In this issue of *Family Medicine*, we feature a remarkable paper by three family medicine researchers from Japan. Takamura and colleagues describe a 2-year study examining the impact of community health experiences for Japanese interns, learners in the first 2 years after medical school prior to formal residency training in the Japanese medical education system. Each of 10 interns was assigned to work with a community-based group and instructed to “try to make your community healthier in any way”. The interns then joined community groups and met for monthly debriefing sessions to share their experiences. On the face of it, this is not particularly novel. Some American family medicine residencies have assigned residents to work with community groups for decades. But three features of this study make it very innovative indeed. First, the project took place longitudinally, allowing each resident to become involved with a community group over a 2-year period with goals determined by the community and not the training program. In fact, these interns averaged 19.4 community visits over their 2 years in the program. Second, the evaluation strategy used a multimethod approach including both quantitative surveys and qualitative focus group interviews and even used a control group of community groups without an assigned intern. Finally, the program evaluation specifically examined the impact of this program on the community itself and on the community members working in the groups, not just on the young physician participants. Taken together, these characteristics make this study one of the most innovative we’ve seen at *Family Medicine* in several years.

Partnering with patients, families, and communities is a core principle built into family medicine’s new strategic plan, *Family Medicine for America’s Health,* but the origins of this idea go all the way back to the founding of our discipline. The authors of the Folsom Report, one of the foundational documents leading to the creation of family medicine, specifically called for a new model of primary care based on community-defined problems and community-defined solutions. The assumptions hard wired into these recommendations were that community problems are unique and are best understood at the local level, and that the best solutions to these problems arise from within the community itself. This stands in marked contrast to recent changes in American health care that seem to seek homogeneous solutions across large national or regional populations. These solutions usually focus on chronic disease states or high cost patients while systematically ignoring idiosyncratic community characteristics. As health care costs continue to rise, many argue that such standardization is needed to improve efficiency, an idea that can be traced back to efforts to improve industrial efficiency. Health care improvement efforts are focused on disease treatment at the level of individual patients and quality is assessed using regional or national standards. As a result, local health care, much like local public education, has been systematically removed from local control.

While these changes are not lost on local communities or on the health professionals that serve them, larger financial interests tend to override local concerns. To a significant degree, attempts to standardize one model of care for everyone lie at the heart of declining...
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public satisfaction with health care and may contribute to the growing problem of burnout among primary care providers. The local community does not always define quality in the same way as health insurers or large employers, and local care providers find themselves stuck in the middle. Perhaps a lack of attention to what communities want for their health care lies at the heart of ongoing disagreement about health reform at the national level. Communities in America will never have exactly the same goals for health care because communities in America are not all the same. The authors of the Folsom report knew this more than 50 years ago.

This is why the emerging new model of family medicine is so important. Family Medicine for America’s Health calls for an expanded patient-centered medical home that fully incorporates mental health and population health at the community level. This requires a deep understanding of the community being served and incorporates many of the traditional principles of community-oriented primary care. If this is done properly, it has the potential to restore a sense of local control over our health care system. A new primary care system should be built from the bottom up, not from the top down, and only a system firmly rooted in the local community can make this vision a reality. In the conclusion of their paper, Takamura and colleagues state, “...people in the community favor the idea of ‘designing their own doctors’ and are eager for the opportunity to do so.” The American people would certainly agree. No matter what happens with health reform at the national and state levels, it is up to us to empower the local voices of those we serve.

References