Family medicine is facing its greatest danger since its inception 38 years ago. While the value of family medicine and primary care is well documented, the current model of practice is outdated, the hassles of insurance and paperwork are choking career enthusiasm, and reimbursement is low. There is an urgent need for radical change in family medicine if it is to survive in the US health system.

In the first decade of the new millennium, we have exposed the quality chasm in American medicine—the difference between the care people could receive and the care that is delivered. Cost inflation has resumed as managed care has faded. Consumer-driven health care has arrived with both good and bad consequences—good in that there is a call for more patient centeredness in decision making and bad in that people are bearing more of the costs of their care to the point that basic care is unaffordable for many. The decade of health information technology has been declared, and evidence of the transformation of delivery systems with modern tools and methods is underway. In the face of all this change, will it also be a time of transformation in family medicine?

A big question looms over primary care as health systems develop disease management programs and interactive Web sites where patients can arrange the services they need. Is family medicine simply a range of services, or will it be based on personalized relationship-centered care? If relationship-centered care from a personal family physician has value and is to continue, family medicine will need to come up with new models of care that are effective in the patient-centered and information-rich health systems of the future.

The Value of Family Medicine

The value of family medicine has been well documented. Stange and a team of investigators performed direct observations of family physicians in practice and documented many added values such as the care given for other family members and other problems during a single office visit. Greenfield and Rosenblatt performed studies demonstrating high-quality care by family physicians in rural environments, and Starfield’s work on the importance and quality of primary care is well known. Phillips, Green, and others at the Robert Graham Center have provided data to support family medicine’s value to America’s health, while Epstein, Miller, Crabtree, and others have shown in qualitative studies the importance of relationship-centered care. All of this work shows the value of our specialty, but we should not focus only on our value when there are serious problems to address.

The Problem With Family Medicine

So what is the problem? The problem is not who we are or what we do but how we do it. The problem is that our current process of care is ineffective and obsolete. Why? Because the brief-visit model is an acute care model—whereas today, in addition to acute care, we also provide preventive care and chronic illness management, and we strive to do this using the biopsychosocial model and with a family systems orientation. The brief-visit acute-care model no longer fits these tasks.

Outcome studies show that current office practice with brief visits is a poor way to manage common chronic diseases. McGlynn et al found that with brief visits, patients only receive the currently recommended care for chronic conditions about half the time. Similarly, community surveys of hypertension management show that while about two thirds of patients know that they have hypertension, only about half are receiving treatment, and only a quarter have their hypertension controlled. Why? Because 15-minute visits every 3 months don’t work. Trying harder with the same ineffective model will not work. Indeed, one definition of insanity is doing things the same way over and over and ex-
to provide care! We are diseducating our residents! We forget that entire civilizations and societies collapse from within if new energy is not brought to them, and we may be engendering the “society” of family medicine in our residency programs.

We should immediately eliminate the visit number requirements for our residents. Instead, we should look at the population of patients they care for, their caring interactions, and their quality outcome measures. Most importantly, we should give our residents the time to become effective healers.

**Why Don’t We Change?**

So, what keeps us from changing? There are two processes holding us back—complacency and powerlessness. The complacent among us feel that the problems are external to family medicine. They feel we are in a cycle and that nothing needs to be done because over time, family medicine will come back in style. The powerless, on the other hand, feel they have little control over their work environment, especially in relation to patient schedules, productivity, and finances.

The truth, however, is that family medicine as it has been practiced up to now will not come back in style, and time alone will not change things for the better. Further, we are not powerless to make things change—we need to change things ourselves.

**How We Can Change**

The future of family medicine depends entirely on the quality of care we deliver. In fact, family medicine will be an anachronism if we do not meet today’s quality of care standards, and we cannot do that unless we change how we work. We can take a lesson on how to change from Womack and Jones, who studied the Japanese model of change used by Toyota. They found that the Japanese use two words for change processes: kaizen, which means continuous incremental improvement, and kaikaku, which means radical improvement.

Both kaizen and kaikaku are necessary for success over time. Kaizen, built into the workflow, creates continuous improvement cycles. Periodically, however, it is necessary to step back and implement kaikaku (radical change) to come up with new models, for without kaikaku you may become obsolete even with incremental kaizen change. Many of the individual elements of the Future of Family Medicine report—open access scheduling, group visits, and even the electronic health record—are kaizen (incremental change) in which the basic care model is not changed. It is time for kaikaku in family medicine.

**The New Model**

The new model of family medicine as described in the Future of Family Medicine report has many elements. I want to focus on the first one and discuss it alongside the first rule of change in the Institute of Medicine (IOM) report, *Crossing the Quality Chasm.* The first rule in the IOM report is that “Care is based on continuous healing relationships.” The key word is “continuous,” which is in sharp contrast to the current use of episodic visits. The first element of the new model of family medicine is a “personal medical home.” In patient-centered care, the personal medical home is not the physician’s office or clinic. The personal medical home is the patient’s home. We need to reach into the patient’s home and provide continuous access to services to help patients manage their health and illnesses.

With new health information technologies, all patients will have a “home page” that contains their health information and that provides them with access to medical knowledge and services. The various health information technologies, including electronic health
records, knowledge management for clinical decision support, and secure communication for Web messaging and remote care, can be combined into one product that is intelligent and communicative and that can create a revolution in how we provide care. Family medicine should embrace these new technologies as a means for delivering higher-quality and more efficient services. It is inappropriate to shun these technologies because of concerns that all our patients do not have access to them, for even patients who do not currently have a computer at home, Internet access can be obtained at public libraries and other sites.

In addition to adopting technologies, we must adopt a planned and systematic approach to chronic care. Ed Wagner and his team in Seattle have developed a model for chronic illness care that reflects the best of community-oriented primary care. It involves productive interactions between informed, activated patients and a prepared, proactive practice team. Note that “productive interactions” is the operative term and not visits; not all interactions have to be office visits. Further, the planned care is provided by a team, and team care, done well, may achieve outcomes far superior to that of a single physician. Family medicine should embrace these new methods of care and be leaders in their development.

Real World Examples

How do we implement these new methods? Here are three real examples of how this might occur.

First is the case of Alan Dappen in Virginia, who dropped out of a highly respected family medicine group to form his “doctkr” practice, which uses a new communication model of care. All patient communication begins with a telephone call or e-mail, and patients are seen only when necessary. He has about 1,000 active patients and handles about 20 patient messages each day. He sees four–five patients each day in unhurried visits and makes one–two house calls each week. He charges patients for his time, regardless of how it is delivered. His practice has a Web site and patient newsletter. Dr. Dappen’s experience mirrors mine, in which I’ve found that 40%–60% of patients’ needs can be handled by e-mail.

The second example is Greenfield Health in Portland, Oregon. Led by Charles Kilo, a general internist who originally directed the Idealized Design of Clinical Office Practice project for the Institute for Healthcare Improvement, Greenfield Health’s practice uses secure Web messaging, telephone, and selective use of office visits. The five physicians spend half the day seeing patients in visits that are 30 minutes or longer. They spend the other half day messaging with patients via the e-mail or by telephone. In a day of patient interactions, by volume, 20% are through in-person visits, 40% are via Web-based e-mail, and 40% are by telephone. The practice has a regular electronic patient newsletter, and the office is used for patient education classes. There is an affordable annual fee to be a member of the practice, based on a patient’s age, with a discount for other family members.

The third example is on a larger scale. Kaiser is rolling out Health Connect, a new platform in which patients may communicate with their providers, receive customized health information, arrange for services, and review their health record—all on-line without the need for an in-person visit. Harvard Care Group has developed “Patient Site,” which offers similar services.

By using these new tools and methods, a new model of family medicine emerges. Family physicians take responsibility for a population of patients. We manage our patients’ needs and demands efficiently and effectively. We prioritize our patients’ health problems and use a team approach to their care. We take the time to be effective, and we change our concept and application of productivity. This new model of family medicine can have more caring interactions with patients each day and fewer visits. We work in real time through open access, doing today’s work today. Patients get all the time they need and receive excellent care.

Finances

Any discussion of new models of family medicine should include a comment on finances. Today’s fee-for-service reimbursement and productivity measurement based on visits and relative value units hold back innovation. There are emerging methods of reimbursement that fit the new model, and Task Force 6 of the Future of Family Medicine project has published a report that predicts better reimbursement for family physicians who use the new model.

Reimbursement methods for the types of care I’ve described fall into three groups: fee for service, prepaid or contracted care, and a combination of the two. Fee-for-service reimbursement includes payment for all services, including Web messaging, and there are services available that do this automatically. Prepaid contracts include unlimited communication with the physician for a monthly or annual fee, which can be less expensive than many of the things that our patients already pay for, such as health clubs and storage facilities. Combination models have prepaid fees for Web messaging and telephone communication and fee-for-service charges for office visits. Finances follow innovation; the new models of care described here are better, faster, and cheaper—the dream of any redesign engineer.

What Next?

The radical change I am suggesting is hard work. It requires strong leadership, and a focus on continuous learning of and teaching about new methods of care. It will require
building the capacity for change, using data to drive the improvement. We will need to start with pilot projects and, after achieving incremental improvements of office systems (such as implementing e-mail with patients, open access, and an electronic health record), then move toward the redesign of all systems.

Family medicine is embarking on a project to develop model practices through a national demonstration project. The American Academy of Family Physicians is launching a new company, a practice resource center, to execute the demonstration project in up to 20 practices, including some teaching practices. Hopefully, these new practices will be like the original 15 family medicine residency programs and serve as catalysts to a new future.

We are witnessing the birth of modern medicine. Within 10 years, it is likely that nearly all patients will have a personal home page that contains their medical information and that provides access to services they need. Our current handwritten paper charts and episodic visits will seem like they are from a primitive past. Where will family medicine be when this comes to pass? Will we be in the back rooms of medical office buildings churning out patients? Or will we be front and center in the new methods of relationship-centered care? Will we have the vision and courage to transform our specialty for this new modern age? I am optimistic. I think we can do it. I think we will do it. We must do it. Let’s do it.

Editor’s Note: This commentary is a condensed version of Dr Scherger’s 2005 Blanchard Lecture, presented at the Society of Teachers of Family Medicine 2005 Annual Spring Conference in New Orleans.

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