Family Medicine Needs a Generation of Dreamers

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Does your society have more memories than dreams or more dreams than memories?

Thomas L. Friedman, The World Is Flat.1

Thomas L. Friedman addresses this question to societies such as the United States today and to corporations. We might ask the same question of family medicine.

He follows the question with the observation, “When memories exceed dreams, the end is near.”1

The generation of pioneers that founded and established our specialty between 1965 and 1975 were definitely dreamers. They focused much more on a new specialty of family medicine than on the preservation of general practice. The first residency-trained generation of family physicians were also dreamers. They focused on making family medicine a legitimate academic specialty and one that was exciting for medical students and residents.2

Today, the pioneer generation is older and understandably nostalgic. The first residency-trained generation, to which I belong, also seems nostalgic and is wondering what happened to family medicine. Fewer than half the US medical students who chose the specialty a decade ago are doing so today. Family physicians are struggling to get through their work days and feel powerless to change their work environment.

The future of family medicine rests with a new generation of family physicians, training now, during an era that has little contact and identification with the pioneers and first generation of residency-trained family physicians. They grew up during the dawn of the information age and the new globalization. If relationship-centered care and the commitment of being a comprehensive personal physician are to survive in family medicine, this new generation will have to invent a 21st-century application of these principles.

Previously, I have described the redesign imperative in family medicine,3 an imperative because the complexity of the work in primary care and family medicine no longer fits the traditional brief visit care model. We are now expected to provide comprehensive prevention and the continuous management of chronic illness, along with treating whatever acute problems our patients may have. A review of our records or a survey of the populations we serve show that we do not do this well.4 It is not our fault; rather, our care model is faulty. We need a new model of care that matches our work requirements. This model should be rich in information management and provide “on demand” access to services.

Who will come up with new models of family medicine and implement them in our education programs and clinical practice? Will the dreamers come from the medical directors who worry about the next month’s productivity report? Will they be the residency directors who prepare for the next Residency Review Committee accreditation visits and worry about how to keep the budget going? Will the dreamers be the experienced family physicians who have spent a career learning how to squeeze an hour of caring into 10 minutes of face-to-face time with patients?

No, I don’t think it will be any of these. Just like the young pioneers of family medicine 30–40 years ago and the first generation they trained, the dreamers need to come from the young who readily see the limitations of how family medicine has been practiced and how it could and should be different. This new generation grew up with the Internet, handheld devices that store and present hundreds of hours of entertainment, and cell phones that allow connectivity from virtually anywhere.

The Future of Family Medicine report has been written and is a start of the reform process.5 Like the prior Millis and Willard reports,6,7 the change generation may not read the report but will capture the need and vision for change in the new social context of information exchange, communication methods, and caring interactions.

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Today, medical students look at how family medicine is delivered, and they run the other way. That is not how they want to spend their careers. The idea of being a personal physician to a community of patients is appealing but not while running on a hamster wheel of brief encounters. Today’s residents are as tired as ever, and the excitement of clinical practice in the clinic is rarely felt. Do they have the vision and energy to dream of a better way?

The biggest challenge facing family medicine today is to develop a new generation of dreamers who will change the specialty into new care models that fit the emerging social context of communication, caring, and service. No doubt health care in general is embarking on a major process of change, with interactive Web sites and embedded secure communication, electronic health records shared with patients from their home, and a public with complete access to all health information on the Internet. Who will reinvent family medicine to fit into new health systems? Will nursing and other health professionals become the new first tier of health service online while primary care physicians remain relegated to the back rooms of medical office buildings seeing those patients who still benefit from brief visits? Who will want to enter that line of work except physicians who want a simple work schedule and a low-stress clinical setting?

At the end of *The World Is Flat*, Friedman calls for a:

. . . generation of strategic optimists, a generation with more dreams than memories, ... a generation that wakes up each morning and not only imagines that things can be better but also acts on that imagination every day.¹

How do we create this new generation in family medicine? Current leaders in family medicine must do the hard work of initiating the change process based on a new vision for family medicine. The *Future of Family Medicine* report is a great beginning. Translating that report into action may come from the New Partners Initiative embarked on by the leadership of the Society of Teachers of Family Medicine⁸ and TransforMED, a new initiative developed by the American Academy of Family Physicians.⁹ We need to create a spirit of change and revolution in family medicine that sweeps into all of primary care. That requires discussion and efforts at the grassroots in all family medicine settings. Let us get on with it!

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**REFERENCES**