



## *Introduction*



**T**HIS IS a book about primary care medicine and its increasing importance in solving the health care problems of individuals and communities now and in the future. Because primary care is the capstone of twentieth-century medicine, it is also the foundation for twenty-first-century doctoring.

The restructuring of the American health care system going on now at a thoughtlessly rapid pace is pushing primary care into prominence in managed care organizations throughout the country, with apparently little understanding of what primary care medicine should be. In the unsettled contemporary medical world, it is little noticed that during its rise to prominence the idea of primary care has been changing from largely an organizational concept—related to the hierarchy of services in medical care—to a sophisticated generalism. The pressure for its new form comes from rising costs and current difficulties in health care delivery and sub-specialty medicine. The emergence of the new generalism is also propelled by the mismatch between the high-technology medicine at which we excel and the health care needs of large groups of the population—for example, the poor, chronically ill, aged, and disabled. A shortage of physicians in rural and other underserved areas is also an impetus for finding ways of introducing more primary care physicians into these settings.<sup>1</sup>

The rapid change in the health care system that is bringing primary care medicine to the fore, mostly to reduce costs, also poses threats to its development. At a time when money speaks so loudly, primary care has come to be seen by many as a kind of medicine with financial, social, and organizational advantages, with little regard to it as a kind of medicine in its own right. It is inexpensive compared to high-technology specialist care; it can be provided in a physically accessible fashion and can fit into the social structure of the patient populations it serves; and it is administratively uncomplicated since it can be delivered in community settings (although less so in some managed care environments). Some other common defining characteristics that have been discussed are that primary care physicians are first-contact doctors, that they may act as gatekeepers—aiding the more rational use of resources—and that they are not specialists or are not functioning as specialists. *It is a common and destructive error, because of these obvious organizational advantages, to act as though the medicine itself is simple.*

Primary care medicine is based on the centrality of the patient rather than on an organ system or a disease, as is the case with specialism. It is addressed to both the sick and the well. It understands functional impairment and disease to be processes that enter into the patient's life story, so that its interventions are chosen with the development of that story in mind. Because of this, it is as well suited to prevention as to treatment, to children as to adults, and especially to the care of the chronically ill, who make up the largest number of the sick in our society. Primary care medicine can best be provided by generalists who are specifically trained to meet the broad, as well as the intellectually and technically exacting, demands implied in the definition of the term. These are doctors who are able to come to know the sick or well person and join this information with their knowledge of medical science, disease, and technology in the diagnostic, therapeutic, and preventive processes. So, *generalism* and *generalist* are terms that have come into use, in part, to counter the simplistic ideas often associated with the term primary care.

Thus, the ideas that underlie current understandings of primary care medicine have been evolving since the 1920s, slowly in the beginning but much more rapidly in the last thirty years. In this period two other movements in medicine, as well as widespread social change, have further defined what is asked of primary care physicians. The family physician movement, gaining force in the

1960s, decrying specialty medicine's concentration on the disease rather than on the patient, sought to focus the doctor on the patient in a special way. In G. Gayle Stephen's words in 1975:

Family physicians know their patients, know their patients' families, know their practices, and know themselves. Their role in the health care process permits them to know these things in a special way denied to all those who do not fulfill this role. The true foundation of family medicine lies in the formalization and transmission of this knowledge.<sup>2</sup>

A second movement, increasingly visible in the 1970s, became another force that led to the care of a patient as a sick person within a family and community matrix; it became known as the *hospice movement*. Indeed, the term *palliative care*, which was adopted, implied the failure of disease-oriented medicine to cure the patient or meet the needs of the patient and family. Palliative care is often associated with symptom control, but hospice physicians know that symptom control is inadequate in the absence of a much broader understanding of dying patients. Suffering is an affliction of persons, not bodies, and can occur in relation to any aspect of a person: physical, psychological, social, or spiritual.<sup>3</sup>

The family physician and palliative care movements were born during a period in the United States marked by a great expansion in our understanding of the concept of person. The civil rights and women's movements, the rise of bioethics, the embrace of difference and diversity, and the consequent disappearance of the melting pot metaphor all celebrated the emergence of an enriched concept of person. For medicine, this meant not merely an individual or a bearer of rights but: "Me, doctor, treat *me*, not just my lungs or liver."

The family physician movement grew rapidly in the early years after its official designation as a specialty in 1970 but then faltered, its growth slowing until its recent marked resurgence. Palliative care continues to struggle to gain acceptance within mainstream medicine, although the number of hospices in the United States continues to rise. During these years, despite the problem of acceptance and well before the contemporary managed care explosion, the medical literature reflected a progressively increasing interest in generalism. In light of the attention given to the subject and its importance, however, what has been written about primary care medicine is disappointing because it is incomplete. The literature makes it clear that primary care physicians—generalists—will no longer focus on a

patient's physical disorder but will also be aware of psychosocial factors in health and disease, and of their patient's and their own place in the community. They will be responsive not only to the varied needs of individual patients but also to the other demands of the health care scene, from economic to environmental. They will understand the importance of preventive medicine and their role in helping their patients and communities lead healthy lives. But several questions remain: *How will this new generation of primary care physicians accomplish these things? What new kinds of knowledge will have to be gained? Who will teach these doctors-in-training? And what will actual, day-to-day doctoring look like?* One might object that the family medicine literature now, and for years, has, for example, emphasized the doctor-patient relationship, the whole patient, communication skills, the context of the patient's family and community, and a biopsychosocial model of illness.<sup>4</sup> No one questions the soundness of these ideas; the problem is that after a full generation of prominence they simply have not thrived within a disease-oriented, technology-driven medical establishment. For two generations we have asked doctors to focus on the patient as a person, yet, more often than not, we still see the patient's human concerns swept away by the technological imperative. *If primary care is a better medical practice, why hasn't it won the field?*

The failed medical programs of the 1960s must be kept in mind for the lesson they teach. Virtually all the descriptive ideas and terms currently used to envision the advantages of primary care—for example, continuing, coordinating, comprehensive, treating the whole person—characterized the medical programs funded as part of President Lyndon Johnson's War on Poverty. Naturally enough, as the money dried up, the programs and the medical care institutions that were part of them disappeared (with the exception of today's community health centers, the grandchildren of the neighborhood health center). *The ideas, unfortunately, also withered*, suffering from malnourishment. They did not catch on or become institutionalized because, without medical knowledge and skills to match the rhetoric, they were blown away by the fresh winds of specialty medicine and burgeoning technology. During the same period, many medical schools had social and behavioral science programs that also generally failed to translate their teaching into medical practice, and they too faded. If medical generalists are ill-trained to meet the expectations imposed on both physicians and

the public regarding primary care medicine, primary care medicine will fail.

There is little evidence that the lessons of this history have been learned. Each new generation of educators attacking the problem and trying to broaden the approach of physicians to include sick and well persons, in all the dimensions of the word *person*, confuses the fact that because they know the need to solve the problem, they know what is needed to get things done—as if both are the same. Caring is not enough. In each new era, some persons tend to act as if no one else knows what has to be done, or as if others are not true enough to the ideals, or lack desire or will—as though what has to be taught are the *principles* of primary care. This book is based on a very different supposition. Let us start by acknowledging that the central idea of primary care—that the person is the subject and object of medical care—is already widely known and accepted. Suppose, further, that it is known and accepted that the social and psychological elements that characterize the lives of persons have an impact on their illnesses. That students and physicians-in-training know these things but are unable to put them in practice to the extent that they win out over disease-oriented medicine and our ubiquitous technology. Granting the truth of these statements changes the educational problem.

The issues are clarified by realizing that primary care medicine stresses not only the central place occupied by the individual patient, but equally the position of the individual doctor.\* The title of this book, *Doctoring*, reflects the fact that in primary care medicine it is the being of the physician, not just doing, that counts. Physicians are not merely bearers of knowledge and skills, vitally important as those are, but are themselves the instruments of care. This represents a shift away from the idea that has occupied twentieth-century medicine: that it is impersonal objective medical science that knows the disease and effects the treatment. It also represents a change in the requirements of training. Much of what is required to care for sick *persons* we have asked the art of medicine to do in generations

\* Primary health care can be, and is being, delivered by nurses and physician assistants as well as by physicians. The need and the function create a framework in which to put roles. There is no need to get tied up in conflicts of power and hierarchy. What needs to be stressed are that the same principles, the same knowledge base, and the same skills are required of all. It is the kind of medicine that counts, not who does it.

past. Education in regard to medical science and technology has far outpaced that of the art. The training of primary care physicians must recognize a distinction between doctoring itself and the medical science on which it is based. If primary care physicians are to fulfill their anticipated role, teaching the techniques and knowledge base of doctoring as well as how to be a doctor should be as explicit as teaching medical science. A true and sustained shift toward the training of primary care physicians, therefore, will rely on distinct changes at all levels of medical education. The principles are clear enough; there have been enough classes that provide examples or even role models; what is needed now is knowledge-based skills. For example, properly taught communication skills based on knowledge of how the spoken language works and an understanding of the nature of relationships will endure within physicians who practice long after the knowledge of medical science learned in medical school has become obsolete.

One of the problems I am addressing in this book is the need to train physicians so that their subjectivity can meet objectivity on level ground. The newer focus of primary care physicians is the enhancement, preservation, or restoration of physical, psychological, and social functioning within the context of community. The relief of suffering stands alongside the preservation of life. This focus cannot be adopted merely by reorienting the training of doctors or making them aware of patients' needs. The patient, as a sick or well person, is in many ways a new object of interest. For this reason, doctors require the methods of the naturalist—understanding, observation, thought, and judgment—that will allow them to *really see* patients as persons, apart from the mechanisms of disease. We are not speaking of disease and *also* of the patient, the dominant understanding of this century, but of the patient *first* and the disease and pathophysiology *through* the patient. The kind of information that doctors require in order to know patients in this manner is often subjective—arising within the subject who is the patient or the subject who is the doctor. The subjective becomes objective by being thought about—it becomes an object of thought. The information is often a result of observations and interpretation by the patient that must, in turn, be disentangled by doctors. The patient, after all, is the singular source of facts; only patients themselves can know what they experience. The information that physicians can optimally obtain directly from their senses results from a medical

empiricism whose method reaches back to Thomas Sydenham and John Locke.

The problem of designing educational systems to teach these methods is complicated by the fact that the kind of knowledge by which physicians know disease and the output of technology is different from and often in conflict with the kind of knowledge by which persons are known. Knowing the history of this conflict, as well as how it is expressed in day-to-day medical practice (discussed in Chapter 2), is important to educators if students and physicians-in-training are not to be constantly subverted by the lure of "hard data." The sweet song of technology itself requires understanding so that physicians are actively trained to make it a tool rather than a master. Considering the unparalleled growth of technology in the last decade and the manner in which it has come to dominate the medical scene, it is clear that this is no simple matter. Chapter 3 addresses this problem.

I may seem to be more attentive to graduate medical education than to the teaching of medical students. This is not the case. What is proposed as necessary for the modern generalist should be part of the training of all medical students and part of the skills of all physicians. It is common knowledge that curricular change in American medical education is a slow process subject to powerful internal and external political and economic forces.<sup>5</sup> This seems particularly true of the traditional medical schools of the Northeast, which may be the last to get the idea. Since this is the milieu in which I live and work, I had developed a certain cynicism about the possibilities for change. Cynicism is generally an ineducable state, but in writing this book I have discovered that many schools in the United States are challenged by the need to teach the fundamentals of primary care and are moving in that direction.

A recent study of five schools dedicated to the ideals of medicine that underlie this book found that "The most striking institutional characteristic—present in them all—is the strong presence of an explicitly stated mission, philosophy, or theoretical model that embraces and advances a more integrated approach to care and forms the foundation for the curriculum."<sup>6</sup> Forging a new institutional philosophy that is widely embraced is difficult, but it is happening. The managed care explosion may provide further impetus for change. Graduate primary care programs, on the other hand, control their own teaching, so that they do not have to wait for a

change in their schools' curriculum. They are also smaller and require fewer faculty. Successful graduate programs can demonstrate the effectiveness of the ideas and serve as a training ground for faculty, which will make it easier to change the local climate of opinion and move the program into the medical school.

The fundamental knowledge base for primary care remains the traditional preclinical science of medicine. It is the foundation from which modern Western medicine derives its legitimacy. It is the basic source of knowledge about nature as it is expressed in the body in health and disease. All surgical and medical interventions in the pathophysiology and pathoanatomy of disease are founded on it. It is about what Carl Rudebeck calls the *body-as-nature*.<sup>7</sup> We must hope that when we get our recent graduates, they know it well. There is no substitute for clinical skill. It would be nice if they also knew social science, but this is too often not the case. It would make easier our task of teaching about the body-as-self, again after Rudebeck.

What primary care doctors require as part of their mandatory training are additional kinds of knowledge and skills. They must be taught the behavior of sick and well persons, advanced communication skills, the lessons about the evaluation of data from clinical epidemiology, how to acquire information from disparate sources and use it in making judgment and decisions, and a greater understanding of human function and disability. They must also learn to master technology through explicit training, as well as learning modern therapeutics. A thorough grounding in preventive medicine is also necessary. These educational developments will provide opportunities for exciting curricular innovation. Chapter 7 is devoted to a detailed discussion of these kinds of knowledge.

Chapter 6 addresses who will teach the new knowledge on which modern generalism is based and what to do in the absence of a sufficient cadre of teachers. There is always the danger that new programs will speak about, for example, communication skills, the importance of psychosocial elements, and the place of the community but will not teach them adequately because we lack adequate ideas or teachers. It will be sad if the inadequacies of the primary care physicians trained in these programs are taken as evidence of the failure of the underlying concept. It is a hazard for which we must be alert.

When examining any method of teaching, it is reasonable to ask what are the fundamental beliefs on which it is based and then see if the teaching method and content follow logically from the beliefs.



Thus, if effective communication is considered important, does the teaching method merely emphasize that point, as in those exercises in which a resident's interaction with a patient or family is videotaped and then critiqued? Or, alternatively, are the fundamentals of effective language use taught in recognition of the fact that in medicine we are most effective when our skills are based on underlying basic knowledge, as is the case with physical diagnosis, which is based on anatomy and pathophysiology? How and where the knowledge base of primary care should be taught is examined in Chapter 6.

Much of the suggested change in education has focused on the place of training. It seems clear that the traditional method of training physicians primarily on the wards of teaching hospitals is inadequate. Many consider it essential to provide primary care training in an ambulatory setting such as an outpatient clinic, an office practice, or in the community.<sup>8</sup> Unquestionably, the problems presented by patients outside of the hospital are different from those of inpatients, and different skills are necessary for their care. Furthermore, many patients who previously required a hospital for their care or surgery are now commonly treated outside the hospital. But there can be no change in the direction of medicine without a concurrent change in the training of doctors, so that their education prepares them for their actual tasks in the care of patients. This goes far beyond merely changing their place of training.<sup>9</sup> Changing the place of training also changes the kinds of problems physicians face. In an outpatient setting they will gain experience in the everyday issues that face primary care doctors. A number of writers about primary care point out that knowing the frequency of diseases in the populations that family physicians actually see teaches us that patients often come to doctors with symptoms but no disease. This is a reason to change the emphasis from recognizing disease to understanding and ferreting out the biopsychosocial process that leads to the symptom. All symptoms have causes, pathophysiology, and meaning. There is no reason to avoid training about serious diseases even if they are rare. It would, for example, be an egregious and probably fatal error for a doctor to not recognize and treat early meningococcemia because it is uncommon. On the other hand, musculoskeletal disorders are very common and, except for the osteopathic schools, their recognition and treatment are generally inadequately taught to undergraduates or residents. The underlying problem correctly addressed by the stress on knowing the illness patterns of patient populations is the

still too common belief that diseases are more real than the patients who have them.<sup>10</sup>


The goals of postgraduate training of generalists cannot be adequately met by clinical training alone, no matter what the setting. Systematic instruction in classrooms or seminars is necessary to solve the problem of the conflict and lack of balance between trained objectivity and trained subjectivity already discussed. I am well aware that this idea is both unfashionable and repugnant to most medical educators, but I believe we must reexamine it carefully. The present method of training was developed in Sir William Osler's era, when Osler's objective (see his textbook) was to teach about the actual presentation of disease and its variability among patients, as well as the impact of this on the diagnosis. He and his colleagues were wedded to the new ideal of science in medicine that was just coming on the scene. The newly developed clinical laboratories were just off the wards of The Johns Hopkins Hospital, and they demonstrated the direct applicability of science to clinical medicine. Most doctors ultimately did either medicine or surgery (or both), and their teachers did the thing they taught—they were practicing physicians. The lesson of Johns Hopkins was then introduced into practice. Osler's basic message is now taken for granted, but it is forgotten that his teaching method was in the service of an idea. The necessary skills of doctoring are now much more advanced, and new methods of teaching must be developed to meet the idea. Postgraduate instruction must teach doctors to be their own instrument with such confidence in the discipline of their subjectivity that it can compete with possibly conflicting images seen on films or ideas embodied in the numbers on a printout. Hands-on postgraduate training is no longer adequate to this task.

Primary care is not a unitary field. Family physicians, general internists, and general pediatricians have different perspectives. Family physicians have a wider range of clinical skills and are more concerned with well persons. General internists are more concerned with sick persons, and their knowledge has greater depth but less breadth. General pediatricians are, by definition, interested in children and adolescents, and focus on growth and development. For them, as for physicians in the other fields of primary care medicine, the patient has center stage. Despite their differences, these disciplines share a fundamental concern with persons, sick or well. This book discusses what is common to these different approaches to

primary care and the kind of training required by all. Specialists undoubtedly should also care more about their patients than about their diseases, but appropriate changes in their training are not under the control of generalists and will more likely come about after, rather than before, primary care has demonstrated success in training and clinical performance.

This book is written by an internist in the urban Northeast of the United States. It bears the stamp of the context of its author's life experience. In the current intellectual climate, it is no longer possible to claim that a set of ideas or the problems from which they arise have timeless or universal relevance; even the belief that concepts of molecular biology meet such standards will not hold water. Instead, one wants to see how an author thinks about the problems he or she raises. One also wants to see whether the ideas and the methods of thought are applicable or can be adapted to a different place and time, and under different circumstances, because the organizing thesis has wide applicability. For me, the central issue of this book is that the care of patients, sick or well, has not been adequately served by the high-technology specialty medicine from which we are evolving or by the ideas about patient care inherited from the past. Clinicians have always had to find methods to overcome the inadequacies of the medicine they were taught. Some solutions are private or even unspoken, while others are shared or published. Few clinicians, however, are fully or adequately trained to take advantage of all that we have come to understand about the state of patienthood and doctoring. Some training programs are ahead of others, and some parts of the nation are (thus far) less afflicted by the current profound changes in the organization of medical services than others, but all of us have a long way to go. This book is in the service of the journey to educated doctoring.

The perspective from which I write may disturb some because of my apparently single-minded concentration on the individual patient and doctor and on their relationship. I believe one cannot know any particular patient except through the relationship with that patient—not any relationship, but the doctor-patient relationship.<sup>11</sup> The impact of culture, society, community, or family on the individual patient and illness is profound and omnipresent. These constitute the social fabric of the patient, but their influence comes about because they are instantiated within the person—within the concepts and language, knowledge and beliefs, habits and social



rules that direct behavior. Physicians and other caregivers acknowledge the importance of the social makeup of the patient for health or illness by facilitating the flow of information from the patient to them based on respect for persons and unfiltered through preconceptions or prejudice.

When physicians are in the presence of the patient, connected through the relationship so that they can know the patient, they bring to the experience their knowledge of the social and personal dimensions of the human condition that helps direct and interpret the interaction. In order to understand the individual, doctors must know about the wider cultural and social milieu in which their patients live. If doctors do not know, for example, that corporations are currently downsizing, they will have difficulty understanding the concerns of an apparently successful middle manager. Similarly, not to know about the Hasidic family structure is not to understand the dynamics of the Hasidic couple in the consulting room. The saying that anything a doctor does or reads teaches medicine is a truism because it is true. Caution is required so that physicians do not use this knowledge to create abstractions that would interfere with their direct knowledge of the patient. Acting only on knowledge of families in general can produce errors as easily as acting only on knowledge of pneumonias in general. How knowledge of all the aspects of personhood is employed will vary, of course, with the clinical problem—for example, the care of a dying patient or the encouragement of a healthier lifestyle in a well one.

The concept of disease is omnipresent in this book, as it is throughout medicine, so I should be explicit about what it means to me, especially since there are critics who believe I am still afflicted by a nostalgic desire to hunt diseases down and trap them in their lairs—which is partially true. When I see an acutely ill patient and I want to know what's wrong, I think in disease terms—pneumonia, idiopathic pleuropericarditis, diverticulitis with abscess formation, appendicitis, and so on. They are helpful concepts that contain a large amount of knowledge about etiology, course, prognosis, and treatment. They are always in my mind anytime I hear a patient relating symptoms, in person or on the telephone; they inform my questions and my thoughts. I know that the most common reason for not making the diagnosis of serious disease is the failure to think about it (and not take an adequate history). In the chronically ill, knowledge of disease is the organizing system for understanding

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some of what is happening to the patient, as well as, for example, reading, listening to consultants, and keeping the experience of years in convenient categories. When I get the feeling that something is wrong with a patient—and the feeling is not more explicit—ideas about disease underlie my diagnostic actions, conversations with the patient and family, scheduling of visits, and so on. *I always know—by now in the marrow of my bones—that a disease is not an object, a thing to be found; it is a process inextricably bound up with the unfolding story of this particular patient.* I know that seeing diseases as processes allows me to tap into all the knowledge of pathophysiology that I contain or can discover in the literature or elsewhere. I also know that this process is taking place alongside the processes of the person and (as a shortcut) the context (including me). They exist in relation to one another—person, pathophysiology, and context—and I am trying to discover the relationship so that I can influence its course. These ideas of process and relationship constantly come back to serve me as I try to understand all the states of the human condition to which I am privy. This way of seeing diseases is opposed to understanding them as distinct and exclusive categories, in which the object of diagnosis is to find the category into which a patient fits (the way rheumatologists used to carry on about which kind of inflammatory arthritis a patient had) so that treatment can be chosen on the basis of the category. Still, by the fact of my training, process and relationship start with disease.

In clinical medicine, I believe we know as much about the interaction of pathophysiology and persons, or persons themselves, families, their relations to each other (and to doctors), and to social groups as we knew about the body a 100 years ago. Yet this knowledge is vital to clinical medicine. The following case is illustrative. Many years ago, before modern effective treatment for Hodgkin's disease existed, I took care of a young woman from age fourteen to her death at age twenty. By the standards of that time, her care was successful. She remained in school, maintained relationships, and spent very little time in the hospital or bedbound at home, although at autopsy she was virtually taken over by lymphoma. The effect of her illness on the family, on the other hand, was devastating. Her father subsequently divorced her mother, survived his own Hodgkin's disease, and then died in circumstances suggesting that his daughter's death was a precipitating cause of his death. There also appeared to be profound, long-lasting, destructive effects on the

subsequent lives of the patient's two siblings. The mother continues to be devoted to the patient's memory, almost to the exclusion of other interests. Why the patient was able to function so well despite the extent of her disease and why these things happened to her family remain matters for conjecture despite their importance in the care of these patients. I cite this case to point out that primary care medicine is not the end of an old medicine but a new direction in the exploration of the human condition and its relationship to sickness—what clinical medicine has always been about.

Primary care medicine will inevitably grow and flourish because the roots of its emergence reach deeply into medicine's history. The pace of change and the quality of newly trained generalists are in question. Changes in the health care system going on in the public and private sectors will have a crucial role in this evolution. If new systems treat physicians as the solution rather than the problem, rising morale will help spread new ideas. By contrast, health care changes based on older, simplistic views of primary care and the absence of educational support will slow the diffusion process. The agenda of the managed care organizations sweeping the country is impressing itself on the form of medical practice for good or for ill. It is too soon to know what will ultimately happen, but when I am asked whether physicians can meet the standards of practice implied in this book in a fifteen-minute visit, I think that is the wrong question. I believe that the medicine described here should be more effective in terms of patient well-being and satisfaction, as well as being cost-effective. The fifteen-minute visit is hardly the appropriate criterion. At present, the form and content of doctor visits and the promulgation of practice guidelines are often determined by cost control based on motives other than the best interests of the patient. From this perspective, the physician's act and physicians themselves can be seen as interchangeable commodities in a marketplace. I worry that this will result in a "dumbing-down" of physicians' education, reversing the major trend in medical education of this century. There are many obstacles to be overcome, so primary care medicine as envisioned in this book will probably not begin to truly flourish for a decade or more, and the numbers of new training programs will be insufficient. But this is an old profession, and ten years is not a very long time. In a nurturing environment of academic, political, and social interests, new teachers and programs will spring up. In a medical world of struggle between the old and the

new, between a basic concern for the patient versus an interest in profit—which is the most likely scenario—fundamental interest in the care of the patient, the success of new ideas that bring better patient outcomes, and the lower cost of this medicine will gradually force change, cultivate teachers, and bring increasing numbers of students and physicians into the ranks of modern primary care medicine.