In this issue, we feature four articles that address family medicine’s crucial role in the education of those who care for underserved patient populations. As health reform begins, there are millions of people in America without access to high-quality primary care. Most of us know that providing universal insurance will not assure access to care for everyone. Every day patients experience geographic, ethnic, educational, and cultural barriers to care. For some, the barriers are insurmountable, and this problem will only worsen over the next decade as the population ages. So, it is important that we teach family physicians to work in community health centers, to speak languages other than English, to deliver culturally sensitive care, and to care for patients in inner cities and rural areas. This has always been an important focus for family medicine education. Caring for the underserved is central to our identity. It causes us to care deeply about our work and to be proud to be family physicians. So what could possibly be problematic about that?

In 1973, Don Ransom and Herb Vandervoort published a paper in the *Journal of the American Medical Association* titled “The Development of Family Medicine: Problematic Trends.” Appearing only 4 years after the accreditation of our first residencies, this paper is mostly remembered for making a distinction between the medical specialty of family practice and the academic discipline of family medicine. However, the authors also asserted that it was a mistake to promote family medicine as the answer to what was then considered to be a critical shortage of primary care in America. They argued, “The concern over the primary care shortage is apparently so great that most of the chief proponents of family practice have committed themselves to plugging the gap in the medical care delivery system at the expense of sacrificing what is most hopeful about their young specialty.” In essence, Ransom and Vandervoort worried that family medicine would fail to reach its potential because of a shortsighted desire to address immediate public health needs and that residencies were being built too quickly without sufficient curriculum and faculty development.

In the early 1990s, with the Clinton Health Plan and managed care on the horizon, we again chose to expand residency capacity, adding nearly 100 new programs as we anticipated a gate-kept primary care system. Our program directors have spent much of the last 10 years simply trying to fill these programs with qualified candidates. Who would argue that quality has not suffered as a result?

Today as we work to define and build Patient-centered Medical Homes, we are again confronting an analogous dilemma. Should we spend our time perfecting the medical home model or should we rush to the rescue by trying to produce more family physicians? Is it possible to do both? Reading Ransom and Vandervoort’s paper after all these years, one wonders how our health system might be different if we had built a stronger foundation of research and innovation in our discipline from the start. Has primary care in America eroded to its current precarious state in spite of, or because of, our decisions?

America has a primary care system so damaged and dysfunctional that virtually no one is safe from its deficiencies. How can we address these problems without forgetting the lessons learned from past “problematic trends”? A reformed health system needs to care for everyone. The new system cannot leave out those populations that always seem to fall through the cracks because of race, or culture, or location. But health reform cannot be about us once again protecting those most vulnerable populations just enough to allow the rest of American health care to resist fundamental change. Wisdom comes from thinking beyond immediate needs and expedient solutions, no matter how good such solutions might make us feel about ourselves. The success or failure of true health reform may depend on such choices.

**Reference**