

Will people have personal physicians anymore?

Dr Ian McWhinney Lecture, 2017

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In 2005, David Foster Wallace told a short story as part of a commencement address.

There are these two young fish swimming along and they happen to meet an older fish swimming the other way, who nods at them and says, “Morning, boys. How’s the water?” And the two young fish swim on for a bit, and then eventually one of them looks over at the other and goes “What the hell is water?”¹

The point of this fish story is merely that the most obvious, important realities are often the ones that are hardest to see and talk about.¹ It is possible that one of the most obvious, important realities in health care that is hardest to see and talk about in our current milieu is the personal physician and her or his role—if any—in future, properly designed health care systems.

A materialistic and mechanistic medicine

The current milieu is remarkable for widespread, international reconsiderations of the structure, processes, and value of contemporary and future health care and how best to organize and pay for health care as medicine transitions from the industrial age into the information age in a globalized world. This seems to be one of those every-century-or-so shifts in the practice of medicine—not a few tweaks and adjustments. In my country, the United States, there are daily declarations about the lack of quality, safety, and affordability of health care; medical homes; accountable care organizations; interprofessional teamwork; electronic medical records; and ever expanding measurement demands. Our innate human fascination with the new and novel has turned our collective imaginations toward genetic interventions destined to customize each person’s health care with treatments created in factories, robots that render care and comfort, and computers outperforming clinicians and perhaps replacing most of the need for radiologists, pathologists, and maybe physical and behavioural therapists. There seem to be hundreds of media-enabled, self-determined services via intermittently connected devices driven by artificial intelligence, and there certainly is high interest in avatars, perhaps representing ourselves interacting with people and patients for therapeutic and diagnostic purposes.

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Meanwhile, there is a relative neglect of reports and discourse about the role and place of human relationships in health care. It is the exception, not the rule, to detect the historic personal physician and her or his role in current publications and conversations, even while movies, magazines, and news media depict the tribulations people face as they traverse our elaborate, expensive, complicated health care arrangements. In short, amid a cacophony of change and innovation, there appears to be little attention and few efforts under way to ensure that people have a personal physician. Perhaps the personal physician is no longer needed or desired and can be relegated to being another artifact in the history of medicine.

The current milieu is also distinguished by a persistent acceptance, perhaps without recognizing it, of Taylorism. You might recall that Frederick Taylor became known as the “father of scientific management” and also as “the original efficiency expert.” He believed that the components of every job could and should be scientifically studied, measured, timed, and standardized to maximize efficiency and profit. Central to Taylor’s system is the notion that there is one best way to do every task and that it is the manager’s responsibility to ensure that no worker deviates from it. Taylor asserted that, “In the past, the man has been first; in the future, the system must be first.”² Hartzband and Groopman recently reprised Taylorism and claimed that,

Medical Taylorism began with good intentions—to improve patient safety and care. But ... it has gone too far. To continue to train excellent physicians and give patients the care they want and deserve, we must reject its blanket application We need to recognize where efficiency and standardization efforts are appropriate and where they are not. Good medical care takes time, and there is no one best way to treat many disorders. When it comes to medicine, Taylor was wrong: “man” must be first, not the system.²

Taylorism can be seen to be one part of what Walter Brueggemann³ has labeled “totalism,” a reality that engulfs us all, rather like the young fish were engulfed by water. A totalism, according to Brueggemann, always tries to extinguish all possibilities or voices outside of itself—achieving a “silencing,” perhaps similar to the silencing of discourse about the personal physician. Totalism exhibits an unwillingness to entertain alternatives. The United States exemplifies a totalism as a national

security state committed to a high level of consumption and acquisition of things, tolerance of environmental abuse, and American exceptionalism. The United States is committed to market ideology, from whence comes value and a need for advertisements for doctors, health insurance, hospitals, drugs, and devices. Brueggemann also claims that such totalism results in classes of privilege and poverty and dispensable “throwaway people,” and that it prevails through reminders of fear and human susceptibility to promises to be kept safe and happy. This is rather like circumstances in the Egyptian, Babylonian, and Roman Empires, and the 2016 national elections in the United States. Totalism wants memos and production numbers and does not want ambiguity or poetry.³

It seems to me that ambiguity and poetry, as well as tragedy, intimacy, and transcendence, are part of medicine and within the domain and lived experience of personal physicians. Asking if people will have a personal physician and what she or he is good for could be heard as “a voice from outside” medicine’s current evolution that seems to be dominated by an emphasis on commodities and profit and a neglect of personal relationships and actually caring for patients. Some have called this “the McDonaldization of medicine.”⁴

The medicine of relations

Dr Ian McWhinney thought deeply about what it means to be a person and to be a physician committed to helping people in ongoing relationships. He instantiated his thinking through his teaching, role modeling, and writings, and it is entirely to our advantage for us to honour him today by incorporating some of his insights into our further considerations of the personal physician.

In 1975 in the *New England Journal of Medicine*,⁵ Dr McWhinney asserted that while all physicians have some commitment to persons,

the kind of commitment I am speaking of implies that the physician will “stay with” a person whatever his problem may be, and he will do so because his commitment is to people more than to a body of knowledge or a branch of technology The medicine of this century has been the medicine of entities rather than the medicine of relations Medicine always reflects the values of the society that it serves. A materialistic and mechanistic society must expect to have a materialistic and mechanistic medicine. If science is exclusively reductive and atomistic, and maintains an illusion of objectivity, medical science will tend to be likewise.⁵

Then, citing Lewis Mumford, Dr McWhinney agreed that

our machines have become gigantic, powerful, self-operating, inimical to truly human standards and purposes; our men, devitalized by this very process,

are now dwarfed, paralysed, impotent. Only by restoring primacy to the person—and to the experience and disciplines that go into making of persons—can that fatal imbalance be overcome.⁵

He then proposed so eloquently:

To restore the primacy of the person, one needs a medicine that puts the person in all his wholeness in the center of the stage and does not separate the disease from the man, and the man from his environment—a medicine that makes technology firmly subservient to human values, and maintains a creative balance between generalist and specialist.⁵

Much of McWhinney’s legacy focused on patient-centredness, the nature of a discipline and the essential features of family medicine, fallacies that promote overspecialization and accompanying neglect of generalism, and deep respect for human beings. He wrote of the conditions that might provoke revolutionary ideas and full implementation of person-centred care. I believe he would have welcomed and endorsed further consideration of “the personal physician.” So, let’s examine some prior work concerning the personal physician.

A friend with special knowledge

First, let’s agree that our question is an echo of previous considerations over decades. For example, even as Dr McWhinney was contemplating proper care in England, the United States, and Canada in the 1960s, Group Health Insurance, Incorporated of New York, NY, was convening symposia concerning crucial health issues in the United States, including one reported in 1964 focused on the future of the personal physician.⁶ This report claimed the following:

There is growing concern that the fragmentation of care among many specialties may well jeopardize the personal relationship between doctors and patients, built as it must be on long-term cooperation in health as well as in sickness. There is increasing realization that such a close relationship can mean not only quicker and more accurate diagnoses, but also more effective treatment. In addition, although doctors have less “time to listen,” patients have higher expectations of medicine and make more demands of their physicians.⁶

These words from 1963 could have been spoken in the hallways of any medical school in North America today and been considered contemporary.

Let’s return to the more recent past. Many of you have knowledge of an enterprise going on in the United States named Family Medicine for America’s Health, and some of you might be participants in it and know its acronym: FMAH.

The FMAH is the child of all the main national family medicine organizations in the United States. It follows on the heels of the Future of Family Medicine project (affectionately known as FFM) that was precipitated by the third Keystone Conference's conclusion that there was not much of a future for family medicine unless substantial revisions were made to how family physicians are trained and practise.⁷ The FFM was the beneficiary of Canadian leadership in defining a medical home and the basket of services to be delivered on a transformed platform of local health care delivery. Indeed, there were many successes born out of FFM, but overall, the imagined renaissance remains elusive. Instead, there has been continued erosion of the number of people who have a usual source of care and a reciprocal shift of people who do have a usual source of care designating a place rather than a particular physician. There has been expansion of the number and size of medical schools without a revival of student interest in family medicine and primary care, and a steadily shrinking scope of family physicians' and general internists' practices. A widening income gap persists among various medical specialties, favouring specialties that produce commodities, and many celebrate consolidated corporations aiming to be the entity that provides comprehensive care and dominates market share. New experiments are under way concerning how to pay for care. While estimates of the percentage of total health care spending that is spent on primary care vary, they tend to be about 6% to 7%, topping out at perhaps 11% in certain localities. These developments have been accompanied by the rise of a lot of grumpy doctors and a populace confused about how health care can be so expensive but unsatisfying and so challenging to attain for so many.

In this environment and as a preparatory step for FMAH, the national family medicine organizations in the United States proceeded with a rigorous exercise in defining the future role of the family physician, constraining the definition to fewer than 100 words. This was hard work. But it yielded what it was charged to produce and more.⁸ The selected definition is as follows:

Family physicians are personal doctors for people of all ages and health conditions. They are a reliable first contact for health concerns and directly address most health care needs. Through enduring partnerships, family physicians help patients prevent, understand, and manage illness, navigate the health system and set health goals. Family physicians and their staff adapt their care to the unique needs of their patients and communities. They use data to monitor and manage their patient population, and use best science to prioritize services most likely to benefit health. They are ideal leaders of health care systems and partners for public health.⁸

To further contextualize and contrast this declared role from the lived experience of most family physicians, a "foil definition" was also developed:

The role of the US family physician is to provide episodic outpatient care in 15-minute blocks with coincidental continuity and a reducing scope of care. The family physician surrenders care coordination to care management functions divorced from practices, and works in small, ill-defined teams whose members have little training and few in-depth relationships with the physician and patients. The family physician serves as the agent of a larger system whose role is to feed patients to subspecialty services and hospital beds. The family physician is not responsible for patient panel management, community health, or collaboration with public health.⁸

You can see that the definition seen as desirable depends upon the family physician being a personal physician, and that the foil definition does not.

So what is a personal physician? An explanation of the personal physician is available from writings of another contemporary of Dr McWhinney, T.F. Fox, derived from his 17-page manuscript published in 1960 in the *Lancet*.⁹

The doctor we have in mind, then, is no longer a general practitioner and by no means always a family practitioner. His essential characteristic, surely, is that he is looking after people as people and not as problems. He is what our grandfathers called "my medical attendant" or "my personal physician"; and his function is to meet what is really the primary medical need. A person in difficulties wants in the first place the help of another person on whom he can rely as a friend—someone with knowledge of what is feasible but also with good judgment on what is desirable in the particular circumstances, and an understanding of what the circumstances are. The more complex medicine becomes, the stronger are the reasons why everyone should have a personal doctor who will take continuous responsibility for him, and, knowing how he lives, will keep things in proportion—protecting him, if need be, from the zealous specialist. The personal doctor is of no use unless he is good enough to justify his independent status. An irreplaceable attribute of personal physicians is the feeling of warm personal regard and concern of doctor for patient, the feeling that the doctor treats people, not illnesses, and wants to help his patients not because of the interesting medical problems they may present but because they are human beings in need of help.¹⁰

This composite definition of the personal physician from Dr Fox's 1960 article was the basis of the Preparing the

Personal Physician for Practice educational innovation project sponsored by the American Board of Family Medicine and the Association of Family Medicine Residency Directors that invited residencies to redesign as their imaginations would allow to produce a great personal physician.¹⁰

There is another definition of the personal physician for which I have great affection, attributed to the famous author John Steinbeck, lifted from a letter he wrote to doctors to explain what kind of doctor he was seeking after the death of his personal physician. He said he was looking for a “friend with special knowledge.”¹¹

The person at centre stage


In the milieu that I have described and building off of the 2014 role definition of the personal physician, a fourth Keystone Conference was held in June of 2015, sponsored by the American Board of Family Medicine Foundation.⁴ The organizing question for this conference was “What promises might personal physicians appropriately make and keep with their patients, going forward in transformed systems of care?” The participants in this extended conversation came from various disciplines, backgrounds, and generations, and included Canadians that you may know: Rick Glazier, France Légaré, and Walter Rosser. The preparatory materials, recordings of all plenary sessions, and brief video clips useful in teaching situations can be found at www.gayleststephensconference.com, and the results of this exercise were published as a supplement by the *Journal of the American Board of Family Medicine (JABFM)* and are also freely available online (www.jabfm.org/content/29/Supplement_1.toc). This conference resulted in promises to be held accountable, be present, be clinically competent, meet and delight in patients, pledge undivided time, maintain a broad scope of practice, and work with patients to maximize their health and well-being.⁴ The published promises are organized into the first table in the *JABFM* supplement.⁴ My personal favourite was offered by the youngest physicians in attendance, writing about family medicine’s countercultural heritage and rediscovering relationship-centred care and social justice. This promise begins with: “First and foremost, we will be unwavering in our commitment to relationships, to flatten the power differential between patient and health team, and to be present especially at those critical transitions of care when our patients need us most.”¹²

For those of you thinking about actions to take concerning the personal physician, there is a “personal doctoring manifesto” prepared and published by conference attendees in the Keystone IV *JABFM* supplement.¹³

In conclusion, let’s return to that New York symposium in 1963 and closing remarks made there by Charles

Frankel, PhD, Professor of Philosophy at Columbia University in New York.

It seems to me that the personal physician is essential Almost every social problem I know would be easily solvable if there were no human beings involved. And most medical problems, too, would be easy if there were no human beings involved. They would be easy because, even if you were wrong, nothing of great value would have been lost. But so long as human beings are involved, and the presence of the patient as an individual living human being is taken to be a matter of some importance, the future of the personal physician had better be guaranteed.⁶

I agree with Dr Frankel, and I believe Dr Ian McWhinney would have agreed with him. I hope that many of you will also. If not, what do you believe will be the way the next version of medical practice will meet the needs of persons in difficulties seeking medical help? If so, what do you think is needed “to guarantee” the future of the personal physician? 

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Competing interests

None declared

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