

Editorial

Twelve Steps to Consider in Bringing Family Medicine and Primary Care Back to Their Earlier Promises

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Editorial

People are encouraged to have a primary care physician. However, the view from my window (as a long time educator of family doctors and other primary care physicians) gives me a sense that there is a real dilemma involved in this message; Resident physicians are not properly trained and educated to be quality primary care physicians and that the medical care system is poorly structured to provide the services that are wanted, needed, and should be expected. The gap is enormous both in education, provision of services, values perceived by patients, and challenges faced by providers of primary care. If primary care physicians are to be as we are encouraged to perceive them, major shifts in the process of education and medical practice must happen. Let me explain.

Have you ever been disappointed by the lack of time with your family physician or other primary care provider? Does it seem as if he or she just doesn't have the time to listen, really listen to your concerns? Have you left the physician's office not sure what was accomplished? Why do the other staff ask all those questions that your physician used to? Does it seem the computer has taken up residence in the exam room? Is your physician rushed and appears as disappointed as you are in the lack of time allotted to you? Is your physician never calling you back when you leave a message of concern and when called, it is a nurse or other staff?

If the answer is yes to all or most of them, do not be surprised when I tell you that it is rigged this way for financial considerations. Your physician may be unable to provide their very best care within this health care system and oftentimes cannot provide the holistic and comprehensive care you deserve and need. You have a total of 15 minutes with your physician, but that includes the time with a nurse or physicians' assistant: why you are there and the reason(s) for your visit, your medical history, and medications at least. Probably more. Your physician is in a system that rewards this kind of care and pushes away physicians for taking the time to be there for you. Most if not all belong to huge health care systems that are designated as not-for-profit, but profit is their bottom line. You are being provided care in a corporate medical system with all of its deficiencies.

Your physician practices medicine this way for profit for the system, and with little regard for their own needs and desires to be holistic and comprehensive. Your physician learned how to do this in his or her graduate residency. They are required to have 1,650 patient visits during their three year residency, and the residency program determines the scheduling of how this figure will be met. This number of 1,650 patient visits is

determined by the Family Medicine Review Committee (RC) of the Accreditation Council for Graduate Medical Education (ACGME). Residents are seeing patients in their "model residency" (ambulatory care program) which mirrors the reality of how they will practice after graduation. In addition, they are required to serve rotations that take them away from ambulatory care and thrust them into rotations that include surgery, obstetrics, inpatient adult patients, inpatient children, and inpatient care for the sickest elderly. But they will never practice these specialties. They receive little to no training in preventive health, social medicine, family systems, dealing successfully with families, health related counseling, diet and exercise programs, psychiatry, complementary medicine, behavioral sciences, medical ethics, addiction medicine, or psychosocial components of caring for the dying.

No wonder they have to refer so much and generally have to turn their hospitalized patients over to hospitalists for inpatient care. And yet, they carry the burden of a difficult and important profession as best they can; with little support and recognition for their efforts to be a true medical healer. Working one's way through medical analysis and treatment decision making in a patient's best interest is seldom an emotionally secure experience. We also realize that patient's anxiety and fear will permeate the conversation which is made infinitely more emotional by the very human responses of a caring and empathetic physician.

As I look back at my thirty year career as a Behavioral Scientist in a family medicine program, I sometimes wonder at how and why the practice of family medicine has turned on itself. I was there at the beginning of Family Medicine and I gradually saw it turn away from the values of primary care. From the signposts of holistic care, comprehensive care, outpatient and ambulatory care, preventive care, and family oriented care, the training programs to produce physicians to fulfill these signposts deflected from these heady values.

Family Medicine was created in the 70's to counter the medical culture of specialties, and return medicine to the needed primary care first generated by the generalist physicians. Medical School and maybe a year of internship and they were on their way. With the advance to Family Medicine, residency programs were created to produce and teach these new physicians of the future. People such as myself were recruited to teach and train the Behavior Sciences to the residents in training. The Residency Review Committees were established to develop criteria for training and oversee residency programs.

Medical students who were interested in this new holistic form of medicine filled the ranks of the residency programs and

the energy flowed to develop and implement training programs. It seemed the brightest and the most enthusiastic students choose Family Medicine. And the learners were given the time and instruction to become this new type of doctor, based on the old generalist, but filled with knowledge and techniques virtually unknown only 25 years earlier. Hospitals competed for the chance to become training programs, along with traditional specialist programs already existing.

And then the hospitals and their systems became financially single minded, seeing the learners as excellent sources of labor, training programs shortened the time each resident had with each patient, educators came from newly minted family practice programs with no real world time patientbased experience, and the quality of the incoming classes didn't have the verve and interest in a holistic and comprehensive approach. I saw it happen and how it became.

The amount of medical expertise needed is enormous and I am always amazed how medical students can absorb as much as they do in medical school. This is a given. But there is much more since the problems of blending and synthesizing knowledge, continued learning, problem solving, acute diagnostic formulation, and biopsychosocial treatment planning should be at the post graduate level. Unfortunately, such training programs have become too ritualized and verbalized, too intellectualized and too formalized in their wish to be uniform to do so. Institutions that were developed to oversee the programs became too easily influenced by numbers and uniformity. All this, at the expense of training in the wrong components. Teaching obstetrical care when they would not deliver babies, inhospital care while practicing physicians were turning over sick patients to hospitalists, internal medicine when they wouldn't really practice it, inhospital care of the sickest elderly when it was done by geriatricians, and surgery when surgeons did the surgery. Preventive health care and social medicine were eliminated or reduced in time available to residents. Time was lost to outpatient ambulatory care, from psychiatry and from Behavioral Sciences. No real honor given to ambulatory care, no understanding given to family systems, no respect for cultural differences, no medical ethics and little time to see patients for really quality care. Care became fragmented as it had been before and few complained enough or were willing to see what was happening right before them.

Is it too late to reverse the course and get back on track? Yes and no. No if we keep doing it as we have done it already. Yes, if we create a renewal of faith with our patients and families and find new sources of systems based education, learning, practice, and care. I have included twelve steps to consider in doing so. There may be more, but I doubt if there are less. They are not arranged in any hierarchical order of importance.

1. Development of 'healer' within the resident learner

Too few residents are aware of the real emotional needs of sick people. Illness is interpersonal and should not be lived with alone, and physicians must play a significant part of that interpersonal system.

2. Reflection

The work of physicians is generally filled with the anxiety and fears of those they care for. Learning how to think about and reflect on this work requires mentors and guides skilled in

the craft of doing so. Residents deserve and need time to learn how to handle their own feelings generated by these challenging encounters. Time and experience will not do the teaching of reflection. It is not the experience that we learn from, but the reflection of the experience that is the real teacher of such important wisdom.

3. Self-awareness

The need to understand one-self is paramount in any people-caring profession. It must be explored by physicians. Objectivity is a poor teacher and leaves the learner weakened to the rigors of medicine.

4. Emotional depth

Physicians must be full and complete people with standards of empathy, compassion, moral and ethical judgments. Medicine is a fiduciary profession and someone must teach and proctor such development,

5. "In the moment" with sick persons

Physicians must learn the skills necessary to let go of what they haven't done and not anticipate the future to the point they cannot be "in the moment" with ill people and their families.

6. Knowledge of family and culture

Physicians must be trained in family systems and cultural competencies. They are products of their own families and cultures and must be able to understand the ways and values of others.

7. Wellness and healing

Physicians must learn how to help people get well and stay well; medicine is more than relieving symptoms and eliminating illness. Wellness is preventive health and social medicine and learning the skills of healing.

8. Death and life

Physicians have little training in the ability to allow people to leave this earth when they can no longer be here. They need to appreciate and learn the skills and knowledge to provide care and comfort to passing persons and their grieving families.

9. Respect and honor

Physicians must learn to respect their profession if they are to be respected by their patients. Too many do not appreciate the position that patients oftentimes place them in. Too many perceive medicine as a job and a sometimes career, but not a "calling" that requires their deepest passion over their lifetime of service.

10. Reduce the time in training when it is not going to be utilized

Obstetrics, hospitalized patients, inhospital care of the sickest elderly, and devote the time and expertise to outpatient care. Bring psychiatry and behavioral sciences back as important components of family medicine.

11. Relationships and health related counseling

I believe that physicians need and utilize their profession therapeuticrelationships with their patients to enhance patient

care, facilitate patient health, change patient behaviors to increase their selfcare, strengthen patient's quality of life, and promote health behaviors. None of these are billable and therefore do not fit in a busy billable based corporate practice: but they require time and time that is not available within a corporate medicine structure. Procedures, tests, and diagnostic workups are billed and therefore timeaccountable; basic health related counseling, a fundamental component of therapeuticrelationships is not and therefore subtly and not so subtly discouraged.

I spent three decades teaching the values and clinical importance of health related counseling as part of therapeuticrelationships, only to have residents have their time to learn and then practice the skills eroded by the very same educational system.

I believe that after fifty years in psychiatric social work and three decades of it teaching behavioral sciences, that the only relationships that will really effectively change patient's thoughts, feelings, beliefs, and behaviors about enhancing their health care will come from an ongoing and consistent health related counseling experience with their family physician or other primary care physician. Not by referrals to others who are part of the "team", not reading about it, not even joining a support group, but an ongoing set of conversations between a patient, oftentimes with their families, and their physician. The other options facilitate the relationship, but do not take the place of it. Yet, the time to teach, practice the skills, and fully understand the depth of the power of their relationships to effect positive change is neither supported by their training programs, rewarded emotionally, or paid for by most insurance companies and even Medicare. The lack of understanding of this basic truth has permeated all levels of corporate and insurance health care.

But there is more to the process. Not only is a therapeuticrelationship and all its components essential to enhanced patient care, it is necessary in order to provide essential nurturance and succorance to the physicians themselves. Otherwise, they receive little emotional strength and energy from their work, and become assembly line physicians: a violation of their deepest desire to be true healers. With little support from their corporate medical systems and continuous frustration in not being able to fulfill their desires to be true healers, physicians become high risk candidates for professional burnout; a term from the 1960's but updated to include an inability to deeply care about and be emotionally concerned for those who come to them for care.

I am not even talking about those physicians lost to their profession by impairment due to mental illness, alcohol, and drugs. The reality is that we cannot afford the loss of any physician, and yet educational systems seem to do little to strengthen them to the rigors and challenges of a profession such as medicine.

It is fundamental to family medicine and all primary care that therapeuticrelationships be a core commitment to be reintroduced. If not, family medicine and primary care will remain a procedure based subspecialty of medicine, and ultimately fail.

12. Hospital training programs

I have often thought about the possibility of a union type organization to represent residents. The idea itself tends to become a lightening rod for criticism. And yet, systems like

hospitals frequently cannot care for residents in their current environment, and have proven their methods are perceived as disrespectful and even harmful to young people in defense-less positions.

There is much to consider. Family physicians tell me that they cannot survive in the current medical environment as a solo practitioner or in a small practice with other family physicians. They have to belong to megasystems as we have now. It is about finances and the need for being part of a larger system to have the medical support they need to care for patients, even if it is fragmented and unsatisfactory for them and their patients.

Medicine as a profession can be defined as a reference group. Family medicine is a subcultural reference group, and defines family physicians in terms of how and where they practice their art. Unfortunately, family medicine has deviated from its sub-cultural roots and there seems to be little enlightenment to re-evaluate what went wrong, why it happened, and steps to be taken to fulfill its destiny as originally envisioned. Until then, residency programs will not forge ahead with the mission of the past as a guide post. There will be no mentors or guides to show the way, and hospital systems will remain finance-focused because they are not challenged to change. The desire for maximum profits is realized with a full schedule of 15 minute appointments. Giving physicians the time to fully care for patients will reduce the number of patient visits per hour and thereby reduce profits. There is no incentive to change, yet. What will it take?

Let us recant. This not an easy or pleasant assessment for me to make after spending over thirty years in primary care residency programs. The efforts to teach the above twelve principles became alien and discounted to the negatively evolving family medicine.

But there is much more to be rectified. A profit system that hides behind it are not for profit status will never change unless forced to from outside of its sphere of medical influence. Physicians and their staffs will continue to labor in unfair and for profit constraints. Patients will be forced to accept a broken health care set of systems that have sacrificed holistic and comprehensive care for profit. The programs that are supposed to teach to the needs of sick persons and care for their cadre of medical students and graduate residents have failed and in doing so, have prevented their students from grasping the needs of the present and of the future for their patients and for themselves; but continue to teach outmoded concepts in a less than adequate outpatient focus. Finally, the governing bodies that make educational requirements will have to reverse their course of requirements to put them back on track for highly trained outpatient specialists.

The future of family medicine and primary is yet to be. The future of family medicine and primary care can yet be shaped. The real question is where and how will the changes ever occur.

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