

## The Changing Face of Family Medicine.

The delivery of medicine has changed dramatically over the last 2 decades. Make no mistake about it; the changes are just as significantly felt by the physician as by the patient. A reminder about how medicine used to be, would be to remember the medical melodrama, “Marcus Welby M.D.”, which provided stereotypes for physicians AND patients.

There are many reasons for these changes. Changes in medical technology, access to information, litigation, patient AND physician attitudes, and economics are only some of the more significant reasons for how medicine is provided today.

Traditionally, the family doctor/general practitioner has been the doctor that patients grew up with, and grew old with. That was the doctor that in years past was the one that cared for not one, or two, but often three, or more generations of family members. That was the doctor that was at your home when a family member was too sick to travel out to the office, and the familiar face among the sea of strangers when medical treatment required hospitalization.

Times have changed dramatically over the years. Delivering babies and house calls were the first services to go with the new physicians, and the latest change has been the departure of the family doctor from the hospitals.

I write this, not to criticize or critique, but more to illustrate the changing face of family medicine. Many of these changes are not reversible, nor should they be necessarily, but there needs to be an ideal compromise between tradition and progress, that will also optimize the use of the current resources available, without harm to either the patient or physician.

As a family physician practicing in this community for 18 years, I have had the opportunity to witness the dramatic changes from the “old school work ethic” of 80-plus hour work weeks, with 24/7 personal on-call, to 40 hour work weeks in walk-in clinics and telephone answering machines that “do not take messages”. Not only do family doctors not deliver babies anymore, but many also do not provide pre-natal care. House calls have been replaced with instructions to go to the emergency room. In the hospital, familiar faces have been replaced with “programs” to deal with patients without family doctors to coordinate their care while in hospital.

As medical technology improves and changes medicine from an art, to more of a science, so does it change the doctor-patient relationship. Experience in the examination of the patient has given way to the experience of knowing which test to order. However, the price of this technology is not only in the depersonalization of medicine, but also there is a price in real dollars, and with a limited increases in funding, there will be reductions in other areas, namely, physician human resource. Medical school numbers were decreased dramatically in a shortsighted political decision made about a decade ago, and we now

suffer the consequences of that decision. Compounding that decision is the “new breed” of graduating physician. Medical schools are recognizing the values of a more diversified trainee, and therefore select on this basis. This translates into a physician who is more dedicated to their personal and family life, and in effect, choosing a more balanced lifestyle. Consequently, today’s graduate is not going to be able to replace the “old school work ethic” physician on a one-to-one basis.

Technology also results in more choices, which results in more specialized treatments, and more specialized care. This also gives rise to more questions, and opportunity for litigation. Twenty years ago, multi media advertisements encouraging medical malpractice litigation were unheard of.

Finally, economically, the current fee schedule discourages the participation of family physicians from caring for patients in hospital, simply by dictating that a physician is paid the same or more for treating a patient in the office for a “cold”, than for a patient in hospital with a serious illness. The reasons for maintaining hospital privileges certainly are NOT related to economics for the family physician, but rather to the dedication to the ideal of what a family doctor is, or was. Primary Care Reform in the current form of Family Health Networks, addresses this issue, but does so miserably, as it addresses (and inadequately so) only the financial problems. Our problems with this system are not just with the economics.

Whether it has to do with delivering babies, providing house calls, or maintaining hospital privileges, the decision to provide a service is a personal one for each physician, and it is not likely that a single reason dictates how that decision is made. It is just to know that it is a very individual choice.

Albert Ng M.D.  
Past President, Essex County Medical Society.