

# The work of the family physician

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## Summary

*Family Practice is seen as having two dimensions: the job and the work. At the level of the job the doctor is assured of an income; at the level of work his input and his reward come indirectly and involve a great deal more.*

*The changes in American medicine are discussed, considering the costs involved, the role of hospitals, the excess of physicians, the influence of competition and corporate capitalism in medical care. Finally, it is argued that medicine should continue to be a moral discipline; else it becomes the exercise of raw power, ultimately inhuman and demonic.*

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***A job is what you force yourself to pay attention to for money. With work you don't have to force yourself. Work is paying attention to what matters most.***

Right at the beginning, I wish to establish a distinction between the *job* and the *work*.

The parameters of our job are well known. We are predominantly an ambulatory specialty though American FPs spend about 25% of their work week in hospital settings. Americans make more than 1/2 billion office visits to doctors annually and visits to general and family physicians account for one-third of this total. Our practices are broad in that we see 33-40% of the patients in every age category from childhood to old age. We are the largest single source of care for the elderly. More than half of us practice obstetrics and we share with general internists and general surgeons the broadest spectrum of diagnostic entities.

This is our job, one that is not unfamiliar to you, but it is not about this that I wish to speak. Important as it is, there is something more important and that is our work. What is the difference?

***Important as the job is, there is something more important and that is our work.***

In elucidating this difference, I am drawing on an article that caught my attention recently in a non-medical journal and authored by a non-physician, a teacher in a seminary.

This author referred to a book that may be familiar to you, "*The Snow Leopard*" by Peter Matthiessen and George Schaller'. Their job was studying the habits of Himalayan blue sheep, but in the course of that study, one of them saw one of the rarest and most beautiful of the great cats, the snow leopard. Studying and following the blue sheep became a cover for a more elusive reality. The job legitimized a deeper and more meaningful activity. The author wrote:

"A job is what you force yourself to pay attention to for money. With work you don't have to force yourself. Work is paying attention to what matters most. A job can be only tangential to that . . . There is always a dialectical tension between the dull ordinariness of one's job and the vivid encounters sought in one's work . . ."

"Only a handful of people have ever seen the snow leopard in its natural habitat. It hides so well that one might be staring at it from within a few yards and yet not see it. Curiously, the ones who have seen the beast are those who have not directly gone looking for it, but instead have most carefully engaged in simply studying the blue sheep. Since the leopard principally feeds on these sheep, it can best be seen by those who painstakingly devote their attention to that animal's movements. The gift of mystery then comes indirectly as a function of plodding, inglorious labour. The vision is distinct from the job, it happens of its own accord. But it comes in the very process of attending to the job, with all its aching drudgery."

***The gift of mystery comes indirectly as a function of plodding, inglorious labour.***

What are the "snow leopards" of family practice? What is it that we have the opportunity to discover or experience in the course of our daily job?

There is the trust of a child who discovers with surprised relief that an encounter with a doctor need not be painful or threatening. There is the relief of a mother in labour who feels that the doctor will see her through, no matter what happens. There is the gratitude of the elderly person who finds that life can become more comfortable and that death can sometimes be postponed. There is the joy of understanding that emerges when a psychologically distressed person gains insight into his problem behaviour. There is a new meaning to professional friendship in a person who gains control over a debilitating habit of drugs and/or alcohol.

A transformation occurs in the life of a physician from "life saver" or "disease fighter" to healer and carer. We all know the magical moments and more, but the problem is that we have not been able to talk about them effectively within the broader profession of medicine.

***We all know the magical moments but we have not been able to talk about them effectively within the broader profession of medicine.***

Is General Practice hard or soft? Is Family Practice —

- difficult or easy;
- hard or soft;
- trivial or significant;
- superficial or deep;
- minor or major?

The answer in each case is "Both" and is contingent upon who asks and who answers. The time is long past when we can allow others to pose the question in a way that prejudices the answer.

***We are the only ones who can cheapen our work by failing to see it's deeper dimensions or by withholding our moral commitment to our task.***

It is we who must query ourselves and decide how we wish the question to be answered. What do we understand our work to be? How do we think we are performing it?

In the final analysis, we are the only ones who can cheapen and trivialize our work by failing to see its deeper dimensions or by withholding our moral commitment to our task. If we are careless, indolent and preoccupied with self-interest, we cannot then be surprised when others judge us adversely. Even then the work would not be diminished, rather it would remain undone or left to others.

### REACTIONS TO THE TIMES

What impresses me most about conversations with colleagues nowadays is the earnest conviction we all seem to share that we are living in a time of unprecedented change in the medical profession and the conditions of medical practice. Some view the changes with regret and a certain sadness at the passing of an era that, while far from tranquil, presented calculable problems that they have dealt with more or less on even terms. These face the future with a guarded optimism, founded on their past successes but tempered by their declining energy in the face of greater uncertainty. Others are alarmed at what they believe to be signs of the Apocalypse and plan to retire as soon as they can. A few see the changes as opportunities to be grasped and are busily engaged in discovering the best handles to assure their future security.

Most of the people I talk with, however, seem mainly bewildered about what is happening and what is about to happen. They read and listen to the media, they go to meetings and hear both the sirens and the doom-sayers, but they don't quite believe either. They worry some and they hope some as they try to make sense out of what they see and hear. They are neither panicked nor in despair, but they do not overestimate the future. They are baffled more than defeated.

***In this time of apparently unprecedented change colleagues "worry some and hope some" as they try to make sense out of what they see and hear.***

### WHAT'S NEW?

Several years ago a dermatologist of my acquaintance used to give an annual CME lecture titled, "What's New and What's True About What's New in Dermatology? I will borrow this theme for what follows.

My perceptions may not be the same as yours, but let me see if I can summarize a few widely held opinions without, for the moment, arguing them.

1. Health care costs are disproportionately and unacceptably high and must be controlled, if not reduced; else the system and possibly the country will become bankrupt.
2. Hospital use and costs must be the focal point of control, and if possible about 10% of the nation's hospital beds should be eliminated.
3. There is a growing excess of numbers of physicians in all but a few specialties.
4. There is widespread extravagance, waste, inefficiency and lack of cost-effectiveness in health care.  
Some of this can be reduced by greater emphasis on outpatient and preventive care, lifestyle change, and increased individual responsibility for personal health.
5. Federal health policy currently is to promote competition in the medical market place to provide economic incentives for cost-consciousness among both providers and consumers.
6. Corporate capitalism is entering the medical care arena in an unprecedented order of magnitude.
7. There remain important inequity and injustice in the distribution of health care services, notably to the poor; the medically indigent, the unemployed and the aged. This item is not new but its continued reality is of such importance that it needs to be kept before us.
8. The "cottage industry" phase of individual entrepreneurship in medicine is dying if not already dead.

Undoubtedly each of you would have constructed such a list differently but I assume that most of the items would be included in some way.

### WHAT'S TRUE?

What's true about what's new? I doubt that anyone would be willing to take this, or any other list as either complete or completely true. These items represent my perceptions of trends and developments in a highly dynamic field of disequilibrium.

Some of these changes may actually be *illusory*, or their magnitude may be exaggerated. Philip Rieff<sup>2</sup> wrote:

"Novelty is not necessarily truth, although in a commercial culture, administered by salesmen, it may seem so." (p. 160)

In a time of apparent rapid change the news of change has a way of magnifying our sense of change out of proportion. Our media are so capable of over-kill, our sense of chaos is so powerful and our fears so horrifying that we mistake news for reality and journalism for history. We are so ready to believe the worst that merely mentioning it gives a quality of 'fait accompli'.

*Some changes may actually be illusory or their magnitude may be exaggerated.*

As an example of this phenomenon I refer to an article, "The Maytag Repairman Syndrome" by Harvey M. Sapolsky<sup>1</sup> from M.I.T.

"For at least the last decade, predictions have been frequent that our health care system would soon collapse under the burden of rising costs. And yet the system keeps perking right along, grinding out ever larger numbers with which to amaze us . . .

As a consequence we who are trained in CPR (Comprehensive Policy Restructuring) have nothing to do . . . We have not been called upon to apply mouth-to-mouth resuscitation to the health care system or even the Heimlich Manoeuvre at one of its frequent banquets. And it is getting to look as if we never shall." (p 139)

Sapolsky analyzed two often repeated dramatic statements about the costs of health care to industry:

- a. that General Motors buys more health care than steel
- b. that \$2 000 of the base price of a new Ford represents the costs of health benefits to the manufacturer.

His comments are that while General Motors does buy more from its health insurers than from U.S. Steel, it also buys steel from more than 1 000 suppliers so that "there is still a lot more steel than health care" in a GM car. Further, the \$2 000 represents the annual cost of company-paid health care services for the average auto worker and family, in line with the 5-6% average proportion for health care in relation to wage/benefits packages paid throughout American industry. "The average cost of health care in a new car is \$200 to \$300, depending on the model, not \$2 000."

He and his associates interviewed executives from 69 major firms employing more than 6 million workers and providing health benefits to more than 12 million people, and came to the following conclusions.

1. Firms were not apoplectic about health care costs.
2. For many firms health benefits in particular and labor costs in general are not significant costs.
3. For firms with important labor costs there are other options for economy besides cutting benefit costs.

Moreover only 4 of the firms interviewed were attempting to save costs through redesigning health benefits intending to increase the cost of health coverage to employees. Few of the firms attempted tight claims control for fear that this would be interpreted by employees as management harrassment; also they did not want to risk offending health care providers who may also be customers for the firm's products. Few firms expected that HMO's would provide great savings.

Sapolsky concluded, "Based on that study, I am convinced that high costs alone are not likely to precipitate the crisis necessary for systems reform very soon." (p. 143)

I do not conclude from this reference that the costs of health care are not an important factor in the current maelstrom of change, rather that they may be over-rated. This is one example of illusory change.

**INVISIBLE CHANGE**

In addition to illusory change there is another phenomenon that is always present in society which I will call invisible change. This refers to the deeper, more hidden changes, often more powerful than the apparent changes.

Keith D. Martin<sup>2</sup>, in a recent article, "Setting Economic Policy in the Real World", described seven characteristics of today's emerging political economy "that appear to be invisible to those now setting our course." (p 130)

1. *A Global Economy*

It is no longer feasible to imagine that any nation can attend only to its own internal economy. A 'worldeconomy' is emerging that demands the recognition of national interdependencies. U.S. interest rates affect developing nations and the balance of trade in ways that threaten the solvency of some of our leading banks.

2. *Increasing Concentration of Corporate Power*

In the U.S. 400 of the largest multinational firms account for about half of our gross national product and 800 of our 14 million businesses control 70 percent of the market, "making something of a mockery of traditional free enterprise values such as consumer sovereignty and a self-regulating economy that serves the public interest."

3. *The Quality and Quantity of Economic Growth*

Growth must be seen as occurring within the limits of the earth's resources. Currently, growth *per se* is all that seems to matter, whether it is in the number of video arcades or hospices. "Robert Kennedy once observed that our gross national product measures everything except that which makes life worthwhile."

4. *The Contentious Society*

American society today is characterized by contention rather than community. Instead of utilizing government to develop methods of cooperation to create new wealth we have made it into a referee in the fight to divide the wealth that already exists. "Merger mania" is one of the evidences of "paper entrepreneurialism". "We are losing the competitive struggle because we cannot work together."

5. *Inequality*

The economic and technological changes we are experiencing threaten to exacerbate, not narrow, the difference between the wealthiest strata and the rest of society. McDonald's now employs more people than U.S. Steel, and at much lower wages. "High-tech" industries will provide less than one half the manufacturing jobs lost in the last 3 years. Much of the work in 'high-tech' is actually low-tech and not well compensated. Jobs can no longer be viewed as simply by-products of a market system. Are we incapable of producing adequate employment for our population?

*continued overleaf*

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***Invisible change, though hidden, is often more powerful than the apparent changes.***

6. *Starvation of the Public Sector*

"... especially in times of transition, only government can provide the right things that are necessary to cope with rapid change: education, physical infrastructures, a compassionate and comprehensive system of economic security. All the private capital investment in the world will do little good if the societal base is made of sand... We continue to pursue policies based on the misguided assumption that only the private sector invests while the public sector does nothing but consume."

7. *A Morally Deficient Vision*

"The real crisis of our times is not economic but ethical. The sad truth is that we are captives of a morally deficient social vision. Poor-mouthing has become so much a part of our national rhetoric that we tend to forget the reality. We remain an incredibly wealthy country with plentiful human and natural resources." Somebody needs to take the lead in lifting up the moral content of the economic decisions that must be made in this decade and beyond.

***'The real crisis of our times is not economic but ethical. We are captives of a morally deficient social vision.'***

I take Martin's seven points to represent, in both a positive and a negative way, the terms of the larger national debate in which the health economy debate is embedded. On one hand is the view that the American economy can prosper in splendid isolation from the rest of the world and that big business rather than big government is the proper vehicle to bring about a sparkling recovery. On the other, there is concern about international relations, equity, ecology and matters of the human spirit. I do not take these views to be the exclusive property of either major American political party. They are equally issues in the rest of the world--on both sides of the iron curtain.

Harvey Cox<sup>9</sup> sees the debate in world perspective as between what he terms modern and post-modern understandings of human culture. Modernism is the child of the industrial revolution and the enlightenment and has been working itself out in all fields of human endeavour for 300 years. Its validity rests on what he calls the 5 pillars of modernity.

1. "sovereign national states as the legally defined units of the global political system;
2. science-based technology as the 'modern' world's principal source of its images of life and its possibilities;
3. bureaucratic rationalism as its major mode of organizing and administering human thought and activity;
4. the quest for profit maximization, in both capitalist and allegedly socialist countries, as its means of motivating work and distributing goods and services; and
5. the secularization and trivialization of religion and the harnessing of the spiritual for patently profane purposes, its most characteristic attitude towards the holy." (p 183)

It is not difficult to see how Martin's and Cox's statements are reflected in the changes that are now occurring in American medicine. Medicine perhaps more than most professions deals in the most personal way with how ideology impacts individual lives. It represents a final common pathway for the demonstration in practice of political and economic theories and policies.

***Medicine deals in the most personal way with how ideology impacts individual lives.***

German theologians have a concept of 'Heilsgeschichte', the history of salvation, to refer to that thread of historical development that represents God's acts and will. If you don't like a theological analogy perhaps an evolutionary one will do. In the age of dinosaurs who would have thought that the future belonged to the small mammals scurrying around in the underbrush at their feet?

In Cox's terms nationalism, scientism, bureaucracy, profit-maximization and secularization are the contemporary dinosaurs; they appear unimaginably huge and permanent but they are already *passée*. Changes are already at work in the world that will undermine, subvert, transform or replace them. How ironical that modern medicine should be taking on forms that are already out-moded and that cannot solve the problems being addressed! How can anyone believe that industrial capitalism will do better in health care than it has done in energy, farming, newspaper publishing or even automobiles?

**THE UNCHANGED**

I have dealt with apparent change, illusory change and invisible change. Now I want to say something about what has not changed.

*The Human Predicament*

While the external circumstances of human life have changed a lot the conditions of human existence have not changed at all. Life has always been lived under the sentence of death and pain; sickness and suffering are the lot of everyone. We are governed by chance and necessity and everywhere we are victims of evil and absurdity. We are unjust, violent and exploitive. But we are also the only animal that laughs and cries, the only maker of myths and the only bearer of hope.

*The Condition for Cure and Care*

Pellegrino<sup>6</sup> has written that the fundamental characteristic of clinical medicine is wounded humanity seeking cure at the hands of a physician. This is not the same as a consumer purchasing a commodity. The therapeutic relationship has never been equal. Woundedness makes the difference. The contract is not enough, there must be a covenant that goes beyond what anyone has a right to demand and that cannot be compensated with money.

***The therapeutic relationship has never been "equal". It goes beyond what anyone has a right to demand; it cannot be compensated with money.***

***Cure and care always occur within the context of a community.***

Moreover, cure and care always occur within the context of a community of belief, trust, grace and reconciliation. It is only within a community that people can be known by their names and that their actual historical existence can be taken into account. It is only a community that defends each of us from the loss of self-hood and the despair that accompanies such a loss.

No matter how the system is organized, who pays the bill or how it is paid there must be a relationship of intimacy between doctor and patient, else medicine becomes the exercise of raw power, ultimately inhuman and demonic.

Medicine must continue to be a moral discipline because it has intrinsic connections with substantive human values. There can be no good life without cure and care.

Martin Buber<sup>7</sup> described an event in his own experience that shows the fateful consequence of an impersonal encounter.

"What happened was no more than that one forenoon I had a visit from an unknown young man, without being there in spirit. I certainly did not fail to let the meeting be friendly, I did not treat him any more remissly than all his contemporaries who were in the habit of seeking me out about this time of day as an oracle that is ready to listen to reason. I conversed openly and attentively with him—only I omitted to guess the questions which he did not put. Later, not long after, I learned from one of his friends—he himself was no longer alive—the essential content of these questions; I learned that he had come to me not casually, but borne by destiny, not for a chat but for a decision. He had come to me, he had come in this hour. What do we expect when we are in despair and yet go to a man? Surely a presence by means of which we are told that nevertheless there is meaning." (p. 13)

What does all this have to do with Family Medicine as an academic discipline and as a vocation of practice? I have already warned you that I have no crystal ball. I simply do not know what is going to happen. I suppose that one way or another we are all going to work in a medical supermarket and that is not a happy prospect. But my reading of the past tells me that the supermarket will not be the final stage in the evolution of medical care. Besides, I think that even the supermarket may not be completely beyond redemption.

It is time to remember our own development. We comprise a discipline today because we responded to social change. Now it appears that we were only dimly aware of the magnitude of change that was going on around us. While we were preoccupied with gaining academic legitimacy we were being upstaged by the development of urgent care centers. While we were learning about family care and behavioral medicine the country became entranced by heart transplants and advanced

techniques of imaging. While we were worried about cost-effectiveness our specialty colleagues were becoming millionaires.

Does this mean that we were wrong, misguided or naive? I don't think so. Let us not be stampeded into giving up what we know to be true about doctoring. It seems to me that our biggest problem is not lack of money, money for training or compensation for services. Neither is our problem the lack of need for us and those who will come after.

***We comprise a discipline today because we responded to social change.***

Perhaps our role in medicine and in society is that of salt or yeast. Perhaps we can be the bearers of the public servant tradition in medicine. Can we find better ways of serving the underserved—which is what we started out to do? Can we keep our commitment to the poor, the handicapped, the rural, the inner city, the aged? Can we move the front door of the House of Medicine closer to the people? Can we become patient advocates within or against the system? Can we be trusted with intimacy and necessary dependency? If we can stay close to people, avoid elitism and upper classism I believe that the people will sustain us. Who else have they got to turn to?

I do not believe that people's needs for care and cure can be bought and sold, traded and leveraged in corporation board rooms and stock exchanges.

Health care is now a bull market, the high tech investment darling of the 1980's, promising windfall profits, like IBM in the 60's and OPEC cartels in the 70's. The vision is exhilarating; of consortia, holding companies and networks of hospitals, insurance companies, HMO's, IPA's PPO's, etc., etc. Corporation medicine is licking its chops at the prospects of a medical bonanza based on ever more spectacular repairs of broken and aging human machines.

***Ironically, modern medicine seems to be taking on forms that are already out-moded.***

Part and parcel of this vision is the physician as expert, human engineer, dispassionate, instrumental and interchangeable; commuting to the ivory palaces from the swimming pool suburbs and hot-tub-country estates in fantastic cars to wield the amazing equipment of repair.

It is a heady vision, a high trip, far removed from the squalor that breeds disease and the lonely horror of death that sooner or later comes to all, even to the experts and their corporate masters.

On the contrary, healing is not done by battalions, but one at a time, and I choose to believe that there will always be a place in medicine for the doctor who chooses to share the brokenness and suffering of persons, who knows that death is not the worst enemy, that suffering can be redemptive and that healing can only occur within community. I hope that some of you share *that* vision.

*References on page 239.*