

The Changing Role of the Family Physician — Nirvana or Waterloo? Third Annual Nicholas J. Pisacano, MD, Memorial Lecture

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My topic, The Changing Role of the Family Physician—Nirvana or Waterloo? poses an interesting question that can best be explored if we first look at our recent past. We are all aware of the cataclysmic changes in the US health care delivery system that have occurred within an incredibly short interval. Three years ago President Clinton, standing before a national television audience, held up a small red, white, and blue card and proclaimed that every American citizen would have a similar card entitling the holder to high-quality health care wherever he or she lived. He implied that this card would be available regardless of the person's ability to pay.

His speech triggered an avalanche of changes in the health care delivery system, unprecedented in dimension, that made public policy an unrealistic solution. We now find that market forces are redesigning a system many considered to be completely out of control and hopelessly flawed as a result of high costs, too many uninsured patients, and increasing difficulties of access. It remains to be seen, however, whether the current strategies (managed care, medical savings accounts, and integrated systems) will address such profound problems. The response to the health care crisis at both the national and state level by legislators and government officials has been to adopt a hands-off approach in favor of a market-driven reform.

The proper role of government in this reform is not entirely clear, but as I observe the market response to the health care crisis, I can say with certainty that some emerging trends will favor family medicine. With some trepidation I shall

describe what I see as likely market responses to health care reform—call it one man's observation into a cloudy crystal ball:

- Managed care will become the overwhelmingly dominant mechanism of health care delivery in the United States during the first decade of the 21st century.
- Health care delivery will move its focus from in-patient hospital-centered care to community ambulatory care.
- Integrated networks of providers, including practitioners and hospitals, will replace the expensive duplication of technology and services, which resulted from an uncoordinated system that fostered competition for a finite patient pool—even in rural America.
- The ratio of generalists to specialists in the medical work force will become dramatically realigned. An increased value will be placed on primary care by academic medical centers, payers of health care, US medical students, and most importantly the American people.
- The historic disparity in income between specialists and primary care physicians will gradually close, but the aggregate amount of money paid to physicians will plateau or decline slightly during the next 10 years.
- Providers, payers, and the public will place unparalleled emphasis on quality of health care.
- All these changes will lead to and depend upon an information system that will collect, distribute, and analyze data in a way that could only be imagined 2 years ago.

It would be tempting to explore these projections in greater detail. Although some would be welcome, and others would seem of little consequence, each trend affords an opportunity for family medicine that our fathers could not have

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imagined in their most optimistic moments; alternatively, each is fraught with pitfalls. I offer them only as background, however, for I want to focus on our responses to these tumultuous changes. To do so, it is important to understand what has brought us to health care delivery reform.

Forces for Health Care Reform

The fee-for-service system with its indemnity reimbursement, which we all grew up believing was the world's greatest health care delivery system, had become to the purchasers so badly flawed that reform was the only viable option. In my judgment, three factors provided the impetus for reform: cost of health care, the number of uninsured Americans, and a variety of problems of access to care.

Cost of Health Care

Clearly, cost is the driving force of reform. When employers realized they had to choose between making a profit or providing health care for employees, and when the country realized that most middle-class citizens were one catastrophic illness away from financial disaster, the path to reform had been charted. I like the way former governor of Colorado Richard Lamm¹ said it, "Alas, we have arrived at that point in America when we have invented more health care than we can pay for." Here the connection to family practice is obvious; family physicians have repeatedly shown they can deliver high-quality health care that is affordable to the average American.

Uninsured Americans

The problem of an uninsured and underinsured population is no longer an abstraction discussed by medical economists and politicians. It has resulted in shifting to payers a financial burden they are no longer willing or able to assume. Research in North Carolina shows that 47 percent of the average hospital bill is the result of hospitals passing along the cost of uncompensated care.²

Access to Health Care

Working in the public policy arena for the past 2 years has led me to the unpleasant truth that in America those who are old, poor, unemployed, living in a rural area, children, or persons of color do not enjoy the same access to high-quality health care that the rest of the citizens enjoy.

These, then, are the major unsolved problems that will continue to drive health care reform until acceptable solutions are found. It won't matter which political party is in control; any solution to health care system reform will include family practice. Although there is a clear need for primary care physicians of all types, it is becoming increasingly obvious to policy makers and managed care chief executive officers that there is no substitute for the family physician when it comes to delivery of high-quality, cost-effective medicine.

Alternative Scenarios

So what does all this have to do with Waterloo? If Napoleon had won the Battle of Waterloo on 18 June 1815 and subsequently the war, a French-based culture would likely have dominated Europe and Western civilization. Napoleon lost this battle because the Emperor himself and his subordinates made many mistakes.

Waiting for a More Desirable Environment

Napoleon's first mistake was to delay his plan of attack until the environment changed. (Does that sound familiar?) This delay gave the Prussians time to join forces with the opposing Anglo-Dutch armies. As it turned out, the artillery he waited for was of minimal benefit.

Our ability as family physicians to adapt to whatever environment we are working in has been one of our greatest strengths. The time we have been waiting for, the time of action, has come. Surely we must take risks, but the rewards are great. Delay and we will be passed over.

Be Careful of the Generalism Banner

The second mistake of Napoleon was to place too much confidence and authority in unreliable and unproved associates. There is a lesson here. As good as they are, as much as we need them, we must not make the potentially costly mistake of ceding leadership of health care reform to the internists and pediatricians, or for that matter to directors of accounting in the managed care operations. Primary care must lead the way in market-based reform, and family physicians must not only lead the charge but plan the battle. Most importantly we have absolutely no business waiting around to see how the land lies. Our moment is now and we must take it or lose it forever.

Take Advantage of New Technology

Another costly mistake Napoleon made was to use inappropriate formation by three of his four divisions. Had he used a better formation—one well-known to the Emperor and his marshals—he would have had far fewer casualties and much greater chance of success.

In this information age it is unthinkable that some practices are still not using computers or other means to connect with the information that computer technology now affords. I'm speaking about computerized records, telemedicine, and access to the information on the cutting edge of science for the benefit of our patients.

Alfons Libert³ of the Royal Military Academy of Belgium and publisher of *The Napoleon Series: An Electronic Magazine Dedicated to Napoleon and His Times*, says:

But the responsibility for his disaster lay with the Emperor himself. He had become arrogant and overconfident in his own abilities. The Napoleon before 1815 would not have lost this battle. He underestimated his opponents and appointed second rate commanders when better men were available. In my personal opinion his greatest mistake was his lack of personal control over the battle.

Not by accident of history or coincidence or serendipity are the insurers, managed care executives, hospital administrators, and even the medical specialists turning to primary care as the champion of the emerging system of health care delivery. Indeed, I believe the destiny of family practice began to move forward at the time those few dedicated general physicians of exceptional vision met in Chicago to form the American Academy of General Practitioners. Their principles still hold true, and it becomes us to honor those principles. Since then, American medical enterprise has been on a direct path toward those physicians who not only deliver high-quality health care in a cost-effective way, but also provide that care with a compassion all too often blunted by a technological approach to medical care, recognizing as their enemy the high-cost overspecialized, technology-driven, hospital-based system.

With appreciation to my colleagues in the other primary care specialties, we, the family physicians, are the heirs of those original general

physicians. Here we are today, 50 years later, about to resume again the key position in American medicine—the foundation, if you will—upon which a reformed health care delivery system must be built. Managed care companies are offering two- or three-fold increases in income, and hospitals and integrated systems are hurrying to buy our practices for twice what our own accountants recommend. Medical students are seeking out our graduate programs in unprecedented numbers, and we have more accredited resident programs than any other medical specialty. Surely now we have reached the pinnacle of success. Almost overnight it looks as though this battle is ours for the taking. We have raced from the back of the pack to win the championship trophy; surely we seem to have reached nirvana.

In the Buddhist faith, nirvana occurs when all debts of karma have been paid, when there are no more challenges to face, when a salvation matching only perfect innocence in its purity has been achieved. It is a point of nothingness, a time when all things begin anew. To achieve nirvana, one follows the eightfold path of understanding; detachment from the material world; living a truthful, pure, and monastic life; always striving to achieve perfection; and meditation on one's behavior and on ultimate truths. In this world, then, if even a semblance of nirvana is achieved, it is a time for action, for inaction will unravel it.

My purpose for being here today is not to spoil the victory parade—God knows we deserve it. My purpose rather is to turn down the drum roll just enough for us to remember the fate of the Emperor of France at Waterloo. To remind us that what should have been an easy victory for Napoleon turned out to destroy him and his vast empire.

Sir William Osler⁴ said, "the physician needs a clear head and a kind heart. His work is arduous and complex, requiring the exercise of the highest faculties of the mind while constantly appealing to the emotions and higher feeling."

In the first Pisacano lecture Dr. Edmund Pellegrino,⁵ in his inimitable style, pointedly reminded us that "we must be very clear about who we are and what we are, and we must resist being something else."

Intrigued by the wisdom of Dr. Pellegrino's admonition, and remembering how tenaciously Dr. Pisacano had held that regardless of whether we had certificates of added qualifications or called

ourselves academic family physicians or country doctors, we were first and always family physicians, I tried hard to distill those indelible values that made family physicians different from the rest of the profession. What values have sustained us during these years? After all, George Santyana said, "Those who cannot remember the past are condemned to repeat it."

As I frequently do at such times, I turned to a handful of mentors—those who in various ways have influenced and supported my own development. Without apology these are my heroes. I wrote to them saying that I was planning to interrupt the celebration of family medicine's success long enough to reflect on those irreducible core values that make family physicians unique and asked them for their thoughts. As always, their response was prompt and profound.

Dr. David Marsland, Chair of Family Medicine at the Medical College of Virginia, reminded me that Dr. Lynn Carmichael⁶ had said it all in the original "Essentials for Residency Training in Family Medicine" published in 1969.

Dr. Marsland then reported that at a recent retreat for the Association of Departments of Family Medicine, the original concepts of Dr. Carmichael were again celebrated with slight modification in a summary statement.

The chairs envision the family practitioner, not as a gatekeeping triage officer, but as a well educated clinician with a breadth of knowledge about health, illness and disease, who understands the interfaces of practice and can manage resources. The role of the family physician will persist as systems of finance and organization come and go, reflecting important principles including:

- Continuity of care
- Comprehensiveness of care
- Accessibility of care
- Health promotion and disease prevention
- Coping with unavoidable ambiguity
- Adaptability to meet the needs of populations under care
- Undergirded by relevant information from multiple sources

The value family physicians represent to health care systems derives largely from these principles, resulting in affordable care and satisfied patients.⁷

There they were, the same principles our founding fathers used to describe our mission,

words like comprehensive, continuity, accessibility, prevention, ambiguity, and adaptability.

Next I quote from my friend Dr. Melessa Phillips, Chair of Family Medicine at the University of Mississippi and female academic medical role model par excellence, who offered what should always be our primary principle, "The patient always comes first." Who for emphasis reminded me that they are always our patients—not payers, consumers, plan members, covered lives, or anybody else's business statistics: "We are our patients' doctors—not their PCPs, providers, or gatekeepers" (D. Melessa Phillips, MD, written communication, 10 March 1996).

Dr. Phillips believes that family physicians have more to learn about life from their patients than their patients have to learn about medicine from their physicians. She closes her list of values with two pleas: She asks that we must not do to the other specialties what they did to us. Adopting the Golden Rule, we should be long on accommodation and very short on memory. I think she is asking us not to misuse this new power that circumstance has brought to malign or denigrate the rest of the house of medicine. Finally, she asks me to tell you that now, more than ever, we in family medicine must help each other remember the fundamental values of our specialty. We need to reaffirm who we are and whose we are.

Dr. Paul Brucker, President of Thomas Jefferson University, offered these additional values. "Strive continually to improve as a clinician. Become aware of new, exciting educational tools for you and your patients as we enter the new information age. Medical decisions are yours and the patient's responsibility—not the insurer's. Be an advocate for your patient. Be honest with your patient, but never close a patient visit without some honest expression of hope" (Paul C. Brucker, MD, personal communication, 18 March 1996).

Dr. Brucker, with a call for unity remarkably similar to that of Dr. Phillips, suggested the political cold war between family practice and the other disciplines is just about ended. We need to work with the other disciplines.

His final message would be that although family medicine is riding the crest of a popularity wave, it should not be complacent. We are far from perfect and should strive always for improvement.

In his response, Dr. B. Lewis Barnett, Chair of

Family Medicine at the University of Virginia, uses the Charles Olson poem "These Days"⁸

whatever you have to say, leave
the roots on, let them
dangle

And the dirt

Just to make clear
where they come from.

Dr. Barnett goes on to predict in his eloquent, metaphorical style that our future behavior will be indelibly affected by how intact we keep the soil of the past around our roots. Without the roots firmly nestled in the soil, we become no more than cut flowers, and we will wither and die. It is the soil and the judicious toil in it that have brought us to this day.⁹

There is absolutely no reason why the best of the past cannot coexist with the best of the present and the promise of the future. Again the refrain of doctor-patient relationship: it is far better to be the advocate of the patient than to merely be the adversary of that patient's disease. The satisfaction of being able to reduce pain and restore function, the intellectual challenge of solving clinical problems, and the endless variety of human issues we confront in our daily clinical practice as family physicians will remain the essence of doctoring, whatever the organization or economic structure of medicine.

There are the defenders of comprehensiveness, such as another of my heroes, Dr. William MacMillan Rodney, Chair of Family Practice at the University of Tennessee. While the propaganda experts and the "spin doctors lobby for control of the dollars within the medical-industrial complex by all claiming to provide comprehensive primary care, it is the family physician who can manage a simple fracture, deliver a baby, care for a child, counsel a single parent, run an office, go to the hospital, and when all else fails, comfort the dying."¹⁰

In delivering this lecture last year, Dr. Paul Young,¹¹ Executive Director of the American Board of Family Practice, cited certain principles we cannot afford to sacrifice. These principles, he said, "are those that have sustained us from our very beginnings": (1) comprehensiveness, (2) continuity, (3) relevance to the community, and (4) the avoidance of hubris.

Dr. Pellegrino¹² said most eloquently and succinctly: "Medicine is, at its center, a moral enterprise grounded in a covenant of trust." This trust can never have a for-sale sign nailed on it. Our first obligation must always be to our patients who trust us at the most vulnerable times in their lives. We can never be commercial entrepreneurs, gate closers, or agents of fiscal policy that run counter to that trust. We have an ethical imperative never to allow greed, inclinations to power, personal pleasure, prestige, or any other self-interest to come before our ethical obligations to those we have taken an oath to serve—our patients. "To know who you are you must look into your patient's eyes and see there your own reflection. You might just see your most benevolent self".⁹

Ella Wheeler Wilcox has captured the sentiment I wish to leave you with today in her poem "The Winds of Fate."¹²

One ship drives east and
another drives west
With the selfsame winds
that blow,
'Tis the set of the sails
and not the gales
Which tells us the way to go.

As we sail these uncharted waters, we must be guided by a moral compass that holds inviolate those principles that have defined who we are. Sometimes the sailing will be rough with the winds of change blowing at gale force straight at our bow — at other times, the wind will be at our stern pushing us along faster than we ever wanted to sail. Let the set of your sails steer you in the direction of those values that made you unique. You are America's finest—I believe you have a moral imperative to sustain the highest aspirations of the people you serve—your patients.

I wish you Godspeed for your journey to perfection—nirvana.

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