MEDICINE AND SOCIETY THE PRIMARY CARE PUZZLE

Immeasurable Excellence — What Happens to Medicine without the "Good Doctor"?

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When Adrienne Sabety was pursuing a Ph.D. in economics, her grandmother's primary care physician (PCP) retired. Though her grandmother filled the care gaps with increased specialist visits, her distress suggested to Sabety that the benefits of their contributions added up to less than the overarching benefit of a long-standing relationship with a PCP. Sabety wondered: Could this loss be quantified?

Her dissertation, published in the *Journal of Public Economics*, suggests that it can.[1] After a PCP loss, patients who have relationships with specialists see them more, often relying on them to meet primary care needs. Nevertheless, among patients who have lost their PCP, mortality, emergency department visits, and hospitalizations increase in the year following the PCP's exit, probably contributing to about $46,000 in additional Medicare spending for each exiting PCP.[2] Furthermore, the frequency of adverse events in patients who have lost their PCP increases in proportion to the relationship's duration, suggesting that the relationship itself conferred health benefits.

In what she calls the "no new friends" model of PCP loss, Sabety likens the phenomenon to the experience of someone in her 70s living in an urban area with a steady stable of friends, each of whom shares with her one common activity. "Let's say I have a show friend, a dinner friend, and a walking friend," she said. "If the show friend moves away, you'll probably spend more time with the other friends and see fewer shows. But the average person probably won't make a new show friend." Similarly, after a PCP's exit, only 23% of patients form a new relationship with a PCP. Though some observers might blame the negative outcomes on poor access to primary care rather than the relationship loss itself, adverse event rates were actually higher in more PCP-dense locales, suggesting that poor access wasn't solely responsible. Sabety nevertheless urges caution in interpreting the findings. "This only tells you what happens when people lose an existing relationship," she said. Indeed, the data could raise a diametrically opposed question: If losing a relationship creates risk, why have one to begin with?

That this question in another context could trigger years of psychoanalysis hints at one of modern medicine's tendencies: attaching disproportionate meaning to things we can count. Sure, Sabety's data don't eliminate the possibility that people with a nonexistent or short-term relationship with a PCP will fare better because they'll face fewer harms if the PCP leaves. But can't some things in life, like a relationship with a trusted physician, be worth sustaining even if the benefits aren't measurable? If everyone believed such relationships mattered, however, there would be less tolerance for the constraints placed on PCPs. Because medicine has imbued the measurable with so much power, I loved Sabety's study for assigning a value to this connection. But I wondered: How much has primary care suffered because the worth of the unquantifiable goes unrecognized?

Just a Good Thing

I recently cared for an older man, Mr. T., admitted with worsening cardiovascular disease complicated by coexisting conditions. Given that many phys ing, Mr. T.'s long-standing PCP, still making inpatient visits, co ance, since I was rushing through rounds. But as he descri all-time, I became transfixed — less by details of Mr. T.'s life than by his PCP's capacity to integrate the many moving parts of his care better than I could, despite my familiarity with the medical details.

Was Mr. T.'s care changed in some measurable way by the PCP's involvement? Was my other patients' care worse because I focused more on their cardiovascular outcomes than the arc of their lives? If these questions can't be answered empirically, that's exactly the point. Most physicians recognize good care when we see it. Rather than building a culture around this implicit knowledge, however, medicine is increasingly shaped by the assumption that what's good can be captured in what's measurable — with particularly stark consequences for primary care.

PCPs, for example, face a disproportionate quality-measurement burden that often distracts from patients' true concerns, and the associated overhead costs contribute to small practices' insolvency. The related trend toward consolidation strips physicians of autonomy and feeds widespread burnout, driving many to cut back their hours or quit. Quality measurement alone isn't causing these trends. But insofar as primary care has been shaped by a conceptualization of excellence favoring the measurable over the unquantifiable, it's worth asking whether the field is better off for it.

Proponents of primary care, for instance, often emphasize that it confers greater population-health benefits than specialty care. One commonly mentioned analysis found that for every 10 additional PCPs per 100,000 people, life expectancy increased by about 51 days, as compared with 19 days from a similar increase in specialist density.[3] Though such data seem credible, I've wondered whether using evidence to defend primary care's worth is part of the problem.

For one thing, evidence evolves: as specialists' armamentarium grows and the demographics of the primary care workforce shift, higher ratios of PCPs to specialists might not continue to be associated with better population health. Moreover, primary care varies geographically: family medicine physicians in rural Alaska, often as skilled at caring for critically ill neonates as for patients with advanced heart failure, depend less on specialists than PCPs in large health systems, who are expected to triage and refer. Even if primary care's population-health benefits were sustained, however, some premises underlying claims about its measurable benefits reflect an unfair standard — for instance, the claim that it has a unique capacity to reduce health care spending. We don't look to other specialties to reduce health care costs; why should that be a metric in primary care? Ultimately, though, my skepticism toward this approach may be mostly philosophical: I don't believe that population-health metrics can determine the moral valence of a social good.

Since Medicare's fee schedule is a zero-sum game, there are pragmatic reasons to make an evidence-based case for primary care's relative benefits. But if this approach were persuasive, we wouldn't be facing the field's possible extinction. So can the case be made another way?

The "Good Doctor"

In the early 20th century, when Abraham Flexner undertook his famous review of medical education, unscrupulous physician behavior and a lack of regulatory oversight of medicine had contributed to societal distrust of expertise.[4] Determined to increase education's rigor and scientific focus, Flexner advocated for replacing the community-based practitioners serving as educators with full-time salaried faculty devoted strictly to research and training. Objecting to this change, William Osler described his fear that the profession would evolve into a group of "clinical prigs," more interested in research than "the wider claims of a clinical professor as a trainer of the young,…an interpreter of science to his generation, and a counselor in public of the people in whose interests after all the school exists."[5]

The benefits of this transition to research-oriented enterprises can't be overstated; where would human health be without the discoveries of U.S. academic medical centers? But reading Osler's words today makes me wonder whether medicine got only half the equation right. Did Osler somehow foresee that as science neared its transformational peak, people would stop believing in it? Certain phenomena are readily blamed for this crisis of faith: social media, disinformation, the resulting lack of a shared reality. Yet to interrogate any one person's impulse to seek answers outside medicine is often to confront a relational void created by our health care system. Primary care alone can't fill this void. But without a more robust, accessible primary care system, it's hard to imagine any substantive restoration of institutional trust. In that sense, primary care's problems belong to all of us.

It's not just trust, however, that's at stake. In an essay describing how severing academic medical centers from their communities institutionalized a vision of the "good doctor" stripped of personal context, Richard Baron, who practiced primary care and geriatrics in his community for 30 years, wonders whether the Flexnerian model has shaped our idea of what it means to be good.[6] "Could it be," Baron asks, "that our notion of professional accountability — and of the excellent doctor — changed wh ıtext that came with it?" Baron, who created primary care mode fore becoming president of the American Board of Internal Medicine, is well aware of the structural and financial problems undermining primary care. But his work hints that creating a primary care system that better serves society also requires grappling with problems money can't fix and questions science can't answer.

What, then, is our vision of the good doctor? Must that vision bend to modern medicine’s constraints? If not, who is responsible for sustaining it?

A Matter of Style

Cardiology attendings on the consult service at my previous institution often covered the outpatient practices of colleagues who were away. I didn’t like doing it. But I particularly dreaded covering for Dr. M., who was so renowned for his expertise, and whose respect I so deeply desired, that I worried he’d review my decisions and think I was stupid. Looking back, however, my anxiety has been replaced by a kind of nostalgia. Because though I complained, I also learned. There were clinical pearls, of course. When, for instance, would Dr. M. intervene in mitral-valve disease or aortic insufficiency? But mostly these stints became studies in practice style.

Although many aspects of Dr. M.’s style are striking — chief among them his assumption of responsibility for all his patients’ problems, whether cardiovascular or not — one moment stands out in my mind. Early one Saturday morning, a patient of his paged me to report that she was short of breath and felt like her heart was beating out of her chest. When I said she needed to go to the ED, she asked whether Dr. M. would agree. I promised to try to reach him but urged her to go immediately. Then she said something I’ll never forget: “He will want to know.”

In the immediate aftermath, I realized how much I wanted to become a physician who my patients intuited would “want to know.” But as I’ve since examined the quality movement’s inadequacies more broadly, I’ve considered how profoundly physicians are influenced by our peers, in both developing a vision of the good doctor and trying to embody it. The inverse, unfortunately, is also true: if we observe standards slip without obvious personal consequences, we may take it as tacit permission to be less vigilant. When I attest to trainee notes, for instance, I’m merely required to use a preformatted template and click “sign.” Because writing is how I make sense of the world, this shortcut probably prevents me from thinking deeply about the patient. But if I observe that others do the minimum documentation required, why shouldn’t I? The only person holding me accountable is me. It’s thus striking that for all our investments in improving quality, we’ve paid so little attention to the degree to which excellence is both immeasurable and shaped by people around us.

So what do style and its transmissibility have to do with the fate of primary care? Though tempting shortcuts abound in medicine, I think they’re particularly germane to relational aspects of care for which there’s little accountability. There’s often no consequence, for instance, for not calling a patient back or ignoring an inbox message. And there’s little reward for assuming greater responsibility — speaking directly to consulting physicians or following up on test results when no one else has. Primary care carries a disproportionate burden of such uncompensated goodwill. Though I don’t think the United States will ever entirely lose primary care, without massive resource reallocation, the system may morph into some artificial intelligence–enhanced triage system devoid of a relational core. How would such bare-bones primary care shape physicians’ conceptualization of excellence?

Maybe it wouldn’t. As Dr. M.’s approach highlights, feeling responsible for the entirety of a patient’s care isn’t unique to PCPs. Many specialists, particularly those in more cognitive fields, play this holistic role and are already taking on some primary care tasks as access wanes. I also think it’s insulting to proceduralists to imply that they never build relationships. I used to glimpse an interventional cardiologist, for instance, esteemed for his technical expertise, walking alongside his patients after clinic visits, helping them get where they needed to go. Yet there are reasons to place a premium on proceduralists’ technical expertise. Indeed, when I recently told a patient he needed a surgeon to replace his aortic valve, he said, “I want the biggest asshole ever.” I knew what he meant: true technical expertise is rare; interpersonal skills are probably the wrong criterion for choosing a surgeon.

At some point, however, everyone needs a “doctor.” But if the pragmatic consequences of bare-bones primary care are obvious, the cultural implications are less so. And as a version of medicine centered around the generalist role dwindles, signs of cultural decay are everywhere — in patients’ voices when they say, “My doctors never talk to each other”; in massive clinician chat chains where everyone’s waiting for someone else to take responsibility; in discharge summaries where patients with complex conditions and low health literacy receive boilerplate instructions to follow up with doctors they don’t even have. And I sense it sometimes in my own bare-minimum approach — when I enter a patient’s room after having cared for them for a few days and they look up and say, “I’m sorry, who are you?” and I have to say, knowing I haven’t earned it, “I’m your doctor.”

Inspirations and Aspirations

Most conversations about medicine’s ills turn into lamentations over the system’s corporatization.[7] Prioritizing profits over patients has undeniably been destructive, particularly to primary care. But we have to figure out how to be doctors in the world we have. Blaming our system’s financing for all its inadequacies risks obscuring the role of social norms in shaping doctors’ behavior and our individual agency in establishing those norms in the first place. Maybe we don’t need PCPs to model behaviors of the good doctor for the rest of us. But it’s hard to aspire to a style you rarely see. And as the type of primary care built on relational expertise retreats from our collective vision, the professional norms that once defined excellence may shift as well.

Consider the middle-aged woman with a low-grade fever and cough. She’s diagnosed with an upper respiratory infection at an urgent care clinic, but when she sees her PCP a few days later, despite the absence of alarming objective findings, he senses that she seems off. Ignoring the algorithms, he orders a CT scan that reveals a saddle embolus. She undergoes embolectomy later that day.

Or the older man with no family, admitted with delirium secondary to a bowel obstruction. Because the delirium is mistaken for dementia, a mistake then copied and pasted into every note, he’s deemed a poor surgical candidate and discharged to rehab. Then his PCP sees the discharge summary, identifies the error, calls the treating surgeon, explains that he was living completely independently before the admission, and arranges the necessary intervention.

We shouldn’t need PCPs to teach us to fix the chart or distinguish sick from not sick. These capabilities are within all physicians’ remit. Yet it’s precisely because the phenotype of the good doctor can’t be boiled down to a particular skill set, body of knowledge, or set of responsibilities that it’s so precarious. It’s a style. One that’s already fading from the cultural memory.

Even as I firmly believe in doctors’ power to improve people’s lives, I’m clear-eyed about medicine’s trajectory. We seem to be a profession in decline, facing increasing skepticism of our expertise, widespread agreement about the failures of the system to which we’re intimately bound, and a pervasive disaffection driving many physicians to seek a way out. It’s thus become more difficult to separate the structural problems from the resultant contagious sense of powerlessness. Yet that sense of powerlessness can become a self-fulfilling prophecy.

When I began writing this series, I asked my new colleagues at the Smith Center for Outcomes Research at Beth Israel Deaconess Medical Center whether “we” should be trying to save primary care. Given finite health care dollars, if shifting resources toward primary care means increased availability of algorithmic visits used merely for triage, why not direct resources instead to the specialty care that patients also struggle to obtain? Though my question prompted earnest debate, what I remember most from the conversation was a question Robert Yeh, the center’s director, asked: “Who is the ‘we’?”

One year and five essays later, I’m still not sure how to save primary care. On some days, I suspect it may need to completely collapse before it can be effectively rebuilt. But I think it’s our professional responsibility to distinguish the health care system and its constraints from the culture every physician has a role in creating. A culture without a vision of the good doctor is a profession without a soul. Though much of physicians’ impact arises from tending to the problems of the patients in front of us, some of medicine’s problems can only be solved collectively. The disintegration of primary care has been decades in the making. It seems high time to ask, “Who do ‘we,’ as a profession, want to be?”

NOTES

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Disclosure forms provided by the author are available at NEJM.org.

SUPPLEMENTARY MATERIAL

Disclosure Forms (nejmms2510430

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