What Does Family Practice Need to Do Next? A Cross-generational View

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Background and Objectives: *This paper presents a 60-year view of family practice, including its first 30 years and best projections for its next 30 years as a discipline and field of practice.* Methods: *An objective cross-generational approach was taken based on available evidence.* Results: *Five lessons are drawn from the past 30 years: (1) Neither medical education, medical practice, nor the health care system have been reformed by family medicine. (2) Family practice remains but one of several options for primary care. (3) The generalist-specialist ratio has shifted farther to specialists since 1970. (4) The United States is unique among Western industrialized nations in having multiple generalist specialties. (5) The three primary care specialties are on parallel but separate courses. The health care system is now very different from that of 1970, as a result of managed care; increased burden of chronic illness in an aging population; de-emphasis of hospital care; proliferation of primary care providers; increased emphasis on shared decision making with patients, cost-effectiveness, and value of health care services; and advances in information and communication technology.* Conclusions: *The following course changes are recommended for family practice: (1) Embrace new paradigms of care (eg, evidence-based medicine, population-based care, chronic disease management). (2) Modify practice style and redesign systems of care. (3) Embrace further differentiation within family practice. (4) Reassess and revise educational programs at all levels. (5) Increase emphasis on practice-based research and expansion of clinical electronic databases. (6) Explore feasibility of a unified generalist discipline through new alliances with other primary care specialties. (7) Build organizational and political strength through alliances in advocating for structural change of the health care system to include universal coverage and a generalist primary care physician for all Americans.*

(Fam Med 2001;33(4):259-67.)

It is an honor and privilege to contribute to this Keystone III conference on the future of family practice. We have chosen to take a 60-year view of the discipline—30 years back and 30 years forward. Our perspectives are those of two family physicians of different generations, one (JPG) graduating from medical school in 1960, the other (EB) graduating in 2000. We challenged ourselves first to independently distill our respective views about the next steps for family practice and then collated them into this cross-generational perspective. We have tried to be as objective and evidence based as possible, which at times leads to potentially provocative or politically incorrect recommendations.

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The purpose of this paper is four-fold: (1) to compare the major hopes for family practice at its genesis in 1969 to the realities of the year 2000, (2) to summarize some of the major lessons learned by the discipline over the last 30 years, (3) to briefly mention some of the most important changes affecting the health care system over the last 30 years, and (4) to present our vision for future primary care, together with our recommendations on the next steps for family practice in the areas of patient care, education, research, and organizational development.

Family Practice: 1969 and 2000

Table 1 lists some of the major hopes that many individuals had for family practice when it became the 20th specialty in American medicine in 1969. Despite its many successes, it is apparent that the hopes held in 1969 for the future of family practice fell far short of the mark by 2000.

Lessons From the Last 30 Years

We believe five overall lessons can be learned from the first 30 years' evolution of family practice.

Lesson 1: We didn't reform medical education, medical practice, or the health care system.

Despite some interdisciplinary initiatives in medical education, such as the Association of American Medical Colleges' General Professional Education of the Physician (GPEP) report and its aftermath, to which family medicine made important contributions, medical education and clinical practice remain largely specialist dominated and rely heavily on the biomedical model.

Lesson 2: Because of family practice's limited numbers, family physicians remain only one of several options for primary care.

Although the evolution of family practice so far has been remarkable in many respects, particularly in education, the number of family physicians remains far too limited to provide the major source of primary care for the US population.

Lesson 3: Since 1970, the generalist-specialist ratio in the United Sates has shifted farther to specialists and shows no signs of shifting back toward generalists.

The numbers of family physicians, general internists, and general pediatricians grew by only 13% between 1965 and 1992 (to 88 per 100,000 population), while the number of specialists increased by 121% (to 124 per 100,000).[1] By 1994, the proportion of primary care physicians (by the federal definition) had dropped to only 32% of active physicians in the United States.[2] Moreover, there is no evidence that this trend will reverse over the next 30 years. In fact, according to recent data from the National Resident Matching Program (NRMP), the proportion of graduating US seniors entering generalist residency positions dropped from about 30% in recent years to 28.4% in the 2000 Match.

Rivo and Kindig have made projections to the year 2040 for the generalist-specialist mix, based on different assumptions for the entry levels of medical graduates to generalist residency training. At the 30% entry level, there will be no significant increase in the number of primary care physicians between now and 2040.[1]

Lesson 4: The United States remains unique among Western industrialized nations in having multiple generalist specialties.

In the arena of primary care, the United States continues to see competition among three generalist specialties (four if obstetrics-gynecology is included), as well as a "hidden" system of primary care provided by physicians in the more limited specialties. By comparison, general practice is the unambiguous foundation of primary care in other Western industrialized countries, representing 70% of active physicians in the United Kingdom and 50% in Canada.[3]

Lesson 5: The three primary care disciplines remain distinct tribes on parallel but separate courses.

Though they have much in common with family practice in terms of clinical skills, function, and values as they relate to the care of their respective patients, general internal medicine and general pediatrics still have largely separate educational programs, read different literature, and are organizationally more separated than collaborative—from each other and from family medicine. This divide is ironic, as general internal medicine, perhaps partly due to the influence of family medicine, has shown more interest in the biopsychosocial model and has added to its own residency training in such areas as office gynecology and dermatology. Further,

Table 1

Family Practice: 1969 Versus 2000

Hopes in 1969	*Reality in 2000*
Family practice would become the main primary care discipline.	Family practice is only one of three or four primary care disciplines, with general internal medicine being the largest.
Family physicians would increase as a proportion of all US physicians.	Family physicians represent only 12% of US physicians, down from 18% in 1969.
Family practice would have a well-accepted, central role in medical schools.	Family practice is rarely central and often is marginal.
Family practice residency positions would represent 25% of all US residency positions.	Family practice residency positions represent less than 15% of residency positions.
There would be a family physician for every family in the United States.	Way short
Family practice would integrate the biopsychosocial approach into practice.	Mixed record

practice patterns of general internists have become quite similar to those of family physicians, 75% of whom do not provide obstetric care and thereby have fewer and fewer children in their practices.

Changes in the Health Care System and Needs for Health Care

To set the stage for a consideration of a future course for family practice, we must first recognize how the health care system, as well as needs for health care, have changed since 1969. The extent of change is remarkable, as reflected by eight aspects mentioned here.

The Advent of Managed Care

Although managed care traces its origins to the populist movement of the 1940s (eg, Kaiser Permanente, Group Health Cooperative of Puget Sound), the term *managed care* has taken center stage today because of factors relating to cost containment. As it has evolved over the last 2 decades, managed care now more often involves managed *reimbursement* than managed *care.* In this new landscape, there has been intense economic competition among health maintenance organizations (HMOs), preferred-provider organizations (PPOs) and point-of-service programs. The essential elements of managed reimbursement have led to growing frustration on the part of physicians and patients alike.

Currently, some form of managed care has virtually replaced cost-based reimbursement to hospitals and fee-for-service medicine, both for people covered by employer-based insurance and for those on federally funded assistance programs. In fact, some kind of managed reimbursement now covers 75% of the US population[4] (Black R. Health Care Financing Administration, Office of Managed Care, personal communication to M.H. Bailit, February 28, 1997). About 50% of primary care physicians receive part of their reimbursement through capitation, and almost 50% are employed by a health care organization.[4,5]

Increased Burden of Chronic Illness

Aging of the US population has major implications for the kind of health care needed by the population. The proportion of Americans over age 65 will double (to almost 70 million) between 1995 and 2030.[6] As the population ages and medical technology provides more effective and efficient care of acute illnesses, the predominant burden of disease is shifting to chronic conditions. These chronic diseases are often multifactorial, coexist with other chronic diseases, and require care beyond the biomedical model. Of growing importance are such approaches as disease management, palliative care, and application of the biopsychosocial model through shared decision making with well-informed patients.

De-emphasis of Hospital Care

Although the acute care hospital has been the base of the US health care system for most of the last 100 years, its role is rapidly diminishing as more care is provided in outpatient settings. Hospitals are becoming the site of care only for patients with serious illnesses that often require intensive care. The length of hospital stays has shortened, and patients discharged from hospitals frequently need considerable medical and nursing care after discharge. The escalating costs of hospitalization are partly responsible for this shift from hospital care to ambulatory and other sectors of care, but containment of hospital costs has still not been achieved.[7]

As inpatient care has become more intensive, ambulatory care has become more demanding. The pressures of outpatient care have made it more difficult and less efficient for primary care physicians to remain involved with inpatient care. Twenty years ago, many primary care physicians cared for up to 10 inpatients on any given day, but that number has dropped to one or two today.[8]

Hospital care is now increasingly being provided by dedicated hospital physicians—ie, “hospitalists.” The hospitalist movement is gaining momentum rapidly; it most involves general internists but also some family physicians. Hospitalists, by definition, spend at least 25% of their time on inpatient care and typically care for 10 to 15 inpatients at any one time.[9] There are some preliminary data that suggest that hospitalist care may reduce lengths of stay and costs of hospitalization without compromising quality of care.[10-12]

Proliferation of Health Care Professionals Involved in Primary Care

The primary care marketplace has become more competitive than ever as physicians in other specialties and many nonphysician professionals assert their claims to one aspect or another of primary care. As Edward O’Neill, internist at the University of California-San Francisco, has observed: “There are 150,000 ‘born again’ primary care providers out there.”[13]

Managed care plans, and even state legislatures, have increasingly responded to public pressure by enabling point-of-service access to specialists. In 1997, for example, the Georgia legislature passed a law requiring managed care plans to offer direct access to dermatologists without referral, while Indiana has mandated the opportunity for direct access to anesthesiologists, dermatologists, mental health professionals, and others.[14]

The number of nonphysician clinicians (NPC) doubled between 1992 and 1997,[15] with 63,000 nurse practitioners and 29,000 physician assistants in the country’s NPC workforce by 1997.[16] Although less than 15% of nurse practitioners are in independent practice, 25 states and the District of Columbia have passed legislation removing requirements for nurse practitioners to have physician supervision and/or mandatory collaboration with physicians.[17]

Other health professions are also vying for a piece of primary care, including clinical pharmacists[18] and some alternative care providers. Of 18 major managed care organizations (including Aetna, Kaiser Permanente, and Medicare), 14 now offer at least 11 of 34 complementary and alternative medicine therapies, while Blue Cross-Blue Shield now permits its HMO enrollees to select chiropractors as their primary care provider, even though they lack prescriptive authority.[19]

Shared Decision Making with Empowered Patients

There has been a big change in recent decades in public expectations of health care and in empowerment of patients. Many factors have contributed to this change, including the Great Society programs of the 1960s, increased expectations of the Baby Boom generation for a voice in their health care, and recent advances in information technology (now patients can be instant experts on their problems after 20 minutes on the Internet). Many of these changes are for the better, but the physician-patient relationship has often suffered in this process. Radowski notes the effect on the physician-patient relationship in these terms:[20]

> Patients are better informed, less submissive, and more open. They still seek a captain to lead them against fate but do not sign on as readily and usually wish to know where they are headed. To the extent that science has replaced magic, the doctor-patient relationship has been weakened. The relationship is more fragmented among specialists, in health maintenance organizations (where the organization may be the physician), and in hospitals, because of the house staff. The requirement for second opinions has also changed the relationship, along with the critical view of medical care expressed in magazines, books, newspapers, and on television. Malpractice suits may partly be a consequence of a poorer doctor-patient relationship, but they probably contribute to it also, as must the larger number of people who relocate, have two homes, or visit walk-in centers or emergency rooms for their care.

Advances in Information and Communication Technologies

A revolution in information and communication technologies has already transformed much of the nation's business community. Health care has not been in the forefront of these changes, but it will not be far behind. In its recently published book, *Health and Health Care 2010: the Forecast, the Challenge*, The Institute for the Future predicts that these information and communication technologies will affect health care in four principal areas: (1) process-management systems, (2) clinical information interfaces, (3) data analysis, and (4) telehealth and remote monitoring.[21(pp109-22)]

New technologies are already bringing electronic clinical data systems to physicians by means of handheld computers, and electronic communication between patients, physicians, and consultants is transforming the process of care in ways unimagined only 10 years ago. Joe Scherger, MD, for example, has found that increased e-mail communication with patients has resulted in more continuous and less episodic communication with patients within a busy practice, while reducing unnecessary office visits, providing more service, and enhancing the physician-patient relationship.[22]

Increased Emphasis on Cost-effectiveness and Value

National expenditures for health care have more than quadrupled since 1980, while per capita expenditures have surged from just over $1,000 in 1988 to $4,000 in 1998.[23] This increase in the cost of health care has led to increasing cost containment measures by payers, both public and private. At the same time, questions of cost-effectiveness and value of health care services are being asked more seriously, especially by government, other payers, and managed care organizations. David Eddy has this to say about this new dynamic:[24]

> That environment (in which medical decisions are made) is demanding something that seems impossible; we must simultaneously increase the quality of medical care while curtailing its costs. Indeed, the last quarter century has delivered two huge forces that are changing the way medicine is and will be practiced, forever. They both begin with the people who pay the bills—whether out of pocket, through insurance premiums or HMO dues, higher costs for goods and services (which pay for employee health benefits), or income taxes. The bill payers have said they will not continue to pay health care costs that rise twice as fast as the general inflation rate and incomes. Simultaneously, they have begun to ask about the quality of the product they are receiving for their money. The latter is not a pretty sight: wide variations in practice patterns without any obvious medical justification; studies indicating that, according to expert panels, from one fourth to one half of the indications for which some major procedures are done are inappropriate or equivocal; studies showing that the experts themselves might not know what they are talking about; and exposes that major diseases are being treated on the flimsiest of evidence. Clearly, we need to rethink what we are trying to do and how we are doing it.

Future Evolution of Managed Care

Managed care has become the latest "whipping boy" in US health care. Despite its initial success in cost containment, a powerful backlash against managed care organizations has gathered momentum since the mid-1990s over such issues as "gag rules" for HMO physicians, denial of services, and "drive-through deliveries."[25]

It is already clear that managed care will not continue without major changes. Many HMOs, for example, are acceding to enrollees' demands for point-of-service access to specialists, and less-effective cost containment appears inevitable.

It is important to recognize the distinction between managed care, described here, and managed reimbursement, which was mentioned earlier. Some managed care organizations, especially in the for-profit group, have focused on management of costs of care at the expense of quality of care, for the purpose of making profits for shareholders. Unfortunately, the many achievements toward cost-effective comprehensive care based on evidence-based outcomes, as exemplified by many non-profit managed care organizations, are being unfairly included in the backlash to managed care. Indeed, some HMOs have been committed for up to 50 years to health promotion, preventive medicine, and a population-based approach to optimizing health care outcomes. It is unclear to what extent these efforts will continue.

Where to Go Next in Family Practice?

Based on the foregoing discussion, including what has been successful or less successful for family practice over its first 30 years, we now propose our cross-generational recommendations for significant course changes for family practice. These recommendations fall into four major categories: patient care, education, research, and organizational/political strategies.

Patient Care

Our overriding recommendation is that the foundation of the health care system, for the entire US population, must be a system of accessible, affordable, comprehensive, high-quality primary care. For this recommendation to be put into action, several enabling steps must occur.

Embrace New Paradigms. The first enabling step is the need for the health care system in general, and for family practice in particular, to embrace new paradigms of care. These paradigms include evidence-based medicine, population-based care, and chronic disease management.

1. <u>Evidence-based Medicine</u>. With its roots in clinical epidemiology, evidence-based medicine can inform and guide clinical decision making for individual patients as well as populations.[26,27] The process of evidence-based medicine, augmented by information mastery as developed by Slawson et al,[28] is becoming more widely accepted and applied in family practice. Evidence-based medicine, with an emphasis on positive outcomes that matter to patients, should underpin clinical practice and education in family practice.[29]

2. <u>Population-based Care</u>. Although its application may vary somewhat from one health care organization to another, population-based care typically involves a systematic structure for identifying patients under the health care organization's care that are at high risk for disease or have an established chronic disease, implementing clinical practice guidelines to deal with the patients' health care problems, and tracking health status, outcomes, and clinical performance. The concept is still somewhat controversial, but there are good examples of its effectiveness. For example, after implementing its population-based family practice model, Group Health Cooperative of Puget Sound has demonstrated a 32% decrease in late-stage breast cancer (1989 to 1990), as well as an increase from 4% to 48% in bicycle helmet use among children, with a concomitant 67% decrease in bicycle-related head injuries (1987 to 1992).[30] Some family physicians advocate that population-based approaches can be usefully applied in small group or even solo family practice,[31] while others caution against the possible erosion of continuity of personal care when focused on populations instead of individuals in large health care systems.[32]

3. <u>Chronic Disease Management</u>. As one of the main approaches to population-based care, chronic disease management broadens the goals of health care to include important areas often relatively neglected in our current biomedical paradigm. These include restoring functional capacity; care when cure is not possible; prevention of illness, injury, and untimely death; and health promotion.[21(p187)]

There is good evidence that disease management can lead to improved patient outcomes, as shown by a 1997 HMO Industry Report by Inter Study.[33] Moreover, research on the contribution of health-related quality of life (HRQOL) measures to patient satisfaction and health care decision making indicates that patients with chronic conditions value mental and social health interventions as much or more than they value specific disease treatments.[34] Since chronically ill patients frequently have associated mental and/or social impairments, there is an increasing need to reorient medical practice to address these needs more effectively.

Modify Practice Style and Redesign Systems. An enabling second step in family practice's role in transforming the health care system involves redesigning our practices and practice systems. We believe that several actions are necessary.

1. <u>Group Practices</u>. Because of the infrastructure required for effective family practice, we believe that solo practice is no longer a viable practice option. The trend will be toward larger groups and more integration of smaller groups into larger health care organizations. The

minimum effective practice size is probably four physicians, even in rural areas.

2. Electronic Medical Record. Electronic medical records should be implemented in all practices, permitting physicians to take advantage of its full capabilities, including clinical decision support and reminder systems, quality assurance monitoring, and monitoring of patient outcomes and clinical performance.

3. Variable Patient Scheduling. Family physicians should have more variable patient scheduling, whereby e-mail communication with patients can obviate the need for office visits for some minor problems, while extended office visits can be scheduled for patients with more-complex medical problems, multisystem disease, or personal/family problems requiring more time.

4. Seamless System of Personal Care. It is essential to develop "seamless" systems of personal care, facilitated by electronic information systems, whereby effective care can be rendered regardless of a patient's location—office, hospital, nursing home, at home, or elsewhere.

5. Team Practice. We recommend expanded team practice with other clinical disciplines, including nurse practitioners/physician assistants, clinical pharmacists, medical social workers, and clinical psychologists. Other team members may be actively involved in such areas as care of minor illness, patient education and health promotion programs, disease management, and monitoring of drug therapy and health status.

The family physician's roles in expanded team practice will include emergency care for patients of all ages, including skills in advanced cardiac and trauma life support skills for adults and children. It will also include extended office visits for new patients, including full personal and family history, physical examination, baseline laboratory tests, and assessment of health status; diagnosis, management, and follow-up of complex and multisystem disease; person-centered care of biopsychosocial problems; shared decision making with patients confronting alternative therapies for serious illness; and coordination of care for the population being served by the group.

The future family physician will not need to see every patient cared for by the team but will be in touch electronically with many others. Continuity of care should continue into the hospital when family physicians' patients are hospitalized, most likely through colleagues within the group who have opted for training with an emphasis on hospital practice.

6. Public Health. We should seek closer collaboration with public health officials. Local and state public health departments can help the personal care sector to extend needed health care services to defined populations, plus provide community-based epidemiological surveillance and targeted public health interventions. Strategic alliances should be developed with public health agencies, including electronic communication of clinical information for populations being served (eg, information on immunization rates).

Embrace Increased Differentiation Within Family Practice. In the 1960s, there was a tendency among general practitioners who became board certified in family practice to hold a "macho" view of what family practice should be—full-breadth practice including obstetrics and some surgery. Extent of surgical privileges was a key issue, much as intensive care privileges are an issue today. Given the increasing complexity of our evolving health care system and the progressive shift from acute care to the care of chronic conditions, family practice will need to lose its focus on full-scope practice for all family physicians and diversify more than it has to date. Some family physicians will become hospitalists for adults, with little or no role in ambulatory care or child care. Others will be office-based physicians without a hospital practice, even though their patients may be covered in the hospital by hospitalists from their group practice. Still others may work in a part-time or job-sharing arrangement. In short, it will no longer be possible to "do it all."

Education

The overall goal of family medicine education at all levels should be the translation of best evidence into practice. Education will thus include emphasis on effective systems of practice, shared decision making with patients, team practice, quality assurance, and optimizing clinical outcomes for individual patients and populations being served. Enabling steps to reach this goal involve revision of our educational programs at all levels.

Medical Student Education. Medical student (predoctoral) teaching programs in many medical schools with departments of family medicine are already well established along appropriate lines, including involvement in preclinical courses such as Introduction to Clinical Medicine, plus clinical preceptorships and clerkships with family physicians. The main challenge to improve these programs will be to place medical students in exemplary family practice groups that also use a modern systems approach to family practice as described above. Medical students should also be introduced to the relationships of primary care to public health and a changing health care system, including important policy issues concerning access to care and quality and costs of health care.

Residency Education. The development of family practice residencies has been the real success story in family practice, but there is still room for improvement. A classic paper in 1978 by Stephen Abramson, medical educator for many years at the University of Southern California, called attention to diseases of the curriculum—"curriculosclerosis" (hardening of the categories) and "curriculum ossification" (an often epidemic casting of the curriculum in concrete).[35]

We have examples of both disorders in our family practice residencies, though it may be difficult to see them. For example, is our continuity-of-care requirement for the family practice center (1 half day, 2–4 half days, and 3–5 half-days in the first, second, and third years, respectively) still essential, or has it become so restrictive that it limits or prevents other essential training?

Rivo et al have derived a useful set of 60 generalist training components from a number of national data sources for conditions encountered in primary care.[36] They recommended that generalist residency programs require training in at least 90% of these 60 components, together with a continuity-of-care experience for a panel of patients during at least 10% of the entire training period.

We propose that the following changes be seriously considered for graduate education in family practice: First, we should establish tracks for selected practice competencies, including rural practice, hospitalist practice, and perhaps others. Second, we should restructure required time in the family practice center, permitting more flexibility to allow family practice residents to prepare for special kinds of practice or for additional training in areas of special interest. Third, we should focus on areas that have not yet received sufficient emphasis, such as information and communication systems, cost-effectiveness of care, shared decision making, medical ethics, palliative care, and home and hospice care. Finally, we should model and provide training in aspects of improved systems of primary care, including team practice, quality assurance, leadership and management skills, linkage with public health, and promotion of scholarly projects related to patient outcomes and population-based health.

Continuing Medical Education (CME). Many of our CME programs still rely on the traditional paradigm of medical education—the global subjective judgment of "experts." As outcomes-based clinical research and electronic clinical databases continue to develop, we should transform our CME to make use of these evolving approaches to practice.

Increase Emphasis on Fellowship Training. We need to expand the number of family physicians with master of public health degrees and increase the participation of family physicians in faculty development programs. These include programs such as the Clinical Scholars Program of the Robert Wood Johnson Foundation and other career development awards.

Research

The overall goal of family medicine research should be to study outcomes that matter to patients, such as investigate the quality and cost-effectiveness of primary care interventions for both individuals and defined populations in real-world practice settings. Enabling steps to achieve this goal will involve considerable development of family medicine's research infrastructure.

Practice-based Research. To answer important clinical questions with sufficient generalizability and power, it will be necessary to use a networking approach that links the primary care information systems of multiple practices—so-called "practice-based research networks."

Electronic Databases. For effective research in family medicine, we need to develop electronic databases that capture the data from practice. For physicians to use the information generated by family medicine research, they will need access to handheld computers or similar devices that provide them with the results of research in ways that are practical to use in everyday clinical practice.

Organizational and Political Strategies

We must set a goal of having primary care clinicians assume their full potential as the foundation of the US health care system. Enabling steps to achieve this goal involve organizational and political strategies.

Organizational Strategies. First, and most importantly, we should work to establish linkages among the current primary care specialties to accomplish development of a unified primary care generalist discipline by 2030. This will involve expanding the number of true generalist residency positions in primary care by reserving a larger proportion (perhaps 50%) of internal medicine positions for primary care. This could become possible as some medical schools close, resulting in contraction in the number of specialty residency positions. Within a unified primary care discipline, we should develop tracks for areas of emphasis for future practice (eg, rural, adult, hospitalist).

A second enabling step is to assure the long-term viability of primary care clinical research journals. In family practice in particular, the environment of our clinical research journals remains fragile 30 years after the specialty was founded, mostly due to continued reductions of pharmaceutical advertising. The various family medicine organizations should consider how to stabilize this environment to assure the viability of at least one excellent clinical research journal that is not dependent on and vulnerable to changes in pharmaceutical advertising policies.

Political Strategies. It is essential that we advocate for changes in the structure of the US health care system, not merely changes in reimbursement systems. We should educate the public about problems with our current health care system, as well as progress toward resolving them. We should be active in organizations such as the Physicians' Work Group on Universal Coverage. We should build bridges to public health and advocate for increased primary care emphasis in medical schools and residency training programs. Finally, we must increase our representation with government agencies involved in health care education, policy, and research.

Conclusions

Our cross-generational perspectives have been remarkably congruent. We agree that much has been achieved. We agree that more needs to be done before family practice, or preferably a unified generalist physician specialty, can sufficiently expand its numbers and capability to serve as the primary care foundation for the entire health care system.

Today, family practice meets only a fraction of the nation's primary health care needs, which are also being addressed by other competing allopathic specialties (including a "hidden system" of non-primary care physicians), other health professionals (including allied health and alternative care providers), and osteopathic physicians. The health care system has already been restructured by powerful forces, including public demand, cost-containment efforts by large employers, health care insurers, and governmental and other payers. Medicine, for better or worse, is also no longer the sovereign profession it once was.

Medicine, and family practice within it, remains a service profession, so the question becomes how can it best serve the public interest in a new health care environment. This is not the time for family practice to rest on the laurels of its initial development. The field must look forward and outward and critically reassess where it is and where it is not. Family practice of the 1970s and 1980s is no longer the best model for the 21st century, but the accomplishments of the last 30 years provide excellent groundwork for what needs to be done next. Opportunities for family practice have never been greater, and there is no better time in history to be a family physician, but continuance of the status quo will assure that family practice is just one option for primary care in 2030, perhaps even a marginalized one at that.

Family medicine is but one part of the larger and rapidly changing health care system in this country, the future shape of which is still uncertain. We can be leaders in the effort to transform that system into one that is effective, efficient, and structured to meet the primary care needs of all Americans. In that spirit, we close with these observations:

> The underlying problems that led to turbulence in medicine—the earlier acceptance of the myth of unbridled resources and national capacity, the preoccupation with short-term rather than long-term thinking, the emphasis on immediate gratification, the difficulty of retaining purpose and values in a culture that champions greed and material excess, and the dilemma of providing for public goods and human needs through a private market system beholden only to owners and shareholders—were the same problems that jeopardized other aspects of the country's prosperity.
>
> The key (to rebuilding the public trust in medicine) lies in restoring the tattered social contract between medicine and society. The medical profession must remember that it exists to serve.
>
> *Kenneth Ludmerer,1999*[37]

and further:

> We are the intersection between care and cure, between technology and trust, between economics and social equity.
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> *Bob Graham, 1997*[38] *(As executive vice president of American Academy of Family Physicians)*

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