Responsible and Capable Family Physicians

John Saultz, MD

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For the past decade, our discipline has focused on building a new model of primary care characterized by teams of health professionals delivering patient-centered care that is more population accountable. With so much debate about “care teams” and “patient-centered medical homes” (PCMH), it has become unfashionable to talk about the physician. Perhaps this is to be expected. Many have criticized 20th century medicine for being too physician centered, so we have focused less on physicians to change the balance. But in doing so, we have delayed confronting some major questions about the physician’s role in our new model of care. STFM aims to be “the indispensible academic home for teachers of family medicine.” Because our principal business is training physicians, it is time to address these questions.

My parents are now 85 years old and have received care from the same family medicine practice in their small Midwestern town for their entire adult lives. When their doctor retired about 15 years ago, they started seeing the physician who took over his practice. They are not satisfied with his care. When my father was recently hospitalized, they heard nothing from their family physician. My mother thinks her family doctor is “just a middle man” providing her with one referral after another. Obviously, this troubles me as their son. It also bothers me as a family medicine leader because the choices made by one of us affect all of us; we cannot expect the American people to seek care from family physicians if there is no consistency from one practice to the next. So we need to agree on and live by some basic principles. It seems to me that the family physician’s role hinges on two crucial factors: responsibility and capability. As primary care transformation takes place, there are major questions in each of these domains, and we are overdue in getting them out in the open for debate.

Responsibility refers to the physician’s role in the covenant between patient and doctor. The advent of team-based care suggests that the primary unit of responsibility should become the team rather than the individual. This is a serious misunderstanding of how teams should work. Working in teams can make our care safer and more efficient, but it does not follow that the physician can be less responsible in this new model of care. For trusting relationships to occur, family physicians must remain responsible for everything that happens to our patients all of the time. We have always shared this responsibility with our partners when they are on call for us. In much the same manner, we can share responsibility with the nurses and medical assistants on our teams. Similarly, we have always shared our responsibility with specialists when we refer patients to them. But we remain the patient’s primary physician, so this must be reflected in how carefully we choose our partners and consultants. With teams, patients can have close personal relationships with their nurses, receptionists, and medical assistants as well as with their physicians, thereby improving on our traditional care model. Responsibility is expanded, not shifted.

Discussions about responsibility often seem to degenerate into a debate about the scope of our practice, but these are not the same things. Scope of practice is about what we do; responsibility is about our covenant with the patient. Most of the time, patients readily accept other
team members as extensions of this covenant. They understand that we cannot be available all of the time. For routine matters, they just want to know we are informed and that they can trust the team as an extension of our professional responsibility. But sometimes they want us to be there personally. It matters to them if we are present when their lives are at risk. They want us to be with them when they are afraid or confused and, at such critical times in their lives, may consider the team to be a poor substitute for their personal relationship with us. Our teams are an extension of our personal commitment to the patient, not a replacement for it.

Most threatening to confront is the essential need for the new family physician to be fully capable of caring for sick people in our communities. Many of us hope the PCMH will expand our scope of practice to include population and community health. We are adding new competencies to our residency programs to address these goals. Physicians in the medical home need to know about data registries and sophisticated models of care coordination, but we are in the medical home to work as physicians, not just as care managers. It is easy to send people to the emergency department or to consult specialists when they need a physician rather than being that physician. The cost-effectiveness of the PCMH will depend on our ability to be fully capable physicians when our patients are sick. We want each of our team members to practice “at the top of their licenses,” but too often fail to practice at the top of ours. This cannot continue if we want the PCMH to achieve its full potential.

So, what can we do about these problems? The first step is to think carefully and talk openly about them. Family physicians are working very hard to adapt to new information systems and new models of care. We are not lazy, but we don’t often take time to consider the ramifications of the choices we make. STFM is committed to creating a forum for these discussions. The second step is to listen to our patients, many of whom have clear expectations of us. The third step is to work together to define the responsibilities and capabilities of a 21st century family physician. In the coming months, you will hear about a national planning process called Family Medicine for America’s Health: the Future of Family Medicine 2.0 (FFM 2.0). Sponsored by all of the family medicine organizations, this project will update the strategic plan we created a decade ago in the Future of Family Medicine Project. FFM 2.0, along with our ongoing efforts to establish Milestones and Entrustable Professional Activities for our training programs, will provide frameworks for these conversations.

Finally, we need to live up to our own rhetoric and hold each other accountable rather than blaming the reimbursement system or health reform process for the changes underway in our practices. Practiced properly, family medicine is the most demanding job in all of medicine. This is why many of us chose this path, but we have to work together to make the path relevant to the next generation. The best and brightest medical students want to be responsible and capable family physicians for their patients and communities. Now more than ever, our country needs such physicians.

CORRESPONDENCE: Address correspondence to Dr Saultz, Oregon Health & Science University, Department of Family Medicine, 3181 S.W. Sam Jackson Park Road/Mail Code FM, Portland, OR 97239-3098. 503-494-7206. Fax: 503-494-4496. fmeditor@ohsu.edu.

References