Myth-Information About Family Medicine: Is Fiction Better Than Truth?

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Like the moon, family medicine seems to go through periodic and predictable phases of high visibility and near obscurity. In the eyes of the public and within our academic institutions, we seem to go from being praised as the foundation of our medical system to being called expendable and replaceable by nonphysician providers. The only thing stable about our discipline seems to be its instability.

As a business, one would expect that family medicine would go through economic cycles. In general, each economic boom is followed by a bust, and each downturn gives way to a recovery. Even industries that seem to defy economy gravity, such as the high-tech industry in the 1990s, eventually return to earth. And, most industries that experience periodic economic doldrums usually turn things around—except for those that have outlived their usefulness (like horse-drawn wagons) or face competition from innovative new products (think typewriters).

Compared to most industries, medicine as a whole is seemingly immune from cycles of growth and recession. The medical industry has continued to grow for the last 40 years with no major downturns. Within medicine, however, individual disciplines have undergone times of growth and retrenchment. This is certainly the case for family medicine. But, family medicine is not alone: disciplines such as anesthesia and radiology, which had difficulty attracting any students when provider compensation was falling in the 1990s, are now riding a tide of economic gains. Thus, while medicine has been protected from recession as an industry, the intra-industry disciplines still undergo their own economic cycles.

All this is relevant because right now family medicine is nestled in a downturn. The ability to attract students to the discipline has dwindled, real income for those who practice in the specialty is stagnant, and satisfaction with primary care as a career is low. At this juncture in most businesses, industries either develop new markets or innovative applications for their products. If they fail to do so, they either suffer a serious reduction in size and power or become extinct. With the Future of Family Medicine Project, family medicine has taken the first step to examine the core services that our discipline delivers and to determine how these services can be packaged to meet the current needs of our consumers. These customers include not only the American people but also the insurers who pay for their care. If the fundamental services that comprise our discipline are still valued and if the discipline can be effective in delivering on this promise, the discipline should rebound. But, if our fundamental assumptions are flawed (maybe Americans really don’t want primary care) or if innovation has made the service no longer necessary or too costly to provide using the current business model, then our industry will wither and die. The key will lie in whether payers and patients value the fundamental principles (such as continuity, comprehensive care, and first contact) that comprise the bedrock of primary care.

Some “Myths” About Family Medicine

As Mark Twain famously said, “There are three kinds of liars: liars, damn liars, and statisticians.” There is a fourth type, who is the most insidious of liars: one who lies because he cannot acknowledge the truth. Many of us in academic family medicine bemoan the “myths” that students hear about family medicine. But we need to confront these statements about family medicine and reconcile which are fictional and which are true (but, which we cannot bring ourselves to acknowledge). What follows are a few examples of the “myths” about family medicine that I believe the
discipline needs to reexamine to determine whether (1) they are myths and (2) whether we tell people they are myths but do everything we can to perpetuate them nonetheless.

Myth 1: Anyone Can Do Primary Care

When I was in practice in rural Kentucky several years ago, our hospital administrator informed me that an international medical trainee who had just completed an invasive Endoscopic Retrograde Cholangiopancreatography fellowship at a nearby tertiary care center was going to join the staff of my clinic to fulfill an J-1 visa requirement. I questioned whether this was wise since this individual was never trained in primary care. The administrator looked at me incredulously and said, “But he’s a specialist. Certainly he can do primary care.”

The assertion that “anyone can do primary care” devalues the talents and special knowledge set of primary care doctors. In my opinion, the truth is the converse—ie, not everyone can do primary care. Not everyone has the intellect or temperament required to deal with the breadth of problems that primary care physicians encounter, the complexities of the issues that we deal with, or the uncertainties that permeate our decisions. So, the statement that “anyone can do primary care” is a myth.

Or is it? As a discipline, we say this is a myth but then we behave as if it is the truth. By overzealously expanding the capacity to train family medicine residents and then taking anyone who was willing to fill one of our empty residency slots, we act as if anyone can do family medicine (or at least we can train anyone to do it). If anything, family medicine training programs should be turning away more people than we accept. Only if we are selective in assuring that the right people are doing primary care will we increase the quality of physicians in the discipline and dispel the myth that being a primary care doctor is something anyone can fall back on.

Myth 2: Patients Value Continuity With Their Primary Care Doctor

In the late 1970s and early 1980s, International Business Machines (IBM) was the leader in computer technology. When the market for personal computers began to emerge, IBM was confident that consumers would buy their products over any competitor because IBM was the leader in the field and stood for quality. IBM was so confident of customer loyalty that they did not even bother to restrict the licensing of their first operating system because the company believed that hardware quality and not the software would drive consumers’ buying decisions. The company constructed a gleaming new PC operation in Boca Raton and then stood by as lower-priced competitors (originally disparagingly called “clones”) flooded the market. As IBM learned, consumers did not care about hardware brand. Instead, consumers bought whichever PC offered the best price and widest array of software. Instead of being the factor that drove purchasing decisions, hardware became a commodity. IBM’s Boca Raton facility now stands empty and in decay. And the small company that wrote that first operating system that IBM failed to license, a fledgling group of college dropouts who called themselves Microsoft, now towers economically over the entire world.

In some respects, family physicians look at primary care the way IBM looked at computers. For us, our biggest selling point is the relationship we establish with our patients. We value these close, personal relationships and believe that patients value these as well. But, delivering medical care is not about us. It is about what patients want. Because we value continuity so much, I fear that we may be overestimating the value that patients place on this relationship. Patients often show us this in their behaviors. For example, when a health plan for our patients tells them that it will cost a few dollars less to see someone on their preferred list, our patients change doctors. Or when patients have a small problem or want service at an off hour, they are comfortable stopping in at an urgent care center. These are not the typical actions of people who place a great value on the relationship they have developed with a single family physician. While we like to believe that patients place a great value on their relationship with their family physician, the evidence suggests that our patients often put convenience and cost above this personal relationship.

In many ways, primary care is like many other American institutions that are becoming commodities. With a commodity, consumers see the service or product as a generic need; the person or company providing the service or product is not as important as the price. A parallel from the banking industry is illustrative. In the past, consumers chose their banks because they trusted the bankers who worked there. Customers enjoyed a face-to-face familiarity with bank tellers that gave them comfort and instilled customer loyalty. Now, most Americans probably do not know that people work at banks, other than the employee who stuffs money into the ATMs. American culture has changed to value convenience and price over the personal relationship that used to drive banking decisions. While this culture has shifted, primary care has clung to the belief that patients want a personal physician. We have to reexamine this notion and decide whether this is what patients’ want—or is this what we want.

The Future of Family Medicine Project may help shed light on this issue and point to new directions for primary care. But we will have to
change to meet the needs of health consumers and not expect them to change to fit our values. To tackle this problem, primary care physicians either will have to recognize the new motivators that drive health consumers to choose a doctor or offer services that are worth the extra cost and reduced convenience.

**Myth 3. The Measure of Success of an Academic Department of Family Medicine Is the Percentage of Students Who Go Into Family Medicine**

Often, our discipline seems to believe that the primary mission of family medicine departments at medical schools is to recruit students to the specialty. This is not appropriate. For one reason, not everyone should be a family physician (see myth number 1). Second, even at schools with the highest percentage of students electing to enter family medicine, the overwhelming majority of students enter fields other than family medicine. The value of family medicine educators in any school should be measured by the value they bring to the entire school.

To be a credible academic discipline, family medicine must provide knowledge, skills, and attitudes that are vital for all future physicians. By focusing on recruiting physicians into our field while underemphasizing the importance of primary care concepts and attitudes for all students, we damage our academic credibility and raise serious questions about whether our curricular content or clerkship experiences should be an integral part of the medical school curriculum. Our value to an institution must be measured by the curricular content and teaching that we provide to all students, including the majority of students who will elect other disciplines but who will learn concepts and attitudes from family physician faculty that will make them better physicians regardless of their future specialty choice.

We also need to recognize that while specialty choice is influenced by exposure to mentors and family medicine, it is a complex, multifactorial decision influenced by many internal and external factors. The best way to increase the number of students going into family medicine is to select students interested in primary care in the first place. Departments are probably given excessive credit (and undue blame) when economic conditions, admission decisions, and institutional culture may play a larger role than departments in shaping this decision. Rather than judging our discipline based on the quantity of students choosing family medicine careers, we should be focused on quality. Our academic departments should spend as much time talking people out of family medicine who are ill suited for a career in primary care as nurturing future doctors who will make great family physicians. The measure of success of our academic departments ultimately will not be graded by whether the discipline gets bigger but by whether it gets better.

This is underscored by our experience in my own institution. Between 1997 and 2001, we added significant curricular time in the first 2 years of medical school, expanded the primary care clerkship from 4 weeks to 8 weeks, added a 4-week externship in the fourth year of medical school, and had an associate dean of primary care position created. Yet, the match rate in family medicine dropped from 22% to less than 10% over the same time period. Our associate dean came by to ask me what we should do to counter this large drop in family medicine interest. Given all that we had done over the previous 4 years, I told him it looked to me like we shouldn’t try so hard.

**The Truth Can Be Painful, Sometimes**

These are only a sampling of some of the myths that I think we need to confront. But, these issues illustrate that some of the forces impeding a recovery in the discipline are not external but internal. Until we come to a clear understanding about what we are about, what we can provide that is of value to the American people, and how we can provide care that is of equal or better quality than our competition, we are in danger of becoming irrelevant.

Unlike most circumstances in which academics adopt the right course of action only when that action becomes unavoidable, our academic departments can take the leadership in moving the discipline in the right direction. In my opinion, we need to “right-size” the number of positions available in family medicine residency programs to retain the quality candidates but exclude those for whom family medicine is a poor choice. We need to put the emphasis on quality of care and develop models of care that revolve around safe and effective treatments for all patients who should receive them. We need to develop care delivery systems that meet the needs of our patients rather than satisfying our own needs and desires for continuity and other tenets of our discipline.

To do this, our discipline will need to heed the warnings that are imbedded in the Future of Family Medicine report. We should not focus on the self-serving aspects of the data but need to seek what is critical of our discipline. As Thomas Kuhn pointed out in his classic discussion of the nature of science, it is easy to see what we believe. But sometimes what does not fit into our paradigm becomes invisible. We cannot afford to ignore negative findings. Kuhn points out that it usually takes a generation before what was overlooked becomes accepted as truth. But, in the case of our discipline, if we overlook the truth now, we might not have another generation.
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