ON TRACK

The Heart of Family Medicine

Robin S. Gotler, MA, Reflections Editor
Elizabeth A. Bayliss, MD, MSPH, Associate Editor

Ann Fam Med 2010;8:464-466. doi:10.1370/afm.1183.

The recent *Annals* online discussion strikes at the heart of family medicine and primary care—what it means to be a family doctor, the design and tools of primary care practice, and the ethical foundations that guide us.

A PERSONAL DOCTOR

An essay honoring the legacy of John Anderson[1]—"a doctor who lived as an integral part of his community"[2]—resonated with family members, policy experts, medical students, and seasoned physicians. The essay prompted many writers to reflect on the deep connection that can arise between doctor and community, a connection that includes shared stories[3] and shared pain: "[Doctor Anderson's] participation in the life of his community penetrated into mystery wherein communities become the true loci of healing by absorbing each others griefs."[4]

Dr Anderson's qualities as a physician stand in sharp contrast to the current health care environment, according to several comments:

> What is most striking to me about the stories told about Dr. Anderson at a time that often seems to prioritize algorithmic efficiency and productivity in medicine is the personal knowledge he demonstrated about his patients, and his creativity in tailoring treatment approaches that honored their individual values and preferences.[5]

Indeed, his focus on the individual guided not only his medical practice but his work in health care policy:

> The thing about Dr. John Anderson was that, regardless of the issue we discussed—managed care, certificate-of-need, Medicare reform, whatever—he always, always kept his eye on one ball: what would be best for the care and well-being of patients.[6]

Several medical students found inspiration in Dr Anderson's example and encouraged the sharing of such stories "publicly, boldly, and unapologetically."[7] Doing so may inspire new generations of physicians, as well as those already in practice, "to stop and listen, and to care courageously for those in their own communities."[2]

The story of John Anderson generated reflections on other aspects of primary care as well. One comment noted the link between a new measure of complexity[8] and both the joys and challenges of primary care practice: "…somehow, healthy patients and healthy communities emerge out of the nonlinear dynamics that form complex systems. John Anderson shows us how it is done."[9] Another comment expressed concern over the implications of electronic medical records that do not allow for adequate narrative and honest documentation:

> We cannot allow the "Technologic Imperative" to change the entire culture of Clinical Medicine without a fight…. John Anderson would not have stood for it…. Perhaps his memory can be our touchstone for gathering together to make certain that the potential advantages of Electronic Medical Records are not sacrificed to the causes of the Financial Offices and Information Technology people….[10]

TECHNOLOGY, CHRONIC CARE, AND ORGANIZATIONAL ETHICS

While electronic health records (EHRs) engender concerns among some, they are welcomed by others. A study by Shield et al,[11] in which residency clinic patients maintained strong trust in the doctor-patient relationship during EHR implementation, convinced one reader that, "if the verdict was not in, it is now. The benefits of EHR far outweigh the various costs associated with their implementation."[12] Another reader, however, questions whether the study's positive findings could be replicated in a nonacademic setting.[13] Still another reader is looking ahead:

> The next step is to make [the EHR] accessible online, particularly to patients, so that equal access to information can lead to truly shared decision making by patients and their doctors.[14]

In an evaluation of physician satisfaction with a Guided Care intervention,[15] physicians enrolled in the study reported increased satisfaction with patient

and family communication and improved knowledge of patients' clinical characteristics. This discussion of efforts to improve care of complex elderly patients in primary care struck a chord with readers. Several commented that such successful programs demonstrate the need for ongoing health care reform to support similar efforts, and that programs in turn have the potential to inform the implementation of such reforms.[16-19] Other readers emphasized the importance and complexity of team-based care and suggested that the use of such programs can promote and enhance the development of specific roles of team members in multiple ways.[20] Suggestions included encouraging further training in team leadership for physicians, using qualitative debriefing of team-based processes, expanding teams to include roles for other clinical professionals, and conducting needs assessments of clinicians.[21-23] Finally, one of the sponsors of the investigation re-emphasized the importance of studying care processes for complex elderly patients and provides a list of additional committed sponsors.[24]

A pair of essays recently provided an ethical point/counterpoint on the potential for conflict of interest in Coca-Cola's funding of American Academy of Family Physicians' patient education materials on obesity prevention.[25,26] Essay author Brody further commented on the link between conflict of interest and an organization's ability to maintain the public's trust,[27] and another ethicist admonished professionals and organizations to exercise their moral obligation to avoid conflict of interest situations.[28] Readers voiced concerns that conflicts of interest create bias "in subtle and hidden ways"[29] through such tools as language[30] and advertisements[31] and expressed fears that "all of us in medicine are truly being duped by big money."[32] They called for "responsible partnerships"[33] and efforts to protect the "integrity, credibility and independence of the medical organization."[34]

EVALUATING THE PATIENT-CENTERED MEDICAL HOME

The relationship between patient and physician, at the heart of John Anderson's practice, was a theme in the American Academy of Family Physicians' Patient-Centered Medical Home National Demonstration Project (NDP). In June of 2010, the *Annals* published a supplement evaluating the NDP, the country's first national demonstration of the patient-centered medical home concept.[35] Using a range of different descriptions, readers reminded us that the patient-centered medical home (PCMH) is many things (a political construct, a series of practice criteria, team-based care, a new mental model of care), but in no way does it replace a personal, continuous relationship between patient and clinician.[36-40] Several readers expressed concerns about the potential financial cost and viability of the PCMH model in the absence of a cost-effectiveness analysis for the project—especially in the absence of concurrent primary care payment reform.[41,42] Others expressed concerns about the generalizability of equivocal patient-level outcomes.[39,43] There were also expressions of enthusiasm for newly developed research methods that can be used to gauge progress with necessary practice changes as primary care adapts to the 21st century, and celebration of the practices that were willing to initiate some of these changes as part of the NDP.[36,44,45] In acknowledging these current and future complexities, clinicians from multiple backgrounds emphasized the importance of facilitation and mutual support during periods of change.[36,37,46,47]

Share your comments on *Annals* articles at http://www.AnnFamMed.org.

References

1. William RP, Green LA. A public celebration of a personal doctor. *Ann Fam Med.* 2010;8(4):362-365.
2. Anderson KR. Honoring Dr. John Anderson [eletter]. http://www.annfammed.org/cgi/eletters/8/4/362#13532, 23 Jul 2010.
3. Solberg DA. Thank you for getting it right [eletter]. http://www.annfammed.org/cgi/eletters/8/4/362#13535, 23 Jul 2010.
4. Stephens GG. Dr. Anderson's memorial [eletter]. http://www.annfammed.org/cgi/eletters/8/4/362#13636, 27 Jul 2010.
5. Shapiro J. A complete life [eletter]. http://www.annfammed.org/cgi/eletters/8/4/362#13530, 23 Jul 2010.
6. Katz AB. Some meaning in one life and one death [eletter]. http://www.annfammed.org/cgi/eletters/8/4/362#13843, 3 Aug 2010.
7. Meyer H. Celebrate the specialty [eletter]. http://www.annfammed.org/cgi/eletters/8/4/362#13567, 26 Jul 2010.
8. Katerndahl DA, Wood R, Jaén CR. A method for estimating relative complexity of ambulatory care. *Ann Fam Med.* 2010; 8(4): 341-347.
9. Pretorius RW. A fortunate man, a fortunate community [eletter]. http://www.annfammed.org/cgi/eletters/8/4/362#13833, 2 Aug 2010.
10. Kirk JW. The shining model [eletter]. http://www.annfammed.org/cgi/eletters/8/4/362#13858, 4 Aug 2010.
11. Shield RR, Goldman RE, Anthony DA, Wang N, Doyle RJ, Borkan J. Gradual electronic health record implementation: new insights on physician and patient adaptation. *Ann Fam Med.* 2010;8(4):316-326.
12. McGrath JM. More evidence favors electronic health record [eletter]. http://www.annfammed.org/cgi/eletters/8/4/316#13856, 3 Aug 2010.
13. Shaw NT. Would the same results be observed in the 'real world' [eletter]? http://www.annfammed.org/cgi/eletters/8/4/316#13722, 1 Aug 2010.
14. Walker J. The human story [eletter]. http://www.annfammed.org/cgi/eletters/8/4/316#13869, 4 Aug 2010.
15. Marsteller JA, Hsu YJ, Reider L, et al. Physician satisfaction with Chronic Care Processes: a cluster-randomized trial of guided care. *Ann Fam Med.* 2010;8(4):308-315.
16. Mach J. Health outcomes will ultimately drive physician satisfaction with chronic care programs [eletter]. http://www.annfammed.org/cgi/eletters/8/4/308#13632, 27 Jul 2010.
17. Russell GM. Guided care: still questions to answer [eletter]. http://www.annfammed.org/cgi/eletters/8/4/308#13571, 26 Jul 2010.

18. Green AR. Improved communication: an important piece of the puzzle [eletter]. http://www.annfammed.org/cgi/eletters/8/4/308#13560, 26 Jul 2010.

19. Burton JR. Guided care continues to show promise [eletter]. http://www.annfammed.org/cgi/eletters/8/4/308#13539, 23 Jul 2010.

20. Regenstreif DI. Physician satisfaction and relevance/adoption of the guided care model [eletter]. http://www.annfammed.org/cgi/eletters/8/4/308#13557, 26 Jul 2010.

21. Sommer A. Guided care—more intriguing results [eletter]. http://www.annfammed.org/cgi/eletters/8/4/308#13544, 23 Jul 2010.

22. Chodroff CH. The importance of team and leadership skills for primary care physicians [eletter]. http://www.annfammed.org/cgi/eletters/8/4/308#13520, 23 Jul 2010.

23. Zweifler JA. Physicians need chronic care too [eletter]. http://www.annfammed.org/cgi/eletters/8/4/308#13516, 22 Jul 2010.

24. Berman AJ. Improved physician satisfaction [eletter]. http://www.annfammed.org/cgi/eletters/8/4/308#13523, 23 Jul 2010.

25. Brody H. Professional medical organizations and commercial conflicts of interest: ethical issues. *Ann Fam Med.* 2010;8(4):354-358.

26. Heim L. Identifying and addressing potential conflict of interest: a professional medical organization's code of ethics. *Ann Fam Med.* 2010;8(4):359-361.

27. Brody H. A reply to Dr. Heim [eletter]. http://www.annfammed.org/cgi/eletters/8/4/359#13496, 21 Jul 2010.

28. Shafer A. Things don't always go better with Coke: why the American Academy of Family Physicians should no be taking money from Coca Cola Corporation [eletter]. http://www.annfammed.org/cgi/eletters/8/4/354#13882, 9 Aug 2010.

29. Doucet M. Conflict of interest and bias [eletter]. http://www.annfammed.org/cgi/eletters/8/4/359#13643, 27 Jul 2010.

30. Lesser LI. Tone of AAFP's language on sugary beverages [eletter]. http://www.annfammed.org/cgi/eletters/8/4/359#13506, 21 Jul 2010.

31. Backman RL. Long live the corporate alliance program [eletter]. http://www.annfammed.org/cgi/eletters/8/4/354#13494, 21 Jul 2010.

32. Murray JL. Definitely the "Real Thing": being dupes [eletter]. http://www.annfammed.org/cgi/eletters/8/4/354#13871, 4 Aug 2010.

33. Lucan SC. A sticky situation—the AAFP alliance with Coca Cola [eletter]. http://www.annfammed.org/cgi/eletters/8/4/354#13554, 26 Jul 2010.

34. Kissling B. Conflict of interest [eletter]. http://www.annfammed.org/cgi/eletters/8/4/359#13878, 6 Aug 2010.

35. Bayliss EA, Phillips WR, eds. Evaluation of the American Academy of Family Physicians's Patient-Centered Medical Home National Demonstration Project. *Ann Fam Med.* 2010;8(Suppl 1):S2-S92.

36. Green LA. Raising roses in the desert, with a cup of water [eletter]. http://www.annfammed.org/cgi/eletters/8/Suppl_1/S2#13117, 2 Jul 2010.

37. Bauer DW. PCMH: The difference between having one and being one [eletter]. http://www.annfammed.org/cgi/eletters/8/Suppl_1/S2#13093, 28 Jun 2010.

38. Kuzel AJ. Critical insights [eletter]! http://www.annfammed.org/cgi/eletters/8/Suppl_1/S45#12584, 8 Jun 2010.

39. Lesko SE. Personal doctoring versus the PCMH [eletter]. http://www.annfammed.org/cgi/eletters/8/Suppl_1/S57#12612, 17 Jun 2010.

40. Antonucci JM. The NDP [eletter]. http://www.annfammed.org/cgi/eletters/8/Suppl_1/S80#12600, 13 Jun 2010.

41. Watkins RS. What will the AAFP do now [eletter]. http://www.annfammed.org/cgi/eletters/8/Suppl_1/S2#12879, 21 Jun 2010.

42. Iliff RD. The remains of the day [eletter]. http://www.annfammed.org/cgi/eletters/8/Suppl_1/S2#12591, 11 Jun 2010.

43. Moore GL. Good learning from NDP: we need more than one approach to transformation [eletter]. http://www.annfammed.org/cgi/eletters/8/Suppl_1/S2#12595, 11 Jun 2010.

44. Borkan J. Value of this work [eletter]. http://www.annfammed.org/cgi/eletters/8/Suppl_1/S80#13108, 1 Jul 2010.

45. Sinsky TA. Thank you TransforMED [eletter]. http://www.annfammed.org/cgi/eletters/8/Suppl_1/S2#12606, 17 Jun 2010.

46. Margolius D. Future victory [eletter]. http://www.annfammed.org/cgi/eletters/8/Suppl_1/S2#12636, 19 Jun 2010.

47. Mang EJ, Gutkin C. Comment from the College of Family Physicians of Canada [eletter]. http://www.annfammed.org/cgi/eletters/8/Suppl_1/S68#13231, 11 Jul 2010.