Mourning Dr Welby

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(March Welby is dead. It must be true because so many smart people say so in speeches or articles about health care reform. Indeed, we are now almost a decade into a redesign of primary care in America, and many of the familiar attributes of 20th-century family medicine have been relegated to the history books. More of us now practice as employees in large groups or health systems than in small, physician-owned businesses. Few of us manage our own office laboratories or x-ray facilities. More than half of us now use electronic health records, and we are learning to work in interdisciplinary teams. Most of today’s family physicians came of age after “Marcus Welby” ended its run as a popular television show; many of us are not so sure what Dr Welby stood for anyway. So we assume that “Marcus Welby is dead” means that family physicians no longer work all the time, no longer try to do everything, and no longer work without the support of 24-hour emergency room coverage. So, we cheer Dr Welby’s demise and look ahead to better days.

In this issue of Family Medicine, we publish two papers that provide glimpses into the changing nature of our discipline. In a paper describing residency graduates in South Carolina before and after residency work hours limitation, Carek and colleagues tell us that although graduates remain confident in their skills, significantly fewer take call after hours, care for patients in the hospital, make home visits, or care for patients in nursing homes.1 In a survey of family medicine faculty in Pennsylvania, O’Gurek and colleagues report that less than half of those surveyed participate in home visits, hospice care, nursing home care, or maternity care.2 Is this what people mean when they say “Marcus Welby is dead”? Does it mean that family physicians are no longer available after office hours and no longer visit patients when they are admitted to hospitals or nursing homes? Is this something to cheer or something to mourn?

Caring for patients regardless of where they are located has been called geographic continuity of care.3 For 40 years, every family medicine residency graduate has been taught that after-hours coverage and nursing home visits are essential elements of practice. I doubt that many of us have given much thought to why this ACGME requirement exists; it has always been an unspoken value in our discipline that the relationship between family physician and patient should transcend the time of day and the location of care. Speaking about the role of the family physician at the Keystone Conference in 2000, Phillips and Haynes emphasized the traditional value of being present with patients at important moments in their lives stating, “You can pretend to know, you can pretend to care, but you cannot pretend to be there. It is by being there that family physicians provide the things patients seek; touch, trust, understanding, comfort, and healing.”4

Their comment was one of the most memorable moments at the conference, and it was not controversial at the time. Do we still believe this is true? It is time consuming to visit patients in settings outside the office, and it certainly is hard to justify economically in a world of fee-for-service reimbursement. On the other hand, we know that serious errors are common when patients move from hospital to nursing home to home, undermining safety, increasing cost, and harming patient satisfaction. It’s entirely possible that geographic
continuity of care could become an essential and economically viable element of a reformed health care system. Perhaps family physicians who do not provide this care have teammates who do. When is personal presence essential, and when do teams work just as well or even better? We have little evidence to guide us, but the answer may depend on what kind of doctor-patient relationships we want to have.

Most of us chose to be family physicians seeking enduring doctor-patient relationships. The building blocks of such relationships are memories that are assembled over time into stories. Shared experiences define the plots of these stories, and the list of characters includes the patient, family, and physician. Today, we are adding other members of our care team to the list of characters. This could either make the stories richer or cause them to unravel. But the family physician cannot remain a character in these stories if he or she is not present when they take place. Although we might be able to reduce errors by closely collaborating with nursing home doctors and hospitalists, we risk losing a lot if we take shortcuts when it comes to being present for the critical events in our patients’ lives. Team-based care should be an extension of our relationships with patients but cannot substitute for them.

We now have sophisticated information and communication tools that would astound Marcus Welby, tools that make it easier than ever before to be connected to patients and to others on our care teams. Isn’t it ironic that our personal connections to patients seem to diminish as the tools to maintain them improve?

References