Necessary Change in Family Medicine: Entering Adulthood

Alan K. David, MD

The discipline of family medicine began as a counterculture movement in response to the increasing specialization of US medicine, in which the patient care was segregated by age groups and treated according to affected organ system or disease category.1 Whether one agrees with this political interpretation or not, family medicine grew from the perceived need for personal physicians who would provide care to all age groups in a continuous, comprehensive, caring, and competent manner. The intent was to provide better access to the health care system as well as better care through coordinated management and patient advocacy.

Family medicine’s innovations were both profound and intuitively “correct.” With the biopsychosocial model, the patient was reintegrated as the sum of all parts—including the mind, the family, and the community—in the broadest context for well-being. This has been called the counterculture phase of our development.1,2 The discipline’s early goals were to become established in the academic milieu, master the rules of the system, enter into the curriculum, gain promotion and tenure, acquire sustaining resources, and be accepted by physicians in other specialties and medical leadership, as well as by patients.

Education in the ambulatory setting was emphasized as family medicine departments in academic institutions sought parity in terms of access to students, resources, and development of a research agenda. The discipline embraced educators, behavioral medicine faculty, physician extenders, and an interdisciplinary team approach to health care. The beginning was robust and filled with promise, and great strides were made. For the most part, these early developmental tasks were accomplished and achieved some measures of parity—the second developmental phase.2

Current State of Affairs

Today, however, many Americans do not have a family physician and, often preferring quick access to specialists, do not seem inclined to seek one. This is especially true of more-educated consumers.3 The discipline expresses frustration that patients don’t understand our value. Occasional attempts are made to educate and inform the public about family practice, but the success of these attempts is hard to measure and seems to have more emotional and anecdotal rationale than actual data. Interest in family medicine by medical students is critically low, with students responding positively to the high technology subspecialties with their perceived need, status, challenge, and positive economics.

Twenty years ago, Stephens asked “Why is primary care a problem in the United States at this time, and for whom is it a problem?”1 The question resurfaces today, and the problems of the health care delivery system that Stephens noted (accessibility and impersonality) are at least as pressing now as then.

Why is primary care in trouble? And whose “problem” is it? One can point to the medical insurance complex, to the continuing preference in medical schools for narrower subspecialties, to government policies, to the economy. Scherger proposed in 1997 that family medicine is in the third phase of its development: integration. Perhaps that integration has made it indistinguishable from other primary care disciplines and from the rest of academia.

Until we claim the problem as our problem, there will be no progress toward fixing it. Perhaps it would be better to say that there will be no progress by us. The continuing existence of family medicine is in question, and it may be that instead of a “real turn in the history of medicine,” the rebirth of family medicine has been a mere “deflection in medicine’s trajectory...
that will soon be ‘corrected’ by the prevailing powers."

   Stephens postulated two ways in which family medicine might disappear: splintering into special interest groups or “putting our interests at a higher priority than the public’s need . . .” Have we continued to put the public’s needs first, or have we fallen into the comfortable place of serving ourselves? What must we do to better meet the health care needs of patients today and in the future?

A New Stage of Development Calls for Deliberate Action

The current crisis in family medicine is an opportunity—or perhaps an ultimatum—to move forward. We can no longer be codependent on others. We have reached the fourth developmental stage, that of maturity—or young adulthood. In this stage, people often reevaluate their view of themselves, their priorities, and their long-term goals. Successful, competent adults develop strategies to achieve their important goals and periodically assess their progress toward those goals. Above all, they take responsibility and hold themselves accountable for their own actions. Those are the tasks before family medicine now.

In business, getting where you want to go requires planning. We are in a national business—more than a $1 billion-a-year enterprise. We think it is the business of producing family physicians for the people of this country, although it is possible that we are in another business that is not yet clearly defined. But, we have little or no market research to tell us what business we are in that might better guide our efforts. We have not yet demonstrated the benefit of our “product” to the health care consumer—our major stakeholder. And, we have no strategic plan to help us set and reach goals and evaluate our successes and failures. Efforts are being made to reengineer the practices of tomorrow, revise the content of residency programs, and improve the quality of care we provide. The Future of Family Medicine Project is a collective, organizational response to the problems. But, can five separate committees really design a cohesive plan? What are the expected outcomes of the initiatives, and how will their effectiveness and impact be measured?

Problems With Solutions

Even without doing a more-careful analysis, a number of key problems are clear. Fortunately, possible solutions are often just as clear. A few to consider:

   Continuity of Care

Currently, continuity of care is an illusion. We continue to place high value on continuity of care, yet our training programs are discontinuous. Stephens and others long ago identified providing continuing care and proving the value of the managerial model for clinicians as the key to reforming US medical practice. Yet, existing research is inconsistent and conflicting. We have never adequately researched the value of continuity to patients, outcomes, and cost-effectiveness. Along with research, solutions include requiring residency programs to measure continuity and evaluate its impact.5

   Quality of Obstetric Training

Maternity care is another traditional value of family medicine. It continues to be an important aspect of family medical care for family physicians who are well trained and interested and especially for those who are practicing in underserved areas. However, while some programs do an excellent job in obstetrical education, overall, the majority of family practice residents are minimally trained in obstetrics. As a result, more than 70% of graduates never practice obstetrics after residency. For many, the issue is one of integrity: without adequate training for doctors, both patients and physicians are at risk. It seems that programs must decide to provide excellent obstetric training to produce competent obstetrical practitioners or decide to include it intellectually but not in enough depth for use in practice. Our current Residency Review Committee for Family Practice requirements leave us little but the minimalist choice for the majority. It is probably not necessary for the entire discipline to make the same choice about obstetrics training. But, conscious choices must be made.

Clinics for Patient Care and Teaching

The family practice center (FPC) is the focal point of resident education, as well as the point of most service delivery. Yet, many programs continue to focus heavily on inpatient medicine, and many residents do not see the FPC as their proper and important “home.” Most teaching clinics are disorganized, chaotic, and difficult places to practice and to teach. We have much to learn from well-organized inpatient teaching services, where there is more teaching and learning in an organized, cohesive format. However, teaching responsibility should not be abdicated to hospital-based specialists. We need to create the same level of excellence in the ambulatory setting by using FPC rounds, active precepting, electronic databases about the practice, and open access models of care.

The Biopsychosocial Model

Communication and Attitudes: Patient centeredness, compassion, professionalism, and advocating for patients in the health care system are core values we not only espouse but also often claim to excel in. While these are philosphic cornerstones of family medicine, we have not expanded our behavioral curricula, our Board exams do not emphasize it, and our behavioral medicine faculty are almost pe-
Commentary

Peripheral to the day-to-day teaching efforts in many of our residency programs, The Accreditation Council for Graduate Medical Education competencies reinforce values regarding doctor-patient communication and the relationship between the two. We should lead—not follow—in the teaching and measurement of these competencies.

Research

As physicians, we must know ourselves and our specialty before we can heal ourselves. Yet, we have not yet identified a research agenda that is uniquely and properly ours. Will we make the easy (and cynical) choice of “anything that can be funded”? Or will we examine the process of care in family physicians’ offices, the quality of our management of chronic disease, health outcomes, preventive care, ambulatory technology assessment, medical education, and behavioral medicine? Identifying our field of knowledge and investigation might enable us to persuade the National Institutes of Health to develop a branch for family medicine research.

The Plan for Strategic Change

Growing into responsible adulthood carries responsibilities as well as privileges, work as well as reward. We have always been good at doing work, but, perhaps, we have not been as good at prioritizing the work that needs to be done to ensure our own professional vitality and relevance. We cannot carry forward our responsibilities to our patients if family medicine becomes a vehicle abandoned by the roadside.

Attracting more students to family medicine is important. So is continuing to establish influence in academic health centers through achieving deanships and vice presidencies. But those accomplishments are outcomes of strategies, not strategies themselves. While the purpose of this paper is to argue for commitment to making strategic change and not to propose the strategic plan, I’d like to point to several plan essentials: (1) Analyze and continue to analyze what the American people value, desire, and will pay for in terms of health care, (2) Research the effectiveness of continuity of care, the value of behavioral training, and the cost-effectiveness of a competent, comprehensive personal physician, (3) Refine and, if necessary, redefine the core values of our practices, (4) Change residency education to increase flexibility and reflect the core values of family medicine: personal, integrative, continuous, caring, and competency-based education that can be measured, regardless of other areas of emphasis that individual programs might choose to build on, and (5) Continue to evaluate all strategic efforts to change our “map” of the world. Make the results quantifiable, and select those efforts that have current and future impact.

Conclusions

I think that our core business is producing family physicians: personal, caring, competent individuals whose integrative function and abilities can be defined and measured, who are available to patients who need them and whose value is the core of the US health care system. We need to take a hard look to see if that is indeed the “product” we are creating. Where we fall short of the mark, we must change to solidify the contribution of family medicine for the future. To do any less would be an abrogation of our responsibilities. After all, we’re adults now.

Acknowledgment: Thanks and appreciation to Chris McLaughlin, editorial and writing assistant in the Department of Family and Community Medicine, for her contributions to this manuscript.

Correspondence: Address correspondence to Dr David, Medical College of Wisconsin, Department of Family and Community Medicine, 8701 Watertown Plank Road, Milwaukee, WI 53226. 414-456-4243. Fax: 414-456-6523. akdavid@mchsi.edu.

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