trenches of service for generations, a resource in which we can participate as individuals but cannot create on our own. We can attend to it, embellish or squander it, but we do not own it.

I take moral credibility to mean the cumulative weight of public trust earned by a profession through the virtuous habits and actions of its members during a long period of time. It is bestowed gradually by a grateful public and represents the collective judgment of generations that the profession can be counted on to live up to its ideals. It is moral because it deals with relationships, intimacies, vulnerabilities, and life events, and it is credible because it is both responsive and responsible. Moral credibility entails the exercise of power in a certain way, according to a learned style. It is not the same as professional competence — the histories of each can be traced separately — although one hopes they are connected.

The roots of moral credibility are deeply grounded in the traditions of merciful care, which originated during the Crusades. They antedate scientific medicine and are embedded in Christian ideals of service to the poor. They flourished in myths of country doctors in the nineteenth century. Even during the decades of attrition in this century, general practice was sustained by its traditions and examples of nonexploitive care in out-of-the-way places, its reservoirs of clinical lore, the competence of "super-docs," and its benevolence to those in need. There was romance, myth, and heroism enough to inspire public trust and make a few converts in each class of medical students.

Moral credibility arises out of availability, intimacy, and personal presence in times of crisis. It grows out of compassion and trying to help, depending less on expertise than good intentions. The public will accord moral credibility to whomever shares with them the suffering and uncertainty of illness, the griefs of painful life events, and the loneliness of death. It is a concomitant of the *role* that general practitioners have occupied, and we should not make the tragic mistake of thinking that moral credibility necessarily will follow us if we change our role. Moral credibility is generated when physicians go the second mile for their patients, when they listen and try to understand. It is not generated by mere duty but by acts of devotion, which cannot be demanded. One gets paid money for doing one's duty, that is payment in full; but there is no money payment for acts of human kindness and devotion above the call of duty.

If these assertions seem hopelessly sentimental, obsolete, or obtuse, compare the moral credibility "quotients" that you attribute to various groups,

organizations, and occupations. Begin with an easy one, like Mother Theresa's order of nuns in Calcutta and tobacco company executives who have been testifying to Congress. If that distinction seems clear, you are ready to move on to other examples closer to the generalist's role in medicine. Moral credibility is not evenly distributed throughout the health care industry. The late Telly Savalas used to say on his TV program, "Who loves you, Baby?" and I suspect that the answer to that question goes a long way toward explaining how we all choose to attribute moral credibility.

A Morally Credible General Practice

This editorial was stimulated, in part, by the following incident. Earlier this year I attended a rural county medical society meeting in my state, where a quorum of about 15 physicians, mostly generalists I have come to know, heard their guest speaker begin with these words: "Change in medical practice is inevitable, irresistible, and imminent." He was a big city attorney whose 90-partner law firm specialized in medical affairs, and he proceeded with an apocalyptic message about changes already happening. I could feel the apprehension rise as he told tales of what hospitals and physicians are doing to prepare for the newest era of competition. At the end he had them believing that health maintenance organizations from California are poised on the borders of Alabama to invade their practices, bringing their own physicians with them. (I couldn't help but muse that the physicians I know in California would rather starve there than move to the rural Deep South.) After 45 minutes of this harangue, the local radiologist interrupted with: "What can we do to circle the wagons?"

My fear is that family physicians and other generalists are being stampeded into new practice arrangements and jobs that betray our legacy, subvert the very aspects of our role that lie at the heart of our unique services, and threaten our moral credibility. Like Samson, we are in danger of being shorn of our strength by Philistines. Things to die for in the past have been bargained away for a pittance. We do not need to circle our wagons if we have a clear perception of our distinctive work and what it takes to make that work possible.

There are four interrelated features of a medical practice that are clues to its potential for moral credibility. I tend to see these as continua, spectra, or even a Likert scale, if that appeals to you. In the form I list these, they should be weighted toward the left; however, if that direction is politically offensive, the order can be reversed and weighted toward the right.

The four features:

1. Autonomy - - - - - - - - Dependency
2. Intimacy - - - - - - - - - Anonymity
3. Universalism - - - - - - Exclusiveness
4. Tenure - - - - - - - - - - Itinerancy

Autonomy

Moral credibility is enhanced when physicians have the power to make and keep promises to their patients. This power entails, among other things, a degree of ownership in the practice that allows them a real voice in its policies. There is a pervasive and seductive illusion, frequently seen in recruiting advertisements, that practice management can be delegated to experts, leaving physicians free to do nothing but practice medicine. The price of such abandonment is a dilution of moral credibility, because inevitably the experts' policies, geared as they are to group behavior, constrict physicians' access to patients, homogenize diagnosis and treatment, and attenuate personal relationships. The pure practice of medicine, unencumbered by policy and management decisions, is as illusory as a marriage without dealing with issues of time, money, duties, child-rearing, and in-laws. The historian Christopher Lasch observed that there are no master mechanics on automobile assembly lines, and I would add that there are no master family physicians chained to 15-minute appointments controlled by someone else.

Autonomy does not imply that physicians cannot work in organized groups, but group practice trades off intimacy for efficiency and is at risk for diluting moral credibility. If the corporation is the form of community within which most physicians are destined to work, it is essential to see that the corporation and its policies are at least as moral as the physicians are expected to be. Medical corporations must become inculcated with the traditions and wisdom of merciful care if they are to share in the legacy of moral credibility that grew out of those traditions.

Intimacy

I presume that no one would argue against the importance of physicians and patients knowing each others' names and being personally acquainted, yet this minimum intimacy cannot be assumed in all forms of modern practice, a great deal of which occurs between and among strangers and is limited to episodes of illness and the professional setting. As a family physician, I would not choose a practice setting that was careless about my identity and did not afford me the opportunity to develop continuing relationships with a group of patients. I am offended by physicians' office buildings with corporate names that have no physicians' names displayed. I object to not having my name printed on my prescription pads. I despise appointment systems that do not make an effort to pair physicians with patients they have seen before.

The intimacy that generates moral credibility is deeper than these superficial items. It takes two forms — professional and social: the former is dependent upon the physician's motivation and interviewing skills and occurs in the professional setting. It might be intense even though the time of the visit is short and when conditions are not propitious, such as emergency departments or walk-in clinics. Professional intimacy, however, even when practiced by experts, is not a substitute for social intimacy that comes from living in the same community where one practices. Other things being equal, commuter physicians miss a dimension of knowing their patients that comes naturally to physicians who live among their patients. Walker Percy[3] explored the differences among familiarity, intimacy, and alienation in his dense but rewarding essay, "The Man On The Train," which uses a commuter as a parable of alienation within a familiar community. The intimacy that heals is only partly, perhaps minimally, a form of expertise. It is also connected to tenure, which is mentioned much too briefly in a later paragraph.

What this boils down to is that the US does not need a new generation of physicians who seek anonymity or join practices that either encourage anonymity or do not support intimacy. Such practices cannot contribute to moral credibility.

Universalism

Something more needs to be said about moral credibility, which I take to mean what Talcott Parsons[4 p 336] described as the degree of trustworthiness in physicians that allows and enables patients to give up the secondary gains of the illness. In the course of evolution of medical practice through the Christian Era, society exempted medicine from some of the constraints of ordinary contractual relationships. In ordinary buying and selling, all parties to a contract pursue their own self-interests within the limits of contract law, which is intended to protect the parties from exploitation by the other. One of the principles of contracts is "Let the buyer beware."

Such an arrangement was seen to be inappropriate for medical transactions in which life, limb, and well-being were at stake. Such transactions are inherently unequal, as are all client-expert relationships to some degree. Moreover, recovery from illness entails a higher degree of self-disclosure, intimacy, and temporary dependency than buying a product or a piece of real estate and therefore necessitates a higher degree of trust than an ordinary sale. For these reasons, there are no examples of medical care systems that are carried on as purely business transactions. Even the crassest medical business organizations couch their services in "caring" terms.

To enhance trustworthiness in medical transactions, society granted physicians special privileges, such as autonomy, self-regulation, control over education, and confidentiality. Physicians accepted higher expectations by setting standards, adopting codes of ethics, and disavowing exploitive self-interest. Also, using the "model of science," physicians became "disinterested" in the sense of detached objectivity as a defense against prejudice, and adopted universalism as a policy to insure that all sick persons would be treated impartially and without respect of persons.[4 pp 325-58]

Patients, on the other hand, to the degree that they accepted these reassurances against exploitation, were freed to adopt the sick role, giving up pretense and deception and their interestedness in being sick by seeking health and following physicians' recommendations.[4 pp 325-58]

Under these social arrangements the entire medical profession elevated its moral credibility, institutionalized benevolence, and pledged allegiance to harmlessness first. Harmlessness triumphed over *caveat emptor*.

Another element of universalism for family physicians is resisting the lure of specialism and further fragmentation of medical care. The *sine*

qua non of family practice is accepting unselected patients with unselected problems, which is a commitment to generalism. We do not have permission to ignore what might be presumed to lie outside our focused interests and clinical hobbies, because we also are committed to comprehensive care. Whatever limited expertise and procedural skills we might develop and nurture should not be allowed to subsume our entire practice. If we lose our interest in unselected problems and patients, we simply will be recapitulating the evolution of mainstream medicine, thereby giving up our claims for funds and other resources to expand our discipline to meet society's needs for more generalists. There is no cogent argument for promoting primary care vocations that do not remain true to the primary care role.

Tenure

While mobility is built into our cultural and social ethos, there can be little doubt that the best general practice occurs when physicians find it possible to practice in one location for a long time. Itinerancy does not contribute much to moral credibility. There are as many reasons to change practice locations as there are for divorce, and I do not imagine that family physicians will find the right location on their first try. But tenure in a practice and commitment to a community have the best chance of demonstrating the full benefits of the generalist's role. Time is an important variable in moral credibility, which entails living with the consequences of one's clinical decisions. Time exposes one's idiosyncrasies and temporary enthusiasms and is the crucible in which character is built. Time changes one's view of patients and their capacity to change in their own best interests. This knowledge is hidden from the itinerant physician, who sees only short-term results and might be tempted to cynicism. All practices tend to have similar problems, and one location is not necessarily better than the next. Wisdom is acquired from working through these recurring problems in one place or another. The important thing is to work them through somewhere. Our idealism should include the intention to stick to our practices long enough to see the accrued benefits of tenure.

Conclusion

This century's transformations of general practice exhibit features in common with other reform movements. Reformers bring vision and energy to their projects, but they are not clairvoyant, and their awareness of what initiated and sustains the reform varies from time to time. Stated goals and objectives properly receive high attention, but their fruition depends upon their attachment to deeper, less visible changes in social, economic, and political arrangements, which frequently are broader than the reform itself. Moreover, things happen that could not have been imagined at the beginning, and reforms have to be revised, relegitimized, and restated by the next generation. Revision, however, ought to be distinguished from mere opportunism, which exploits an advantage and subverts the moral credibility of the reform.

One way of understanding the reform ethos of family practice is that during medicine's historically delayed but intense encounter with forces that rule the marketplace, family practice has allied itself with distributive justice, personal and family-oriented care, and a wholistic approach to illnesses of all types and has resisted fragmentation of care, elitism, and financial exploitation. This is not to claim an exclusive or universal commitment by all family physicians to these values, but collectively they make up a legitimate basis for our expectation of special public support.

My argument in this essay is that family physicians who want to contribute to the continuing moral credibility of the vocation should take these values into account when they deal, as they must, with potential employers and their own ambitions in arranging their practices. Family physicians are as free as anyone else to choose how they will practice, but if the day comes when most of them choose a merely self-interested path, we shall be the worse for it.

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