What Opportunities Have We Missed, and What Bad Deals Have We Made?

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In addition to its many accomplishments, family medicine has inevitably made some choices that have not worked out as well. Respectful consideration of where we may have done so can help inform future decision making. This paper suggests some decisions that in retrospect appear to be bad deals, good deals gone bad, or missed opportunities. Bad deals include the limiting effects of our specialty's name and of our go-it-alone philosophy. Good deals gone bad include our affinity for a permanent counter-culture role, our persistent belief that big is better, and limited evolution of our residency family practice centers. We have missed opportunities to lead development of a new model of patient-responsive health care, to change the system of payment for care, to maximize the strength of our discipline by links between university and community family physicians, and to build a powerful program of family medicine research.

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"Faced with the choice between changing one's mind and proving there is no need to do so, almost everyone gets busy on the proof."—John Kenneth Galbraith

Family medicine can celebrate many remarkable achievements from the last 30 years. Many of the papers prepared for Keystone III note these achievements, look back to the important values, goals, and strategies chosen by family medicine, and look forward to future possibilities.

This paper reviews our past from a different perspective: the possibility that we, as a discipline, may have made some poor choices (missed opportunities and bad deals) along the way. There are dangers in such a retrospective analysis. It is, of necessity, selective and based on subjective judgment. We may now see missed opportunities that were not previously visible. We may measure past decisions on the basis of our current environment. The reader might even misinterpret our analysis as criticism of our discipline's leaders, who made decisions using the best information available at the time.

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We therefore offer our comments with caution and humility. No reader is likely to agree with every one of our points. But, the value of this analysis does not come from consensus on any specific issue. Rather, its value comes from the act of questioning basic assumptions about our field. In the current harsh and competitive medical environment, the survival of family practice as a major force in US health care is not inevitable. We must not justify our shortcomings through blame of other specialties or with rationalizations regarding politics, lack of resources, or compromises. Instead, we must critically assess past decisions to inform future ones and design a "new practice of profession"[1] for the future.

Although in the following we discuss both clinical family practice and the academic discipline of family medicine, we focus more on the latter. We have organized our observations into three categories, defined as follows:

Bad deals are fundamental, conceptual, intellectual, or organizational errors, which have limited development of the discipline of family medicine and clinical family practice.

Good deals gone bad are strategic decisions appropriately made at certain stages of development that were not discarded when they were no longer useful.

Opportunities missed include failure to respond to changes that offered potential to advance the discipline.

Bad Deals

Family Practice as a Distinct Specialty

There is power in naming. Our field sought to distinguish itself from its roots in general practice and to do so in an era in which a new name seemed necessary for respectability in medicine. We chose family medicine for the discipline and family practice for its clinical application. While much good resulted from selection of these names, the good also came with a price.

To the good, our field has invented new approaches to the education of students, residents, and faculty. We have conducted research that focuses on common medical problems, on medical education, and on human behavior. We accurately defined our practice as care integrated from the molecular to the community level, as care for whole persons, and as a covenant between physician and patient.

However, we still struggle with our identity. We have debated endlessly about the role of "the family" in family medicine. Some have maintained a focus on family, while others among us emphasize other, less clearly family-centered aspects of our generalist roles. These have included roles such as excellence in long-term doctor-patient relationships, service to urban or rural underserved, care of the elderly, care of hospitalized patients, procedures, maternity care, prevention, or health system reform. Indeed, each of these roles is a legitimate and important manifestation of what we do best. However, debates about which represents the "real" family practice have sapped our energy and distracted our focus from the core intellectual and clinical roles we all serve in this field, no matter which emphasis we choose for individual careers.

The bad deal we made was that, despite much depth of thought and practical effort, we have yet to fully demonstrate family practice as a coherent and unique medical specialty. We were so eager to get about the business of *doing* family practice that we stopped short of developing an in-depth understanding of what it is or might be. The philosophy of family medicine as currently developed simply does not help solve problems faced by practicing family physicians and their patients. Most of the practicing family physician's time is spent managing patients' problems and the business of practice. The practical tools in the daily work of family physicians are traditional biomedical knowledge to diagnose and treat disease, coupled with the interpersonal, procedural, and management skills to get through one's day.

Perhaps the question should not be, "Are we a distinct specialty?" but rather, "Do we have a distinct, unique mission in caring for patients?" All of us share generalist roots, intellectual and clinical skills, and a commitment to service, but we suggest that the titles we have chosen for our discipline do not capture this rich heritage. General practice may have been a stigmatized term in the 1960s, but we paid a price for giving it up.

Go-It-Alone Philosophy

In retrospect, our need to carve out the specialty's place in medicine may also have resulted in a self-defeating isolationism that persists today. For example, in the 1970s, our rigidity over a requirement for surgical training during residency and other issues led the Residency Review Committee to terminate accreditation of the Harvard Family Care Program, an action that lost us the support of some important early friends. We also maintained, perhaps for too long, that family practice is the only "true" primary care specialty.

Our purity of purpose may have seemed necessary for family practice at an early stage of development, but it may also be a cause of the failure to build a primary care infrastructure in this country in cooperation with general pediatrics and general internal medicine. Such a primary care infrastructure would be important from the point of view of the population's health care outcomes.

In fact, most research on the benefits of primary care groups family practice together with general internal medicine and general pediatrics. This research finds that despite staggering per capita expenditures, the relative shortage of primary care in the United States is associated with our rank near the bottom of the industrialized world on most health indicators.[2] Even within the United States, access to primary care is associated with better health: "The higher the primary care physician-to-population ratio in a state, the better most health outcomes are."[2]

Pellegrino recently described common roots in general practice for internal medicine and family practice.[3] His advice for the future is that these two specialties must work together to advance generalism in patient care. Without such a joint effort, he predicts doom for both.

For the sake of our discipline and our patients, it is time to discard our go-it-alone philosophy. While preserving distinctive features of each specialty, family practice should cooperate with general internal medicine and general pediatrics to improve primary care for all.

Good Deals Gone Bad

Permanent Counterculture

Just as family medicine distanced itself from general internal medicine and general pediatrics, we have also emphasized our differences from the rest of medicine. In the 1970s, it was useful to draw on counterculture roots to establish identity and carve a place in medical education and practice.[4] This approach is now a good deal gone bad. Sumner touched on this as he described escorting five third-year medical students to a family medicine research meeting, hoping to convince some of them to become family physicians.[5] Sumner wrote that "the students were turned off by our criticisms of

other specialties. The students said that they had never observed a specialty devote so much effort to defending itself and bashing others." Holloway addressed a similar point:

> We would serve our discipline well by focusing less on the perceived slights of other disciplines and working toward making academic family medicine a truly viable and exciting choice among the numerous career options available to medical students.[6]

It is time to stop any residual defensive criticism of others. It simply distracts our audience and ourselves from the work at hand. We should acknowledge that our discipline is part of mainstream medicine and focus on achieving excellence in family practice. It seems like a long overdue exercise to let go of trying to prove our legitimacy and get about the business of creating a care system that works.

Big Is Better

In the early growth phase of family practice, it was appropriate to emphasize numbers of medical school graduates entering family practice residencies and the number and size of residency programs. Such statistics were essential to obtain federal and state funding and to establish credibility as a force in academic medicine. Indeed, the number and location of practicing, board-certified family physicians still has significance for patient care and for political influence. For example, it is important that family physicians are more likely than others to practice in rural, underserved areas. However, we believe continued emphasis on growth of training programs is now a good deal gone bad because it interferes with achievement of excellence of family medicine education programs, research, and practice.

"Big is better" adversely affects both medical student and residency education. In medical student education, we continue to seek and accept added curricular time despite the reality that many of our departments do not have the financial or human resources to support the effort. Further, our increased presence in the medical school curriculum is not convincing more students to choose family practice; rather, applications to family practice residency programs have declined in recent years. Also, as we have grown, we have become increasingly dependent on community physicians to teach our students. Financial pressures on practicing physicians may lead them to pull back from teaching and thus make our overextended medical student training programs extremely vulnerable.

More important, however, is the fact that excessive growth in teaching programs diverts our academic departments from creating the most useful new knowledge and from identifying and preparing outstanding medical students to become superb family physicians. Departments should clarify their unique contributions to education of all physicians and establish uncompromising rigor in our teaching and scholarly activities. If the very best medical students can be attracted to our field due to the excellence of our practice, teaching, and research, then our future will be bright indeed. Absent this, even if we again see increased numbers of applicants, these numbers cannot make up for mediocrity.

In residency education, "big is better" has emphasized not only the number of residents in training but also the creation of new residencies, placing our specialty in a continual start-up mode, and creating constant struggle to find new faculty and stable funding for new programs. Most of these new programs have been established at community hospitals that now face intense economic pressure. Universities are also under such pressure, but universities, unlike community hospitals, will always hold education and research as core missions. We believe support for our residencies may be fragile to the degree that education, research, and other discretionary programs are jeopardized by increased pressure on community hospitals' clinical revenues.

Model Family Practice Centers

In the early 1970s, residency model family practice centers (FPCs) were useful to demonstrate how community-based practice could be better than traditional residency clinics in teaching hospitals. Few larger group practices existed at the time the first FPCs were developed. Indeed, many early FPCs were created from the merger of the smaller practices of new faculty members. The practice environment at that time was also more civil, less competitive, and reimbursement was less contentious. Managed care did not exist. The FPC of the early 1970s was thus innovative and provided a continuity experience for residents and support for identity as a discipline. However, the FPC has now become noncompetitive, unable to adapt to marketplace changes and usually unprofitable.

More important, we believe that current FPCs do not represent the future delivery of primary care. The practice of the future will need to combine the best of technology, innovation, and management. It will have to demonstrate best clinical practice and be economically sustainable. It will incorporate paperless electronic medical records; efficient, effective, and consumer-oriented practice; and be able to thrive and lead in a competitive marketplace. We believe it is likely that such practices will have fewer residents relative to fully trained practicing physicians. In the words of the recent Academic Family Medicine Organizations Task Force on Family Practice Residencies, it would be a "practice with a residency, modeling lifelong learning,"[7] rather than a residency practice.

The shape of the medical practice of the future has been suggested by thoughtful family physicians[8,9] and others.[10,11] For example, Berwick[11] says it is time to abandon primary reliance on the one-to-one doctor-patient encounter and define our product as healing relationships. Such relationships require full time, 24-hour a day, 7-day a week, 365-day a year access to the practice by the patient. These relationships can be:

> . . . fashioned in many new and wonderful forms, if we suspend the old ways of making sense of care. The access we need to create is access to help and healing, and that does not always mean—in fact, I think it rarely means—reliance on face-to-face meetings with doctors and nurses. Tackled well, I believe that this new framing will gradually reveal that half or more of our encounters—maybe as many as 80% of them—are neither wanted by the patients nor deeply believed in by the professionals. This is an example of a problem so big that we have trouble seeing it. The health care encounter as a face-to-face act is a dinosaur.[11]

The new model FPC should be built to meet the needs of the patients it serves: Internet-enabled, convenient, not constrained by limited access, incorporating true multidisciplinary team practice while still depending on a physician advocate and counselor.[7] This change will be dramatic and difficult. It needs the specialty's best efforts.

Opportunities Missed

Patient-responsive Health Care

Stagnation of the FPC model of training is a specific example of a larger problem for family medicine: our discipline has not created the future of health care services. In the 1970s, family medicine's leaders positioned the discipline as an agent for change. Our founders hoped for a family practice that was community and patient oriented. They hoped to improve the health of people.

Health care services have changed substantially since the 1970s. Managed care has grown exponentially. Consumer expectations have risen dramatically. The Internet is revolutionizing the way information is exchanged and how patients interact with their health care providers. Health care quality improvement and its close cousin, prevention of medical errors, have become topics of daily newspaper stories.

Unfortunately, family medicine, once a leader for change, has not led medicine's response to this changing environment. We have not created new models of health care delivery that demonstrate best practice, eliminate errors, and improve health outcomes. Despite creative efforts to define the scope of family physicians' services,[12] our clinical practice models have evolved little more than has the FPC. The result is that we are faced with multiple studies suggesting that many physicians, family physicians included, fall short of ideals in management of specific health care problems.[13] Models of care based on management of single diseases continue to claim best outcomes. We, on the other hand, tend to believe that single-disease management programs fail to accurately value comprehensive, continuing care of patients with few or multiple health care problems. It is up to us to demonstrate that our model of care improves health. We should have no higher priority as a discipline.

Managed Care, Capitation, and the Gatekeeper

Fee-for-service payment for medical services limits our ability to develop new systems of care that improve health outcomes. It pays poorly for encounters, relationships, prevention, and health status improvement and pays well for procedures and technology.

To our patients' and our specialty's detriment, family practice has failed to change this system of payment for medical care. The alternatives we have seen implemented in recent years are various forms of managed care, with the health maintenance organization (HMO) and capitated payment an integrated delivery system in its most aggressive version. HMOs may reflect a large missed opportunity for family practice.

Managed care at its best should provide data on which care processes lead to best health outcomes. This should enable "standardization (of care) to the best known method"[11] and eventually reduction of both underutilization and overutilization of services, as well as maximization of health care outcomes. Capitation could have encouraged prevention and population/community-based strategies for care. The gatekeeper could have been a guide for patients to best care as well as a source of ongoing, personal care.

The manner in which HMOs have been implemented, however, clearly fell short of these possibilities. Indeed, examples are easy to find of insurance company insensitivity to patient needs and focus on managed *cost*, not managed *care* for patients. However, we suggest that as a specialty, our interactions with managed care systems missed an opportunity to create a payment system to reward population-based care and health outcomes. The American Academy of Family Physicians has recently moved to rectify this problem, making promotion of universal health care coverage a high priority.[14]

Community-University Interface

As conceived, family practice and its organizations were to create a model to remove the "town/gown" conflicts in medicine and enable positive interactions between the community and the academic center. The linkage between academic departments, community hospitals, and practicing family physicians was to be seamless.

Unfortunately, the link between university and community family physicians is not as strong as our discipline's founders might have hoped. This is nowhere more visible than in the relationships between university departments and community hospital residency programs. More family practice residencies are community hospital based and university affiliated or administered than any other administrative structure. However, the university affiliation is often poorly defined or weak. Local agendas can take precedence over faculty development, coordinated research, and exchange of teaching sites and resources. Residency programs often find themselves in competition for patients, with practices made up of their own graduates.

The future requires reestablishing interdependency among academic departments, community programs, and active group practices. Training of all residents should be linked to innovative group practices offering immediate access, personalized care, electronic medical records, Internet communication with patients, and evidence-based practice guidelines. University departments should help develop these tools in partnership with community residencies and practices to create a standard of excellence in clinical family practice and family medicine education for the next century.

Research and Innovation

A closely related missed opportunity is family medicine's failure to develop a well-defined research agenda, strong research funding to support that agenda, and a base of useful new knowledge regarding longitudinal and comprehensive care of unselected patients.

Some academic family medicine departments do have active research programs. Several departments draw on strengths in merged family and community medicine departments to achieve a critical mass of researchers and skills. Different departments have different strengths: rural, urban, or public health; occupational medicine, epidemiology, or behavioral science. Such strengths have not been sufficiently integrated in support of the larger vision of family medicine research.

Our task is to create new models and systems of primary care practice. Family practice research should be in the forefront of practice innovation, medical informatics, clinical decision support, Internet-based patient communication, and cost-effective improvement of our patients' health.

Conclusions

Family medicine and family practice made many superb decisions in the past 3 decades. But, as is true of any human enterprise, our discipline has also made mistakes. We believe attention to bad deals and missed opportunities can help our specialty thrive in the 21st century.

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References

1. Castellani B, Wear D. Physician views on practicing professionalism in the corporate age. Qual Health Res 2000;10(4):490-506.
2. Starfield B. Is US health really the best in the world? JAMA 2000; 284(4): 483-5.
3. Pellegrino E. Can the generalist survive the 21st century? J Am Board Fam Pract 2000;13(4):312-4.
4. Stephens GG. Family medicine as counterculture. (Originally published in 1979.) Fam Med 1998;30(9):629-36.
5. Sumner W. Thou dost protest too much: lessons from the last ASPN convocation. Fam Med 2000;32(6):422-3.
6. Holloway R. Demand for family medicine faculty (letter). Fam Med 2000;32(7):451-2.
7. AFMO/AFPRD Strategic Planning Working Group. Action plan for the future of residency education in family practice. www.afprd.org/actplan.html (accessed November 1, 2000), 1999.
8. Scherger J. Primary care in 2010. Hippocrates 2000;14(3):27-32.
9. Bagley B. Building for tomorrow: the idealized design of clinical office practices. Fam Pract Manag 2000;7(5):13.
10. Kilo C, Endsley S. As good as it could get: remaking the medical practice. Fam Pract Manag 2000;7(5):48-52.
11. Berwick DM. Escape fire. Plenary address presented at the Eleventh Annual National Forum on Quality Improvement in Health Care, New Orleans, December 9, 1999.
12. Ontario College of Family Physicians. Family medicine in the 21st century: a prescription for excellent health care. www.cfpc.ca/ocfp/commun/fp2000model.html (accessed October 9,2000), 2000.
13. Weiss B. Family practice residency training: can we make it better? Fam Med 2000;32(5): 346-9.
14. American Academy of Family Physicians. Universal coverage: AAFP-wide debate begins. FP Report 2000;Oct:1.