‘Medicine of the Family And the Family of Medicine’

Keynote Address at the 1979 meeting of the American Academy of Family Physicians by Edmund D. Pellegrino, MD, President of The Catholic University of America.

Dr. Pellegrino is also professor of philosophy and biology at Catholic University and serves as professor of clinical medicine at Georgetown University School of Medicine in Washington, D.C. Speaking before some 2,000 members of the American Academy of Family Physicians, he was described in the Academy’s convention program as a prominent physician and “thoughtful observer and commentator on family practice and its relationship to other primary care and more narrow specialties.”

I am delighted to have been asked to address you on this very auspicious occasion of the 10th anniversary of the formation of the American Board of Family Medicine and the designation of your specialty as one of the recognized specialties in American medicine.

I’m particularly gratified to do so because, overlooking the fact that I have fallen from grace and become a university professor, my progress from here can only be upward. I promise you that I’ll try to be as understanding as I can about the problems of medicine. I’m still teaching clinical medicine and hope to continue that. I mention that so that you won’t take my conversation and my suggestions, and perhaps some of my recommendations, as being entirely theoretical.

I watched the development of our specialty from several vantage points. First, as someone who himself trained in general practice residency alongside internal medicine residents, beginning in 1952 as chairman of medicine in a small rural hospital, as someone who had the great privilege of appointing the first two family physicians as full-time members of a department of medicine, as someone who has seen the development and has nurtured one or two departments of family medicine within academic medicine. I am thrilled and pleased to see what has happened in the past 10 years.

In 1964, one of my very good friends and colleagues elegantly sounded the eulogy, as he put it, for general practice, and he announced the birth of a new specialty of family medicine. This was a courageous act, since just the year before the American Academy of General Practice had rejected the idea of a whole new specialty. Five years later, the American Board of Family Medicine was formally recognized.

Today, we celebrate a decade of unprecedented success, and I am pleased to help you celebrate this event.

Now, a decade later and without grandfathering in anyone, as so many boards have done, family medicine can boast 22,000 diplomates, 375 residencies, 6200 people in training, and departments of family medicine in the majority of American medical schools. This is unprecedented in the history of American medicine, especially since it was completed against the skepticism and reluctance of academic medicine, as I know only too well, and also the reluctance of some of your own members who felt that general practice as previously construed was not to die or be transformed. Indeed, it seems to me very often that the reaction of the family of medicine to family medicine has been somewhat akin to Joseph’s brothers in the Bible. Having left their youngest brother for dead in the well, they were shocked and stunned by his sudden reappearance as a figure of public importance in the dwelling of Pharoah. Unable to deny him, they could not assimilate him gracefully into the family of medicine.

Family medicine is general practice born again in a more vital and vigorous form. It is a test, notwithstanding. It is, however, still something alien to the family of medicine. Family physicians, after all, paradox — a specialist who specializes in being a generalist.
I will develop this thesis now in three sections—three questions, really. First, looking at the source of family medicine's mandate. Secondly, looking at the forces tending to depersonalize, and thirdly, trying to be more concrete about the obligations that fall from fidelity to the source of your strength and of your success.

First, the source of family medicine's mandate. Let me begin with the fact that family medicine became a specialty without enthusiasm in the family of medicine... family medicine exists today because there were those pioneers, those who refused to accept an idea which was labeled as being absurd and carried it forward. I can understand your confusion and legitimate concern as a still-new specialty, for acceptance within the family of medicine.

But the concerns must not obscure the fact that the real mandate comes from outside the family of medicine. It is rooted in the fundamental need of the ill human being, a need that has always been present and that always will be present, and the need which will structure in contemporary medicine will of necessity be ever more difficult to meet.

That fact will be felt with increasing urgency by our patients. What they are feeling is a need for a physician willing, capable and available to see the uncategorized aspects of illness, to assess the seriousness, to know when to refer, to treat the uncomplicated illness promptly—someone to manage essentially a healing relationship and the multiple elements that go into it... someone to advise, someone to educate, someone to care when technological medicine fails, when it confuses, when it threatens, or when it is simply impalpable. Someone who recognizes the patient as a vulnerable and wounded human being facing perplexities of illness in the unique nexus of personal, social and family relationships—someone who will see to it that the patient's definition of what is good and worthwhile is taken into account.

It is this need that the public expects family medicine to fulfill, and the absence of fulfillment of that need is the source of the greatest disappointment that patients express today about other kinds of specialty care.

Family medicine has succeeded so well because it offers the hope that patients can enjoy the benefits of both the technical specialty and the personal care.

Young physicians, too, seem to sense this. They have brought themselves in great numbers to train in family medicine, to fill those residencies, and, indeed, the number of residencies can hardly keep up with the applicants for these positions. Why? Because they sense that they too want to become close to the heart of what it is to be a physician, and that even the most conscientious specialist — and this is not to denigrate the specialist — is by definition a limited physician.

The best of the general practitioners of the past served these needs when medicine was simpler... Today, treatment only in the specialties and sub-specialties is unparalleled, we know that. What is owed every patient, however, by all of us—our responsibility as a profession—is the advantage of technological medicine without loss of personal care.

Why is this need so fundamental? It is not, as some have suggested, something that we attribute to the patient. The need is rooted in the very nature of illness and of the act of healing. Illness is the salt on our humanity — on the things we associate with being human beings that take control of our destiny, not in a distant public way, the way governments may — but in the most intimate realms of our personal lives. It waltzes with our self-determination and our self-identity with an inescapable directness. When we become ill, our bodies dominate our lives and become the center of our attention, while other interests are subordinated.

We lack the knowledge and skill needed to heal ourselves; we must place ourselves in the power of other persons and institutions who are strangers to us and our families. These strangers demand access to our most intimate secrets. They subject us to multiple examinations and then they define what is good for us.

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but it cannot be the sole part.

Our profession has suffered from some of its members in their anxiety about the most minor illness. What ill persons seek then is to be recognized. What our humanity are feared and experienced with suspicions even when the most minor illness. What ill persons seek then is to be recognized as human beings. Even to be treated with the recognition of the vulnerability illness imposes upon free men and women.

Medicine is most completely medicine when it brings all its science, art and morality to bear on the moment of clinical decision — when we advise the patient before us about what we think is good for him or her. We cannot deal with the question of what is good if we equate it with the merely scientific expedient economically or socially useful decision.

The very uniqueness of the experience of illness must always frustrate that oversimplification. Merely to apply science, economics, psychology is to be a scientist, an economist or psychologist, but not to be a physician.

We become physicians only in the moment of clinical truth, when everything we know converges on this unique person who trusts us to heal him or her, not society, not the family, not science and not even future generations.

Let me turn to my second point: The forces of depersonalization. You know these, but I must emphasize them because the urgency of the moral responsibility we bear is so great that even the obvious must be clear.

Specialists and generalists, obviously both must manage the moment of clinical truth in a morally defensible, humane and personally viable way. But it is up to each of us individually, the obligation that falls to the family physician, because his concerns transcend the narrow interest of specialists, and therefore must embrace more of the patient's life.

Let's look at some of the potent forces that are moving all of us away from a humane transaction — one which is between persons. There are three that I want to emphasize.

First is the scientific base of medicine. Second, is its inevitable bureaucratization, and third, its commercialization.

First, there is a necessity to ground medicine in science. This calls for objectification of the patient — of his symptoms, of his complaints, of the quantification and search for the disease mechanisms susceptible to the scientific method. Man, his body, and organs become objects of study under science. Uncontrolled variables must be reduced to a minimum if valid deductions are to be made. A depression, for example, is a complex entity which differentiates a patient's identity as this unique person must of necessity ensue when we are truly acting as scientists.

Science of medicine is not to be abjured; its benefits are far too manifest. Objectification must continue to be a part of my medicine, but it cannot be the sole part.

If objectification is taken as the whole of medicine, then the patient becomes identified with his disease while his perception of his state or his distress is especially ignored. The more subtle, less probable, but no less important sources of illness are denied. The patient's history unfolds as a chronicle of symptoms, of signs and tests, but not as the biography of a distressed human with a wife, a job, a set of aspirations and disappointments. Clearly, such objectification cannot be the whole of medicine, and the scientist is not a physician even when he is a basic scientist and even when he is a clinical scientist. Medicine comes into existence only at that moment of clinical truth.

The next force I want to mention is that of bureaucratization. To supply needed services to large numbers of people, medical care has become institutionalized, standardized, and correspondingly depersonalized. Your main consideration becomes displaced by organizational means. Access to a physician in a bureaucracy, as we are developing one, is through intermediaries — secretaries, receptionists, nurse assistants, telephone answering services — every medical event is routinized. There is a huge gap between the patient's anxiety and the receptionist's boredom.

In his moment of anxiety, the patient is confronted not with a person, but with the office, the hospital or the clinic. The institution sees the role as important and not the person who performs it. Anyone with appropriate authority will do. Your doctor, your nurse may be on vacation or in a general education session, but the hospital is there and feels justified if it offers you someone else who can do the same thing.

In a bureaucracy, the critical record is the patient's identity card and the source of continuity. Long-standing relationships with one person who knows us are meaningless in a bureaucracy. Every feature of bureaucratic organization forces the patient into dependency. The institution decides what the patient needs, who shall be served and by whom. It defines who has a real problem, who is really sick and who is not. It is the patient who is misinformed, not the bureaucracy. The bureaucracy always strives to save money, deceiving themselves by rationalizing even the most confused, chaotic and quixotic behavior.

The third most distressing force for depersonalization at times is the transformation occurring in attitudes, motivations and social structures of the profession itself. I do not wish here to castigate anyone, or seem pious or self-righteous. Yet, we are all diminished whenever our practices move the care of the sick toward becoming a commercial enterprise.

Some of the signs are disturbingly clear. The emphasis today, necessarily, but with the wrong emphasis at times, are costs and modes of payment. The distortion "cost containment" from a reasonable economic measure to an ideology perpetuated by all of us in an attempt to override the differences between the care of patients, one institution or another, and trying to standardize costs, ignoring the differences which have a normal base in the care of patients. The studies which show excessive use of procedures and operations, the still covered up link of personalized care to financial means and social position, the abuses, unfortunately, our profession has suffered from some of its members in Medicare and Medicaid. The training of physicians has become overemphasized emphatically in the direction at times of a contractual — a business arrangement rather than a moral transaction between two people.

All of these points were metamorphosis of the humane act of healing to the transaction of purchasing of a commodity, and indeed we have representatives of our profession who have strongly put forth the idea that medicine is no different than buying bread and ought to be governed by the same principles.

Out of this comes something that is particularly of concern. Even the ethical code of our profession — if you look at it in terms of its long history from 1845 — has become a much less detailed, a sparser, a less-committed and more cautious statement of our responsibilities for service.

We have a choice: Will medicine evolve further along the lines of a commercial enterprise, practiced by a unionized bureaucracy, and with a craft rather than a professional ethic? I do not know, I hope not, and I do not think so. But like it or not, we have already been perceived this way. Judge Earl Bonds of the Federal Trade Commission's September, 1977 rule said we are indeed in commerce and thus are subject to FTC and not to our own professional ethic. Indeed, these codes were branded as self-serving mechanisms devised to protect our monopoly over care of the sick.

I suggest for a moment we lay aside our justifiable indignation and ponder each of us how much of this is possibly true, and how much of it contributes to the depersonalization of the encounter of a vulnerable person in need with another person who professes to help in that need.

The end result is a greater discontinuity between the patient's
definition of his goals and the physician or institution's definition.

Patients seek help in their own terms, relying on the physician, trusting the physician to assist them in attaining a mutually defined goal. The physician sometimes—sometimes too often—inputs his view of what is the good life and good health of others and overrule in many ways the personal limitation which is defined by his failures as much as by his own identification of himself as a professional, as a person in particular.

I turn now to the last section of what I have to say. Having established—least cursorily—the fact that the strength of family medicine comes from its generalist function and second its source in a fundamental need of the ill, vulnerable person presenting himself to those of us who are professed healers, that that is the source, and as it turns out the structures of medicine as they are evolving, point to family medicine as the only one in the family of medicine who can encompass this fact of personization in the healing transaction.

Then what are some of our special obligations? How specifically can the moral obligation be served in the day-by-day crucible of caring for the sick? I would like to enumerate just a few of these mechanisms.

The first, of course, as I said, is to be truly a generalist, which by definition means that no significant feature of the patient's life situation will be considered unworthy of consideration. The willingness to see the patient on the patient's terms and not to retreat into a special domain of concerns is crucial. By addressing the uncategorized problems, the family physician can begin to coordinate and manage the process of decision-making, that which makes medicine what it is, from the very outset.

The more complex the problem, the more specific the treatment, and the less is the need for that overall management of the person. The more we move to those areas in which there are marginal benefits from specific therapies, the more we'll have to care for a look at this personal dimension of the illness.

I want to point out that the generalist's function must be exercised clearly, however, with rigor, and with the strongest dedication to the highest quality of competence. That function must be exercised with competence because no amount of kindliness and understanding will exculpate the damage a patient can suffer with incompetent care. Incompetence is the first and inexusable insult to any conception of humane care, and the first claim on competence of the family physician is his or her capacity as a generalist across the whole range of human problems labeled illness.

Secondly, however, the family physician must also manage the decision-making process morally and humanely. He or she must be the advocate of the patient in the many layers of decision nexus that characterizes institutional medicine. The family physician can guide the patient, clear up the inconsistencies and confusion with too many instructions and too many people. He can intervene when the institution tries to save face and rescue the patient when the patient is lost in the routine. In short, the family physician can guide the patient through a complexing confusing, denigrating and depersonalizing process that can happen when the benefits of bureaucracy are overwhelmed by its own existence and its own structures.

Crucial to the advocacy role is that as an educator and an advisor to the patient who, ultimately, must decide among the therapeutic alternatives the specialist offers him or her. The sick person needs someone to help him or her weigh costs and benefits of each of the diagnostic and therapeutic procedures, to interject the personal features of the patient's life situation that profoundly affect and shape the choices among the alternatives, assisting the patient and the specialist as well to assure that a morally defensible consent is obtained, protecting the patient against manipulation of that consent even when ostensibly the recommendations are for the supposed good of the patient.

The Golden Rule of decision-making is 'treat your patients with the same treatment you would like to have,' but rather to allow your patients the same knowledge and choices that you would prefer if you were faced with the alternatives.

These observations are admittedly difficult and will at times mean that the family physician may become a critic of the specialist's recommendations. This is a necessary and a particularly vexing role to play. The family physician's critique will not very often be on technical grounds, but he can and must be the patient's advocate as the one who can best understand the patient's values and life situation and therefore examine what is worth while to this patient, regardless of what may be dictated by a particular formula of treatment. The specialist can too easily forget in his zeal for his own technique or his own particular regime of treatment.

The obligations that I am emphasizing extend also to the matter of the competence of the specialist to whom we send our patients. It is necessary for us—for you and for me—for anyone who tends to be a generalist to visit the operating room, to inquire into their morbidity and mortality statistics, to weigh the benefits of asking the surgeon close to home to see this patient as opposed to the one at a distance. The defensible figures and risks are not those in our local community, but those in the best institutions, if we are to fulfill that trust and fidelity placed in us for understanding and serving the good of this patient.

I've said enough—I believe—to be specific about the direction in which I feel family medicine can and will go about its special moral obligation to guard the humanity of the person and the patient amid the complexities and dangers of medical transactions today.

Technology, the sciences, the bureaucracies, the institutionalization of medicine, will continue, as will the economic concerns and pressures in the years ahead. They will continue to transform what is a personal relationship to distort it, to make it one of the most difficult things to carry out morally and defensively.

As you enter your second decade as general practitioners born in a new form with a new concern, with a new direction, I hope that you will rescue, support and sustain that personal concern which your predecessors in general practice had. I hope you'll carry on with your special new competence, being generalists, in a new way, with the family as the context in which you perform and operate, and add to it this third dimension of a deep concern for the morbidity of medical decisions, because what I have been saying is not a matter of choice. It is a moral obligation which flows out of the nature of a relationship, out of the nature of a promise we made to act in the good and for the benefit of a patient, and it cannot be avoided.

Family medicine, if it remains faithful to these dimensions, is assured not only a place in the family of medicine, but I would say, of the first place, because its justification will then rise from the only ultimately defensible source for the existence of any professional part of medicine, and that is the well being, of wounded humanity or person who comes to us for help.

Illness, said Susan Santaub, is the night side of life—a more onerous citizen. It is your task to join with the family, the friend, the minister, to be able to illuminate that night of sickness, to ease that burden, to care, not by displacing the family or the friend or the minister as some would have us do, but rather by bringing to it our special competence—as a gift, and as an obligation—that competence which is built on capacity to be a generalist and also a safeguard for the person of the sick human beings who present themselves to us.

I hope that I have not sounded too moralistic. I have been very vigorous in my statements because I feel very deeply the fact that we have an obligation, that it is based on a moral fact, that as some in our profession begin to take one some legalistic, commercial aspects of production of a service, a commodity, I believe that that trend must be reversed, because we are not simply a craft, we are truly a profession.