Keystone III

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New Zealand general practice evolved from structures and traditions established in the United Kingdom in the early 1900s. By the turn of the century, however, concepts largely derived from health care systems in the United States (e.g. competition, market forces, corporatisation, managed care, and accountability) were strongly influencing the reform of health care provision in New Zealand.

This occurred despite the fact that the United States' population does not have anywhere near the best health in the world[1] and that the World Health Organisation ranks the United States health system as only 37th out of 191 member countries just ahead of New Zealand at 41st.[2]

Some of these concepts are continuing to impact on general practice now, and will continue to do so in the near future. In light of this, when considering the future of general practice in New Zealand, there are lessons to be learned by reflecting on the state of family practice in the United States.

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Keystone III was a structured conversation about family practice in the United States, held in Colorado Springs in October 2000.[3] It was inspired by the previous Keystone Conferences organised by Gayle Stephens in 1984 and 1988. Last year's conference was organised by John Frey, Robert Graham, Larry Green and Gayle Stephens who recruited 19 authors to prepare 10 discussion papers which were circulated to participants and posted on the Web prior to the conference. Several of the authors will be familiar to New Zealand GPs interested in the academic discipline of general practice (Lyn Carmichael, Ian McWhinney, John Geyman, Paul Frame); other names will be new. There were 80 attendees, about half representing a variety of family practice institutions and the other half chosen by lottery and stratified by generation (founding generation, transition generation and emerging generation of family practitioners). Other participants (including the author) were linked via the Internet and a number of the sessions were electronically interactive.

Attempting to summarise the 10 papers and the conversations stimulated by them would not do justice to either the contributors or to the conference. Much of it was not particularly relevant to New Zealand general practice. The papers have been published[4] and the proceedings will be posted on the Robert Graham Center website.[5] I have chosen to provide some short extracts from those papers that seem to me to have particular relevance to New Zealand general practice. Of course they are out of context but they may stimulate reflection and help us to consider our itinerary for the future.

Family Practice became the 20th specialty in the United States in 1969. Rosemary Stevens describes the evolution of family medicine from 1969 to 2000.[6] Her paper provides some insight into the many differences and the important similarities between American family medicine and New Zealand general practice. She concludes:

Given the mixed messages of its history to date, will family practice, as it now is in the United States, prosper, stagnate, or decline? That each of these fates is possible reminds us that the continuing history of family medicine, as of other histories, is contingent on cultural movements, available institutions, and individuals who can seize the opportunities of the moment.

Personally, the most enjoyable paper presented was a story by David Loxterkamp, a family doctor in Maine. He talks about his patients, his practice, dairy farming and cows, using the theme of 'connectedness'.[7]

The family doctor is rarely an agent of meteoric change. But, every day and closer to the earth, we are its vehicle and eyewitness. Doctors who remain deeply connected to their patients will know this privilege, as will those of us who retain the capacity to listen, touch, and tether ourselves to the wounds of others. In modest ways, we accomplish the utterly profound long

before the prescription is filled or the blood test is taken. We profit by the patients' periodic return and by the mutual exchange of friendship, intimacy and trust.

Inevitably, Gayle Stephens' paper is concerned with social and political change.[8] He presents his thesis:

Family practice, in its advocacy for distributive justice in medical care that is humane, merciful, moral, personal, and cost-effective, has a necessary relationship to politics, economics, ethics, and social change. This relationship derives from family practice's unique traditional role in the medical care system of providing universal access to health care for any person, regardless of age, gender, social status, medical condition, or ability to pay. This relationship has undergone fragmentation and attrition, due in large part to unremitting and inimical flaws in the US medical care system.

Therefore, family physicians have a legitimate and obligatory interest in working for reform of the system on behalf of patients, medicine as a whole, and themselves.

He comments on reform:

Reform is always an item of unfinished business because further change is inevitable, irresistible, imminent, and produces unexpected consequences. What gets pushed out the door often returns by the window.

Gayle concludes:

The public wanted accessibility to ordinary services at reasonable cost, but we wanted utopia. In some respects, we have recapitulated the dysfunctional phylogeny of mainstream medicine by fragmenting our basic role into niche jobs and subspecialisation that subverts continuity and comprehensiveness of medical care. We took a hit to our credibility when we were suckered into gatekeeping by managed care organisations. We ought to have nurtured our main asset better and demanded from our educational settings the permissions and wherewithal to prepare students and residents for-full-service practice in communities of need.

Lynn Carmichael, from the founding generation, engages in a dialogue with Susan Schooley, a young family physician who is deeply involved in managed care. At the end of their quite lengthy and wide-ranging dialogue[9] they reflect on the relationship between patients and doctors:

Family physicians have a legitimate and obligatory interest in working for reform of the system on behalf of patients, medicine as a whole, and themselves

Lynn: *I've cared for some patients for more than 40 years. What patients need from us hasn't fundamentally changed: someone who knows them, whom they can trust, and who can help them navigate the uncertainties of illness or the health care system.*

Susan: *Knowing patients and being trustworthy to them demands the same from us now as before. Navigating the uncertainties of illness or dying is still full of the same old mysteries and depends on our growth as human beings. The rest of the navigation job faces a sea change. Let's ask: how does the sailor harness the sea?*

John P Geyman and Erika Bliss reflect on the last 30 years of the discipline and provide their projections for the next 30 years:[10]

Opportunities for family practice have never been greater, and there is no better time in history to be a family physician, but continuance of the status quo will assure that family practice is just one option for primary care in 2030, perhaps even a marginalised one at that. Family medicine is but one part of the larger and rapidly changing health care system in this country, the future shape of which is still uncertain. We can be leaders in the effort to transform that system into one that is effective, efficient, and structured to meet the primary care needs of all Americans.

When presenting their views of the opportunities we have missed and the bad deals we have made, Michael Magill and Terry Kane[11] believe that:

We have missed opportunities to lead development of a new model of patient-responsive health care, to change the system of payment for care, to maximise the strength of our discipline by links between university and community family physicians, and to build a powerful program of family medicine research.

For those who want to define our discipline, the paper by Wayne Phillips and Deborah Hayes *The Domain of Family Practice: Scope, Role, and Function*[12] is among the best that I have read, anywhere.

The generalist physician is not just any general physician. Undifferentiated problems cannot be expertly managed by an undifferentiated physician. The care of unselected patients is not to be left to unspecified providers of health services. These clinical challenges call for the broadest knowledge and the deepest understanding.

Limited specialist physicians may possess these important skills, knowledge, and attitudes but not across multiple fields. They are not generalists. Limited generalist physicians focus on the person but do so within the constraints of age, gender, or disease. It is not having the pieces that is important. It is having them together in one person who is responsive to and responsible for the needs of most of the people most of the time, over time, and across settings of care.

And

There is a crisis of care in the madness of modern medicine. Family practice has both the resources and the responsibility to bring to-

gether the service and the science and the sense we know we need.

The domain of family practice can be viewed best from the high ground of relationship, generalism, and professionalism.

It can be travelled best by following the byways of patient care and community service. It can be explored best by advancing the frontiers of science, systems, and advocacy.

No map can do justice to the rich and varied terrain it represents. As Professor Ian McWhinney reminds us, "When it comes to healing...there comes a time when we have to set aside our maps and walk hand in hand with the patient through the territory."

Kurt Stange, William Miller and Ian McWhinney provide a framework for developing the knowledge base of family practice.[13] They contend that we must expand our knowledge base by integrating multiple ways of knowing.

This involves (1) self-reflective practice by clinicians, (2) involving the patient voice in generating research questions and interpreting data, (3) inquiry into the systems affecting health care, and (4) investigation of disease phenomena and treatment effects in patients over time.

They challenge us to create a culture of generalist inquiry.

Advancement of the knowledge base for generalist practice is important and feasible. We cannot let the competing demands and threats of the current environment dissuade us; they make the need and opportunity even stronger.

Mark Ebell and Paul Frame focus on the impact of technology on family medicine and offer some guidelines for the adoption of information technologies, diagnostic technologies and therapeutic technologies.[14]

The discussion papers conclude with a view from 2020 with Larry Green commenting on how family medicine failed[15] and Marjorie Bowman focussing on what we will need to have done right for family practice to triumph.[16]

We are reminded that Kerr White once said, "It's dangerous to make predictions, especially if it's about the future."

References

1. Starfield B. Is US health really the best in the world? JAMA 2000; 284:483-485.
2. Press Release. World Health Report 2000. http://www.who.int/whr/2000/en/press_release.htm
3. Green LA, Graham R, Stephens GG, Frey JJ. A preface concerning Keystone III. Fam Med 2001; 33(4):230-231.
4. Special Dedicated Issue. The Keystone Papers: Formal discussion papers from Keystone III. Fam Med 2001; 33(4):230-327.
5. The Robert Graham Center. www.aafppolicy.org.
6. Stevens RA. The Americanization of family medicine: contradictions, challenges, and change, 1969–2000. Fam Med 2001; 33(4):232-243.
7. Loxterkamp D. A vow of connectedness: Views from the road to Beaver's farm. Fam Med 2001; 33(4):244-247.
8. Stephens GG. Family practice and social and political change. Fam Med 2001; 33(4):248-251.
9. Carmichael L, Schooley S. Is where we are where we were going? A dialogue of two generations. Fam Med 2001; 33(4):252-258.
10. Geyman JP, Bliss E. What does family practice need to do next? A cross-generational view. Fam Med 2001; 33(4):259-267.
11. Magill MK, Kane WJ. What opportunities have we missed, and what bad deals have we made? Fam Med 2001; 33(4):268-272.
12. Phillips WR, Haynes DG. The domain of family practice: Scope, role, and function. Fam Med 2001; 33(4):273-277.
13. Stange KC, Miller WL, McWhinney I. Developing the knowledge base of family practice. Fam Med 2001; 33(4):286-297.
14. Ebell MH, Frame P. What can technology do to, and for, family medicine? Fam Med 2001; 33(4):311-319.
15. Green LA. The view from 2020: How family practice failed. Fam Med 2001; 33(4):320-324.
16. Bowman MA. Family practice triumphs by the year 2020: what will we have done right? Fam Med 2001; 33(4):325-327.