How Does a Changing Country Change Family Practice?

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The US population is changing. Ethnic minorities are now the fastest growing segment of the US population, and they have higher mortality rates than the remainder of Americans. Members of minority groups also earn less and are twice as likely as other residents to lack medical insurance. Minority communities have poorer health and access to care than the remainder of the population. Women constitute more than half the total population of the United States and are half of the labor force. Family structure has changed such that 53% of African-American, 32% of Hispanic, and 27% of all families were headed by a single parent in 1992. The elderly population has also increased and has a greater prevalence of chronic disease. The physician workforce has more female and younger physicians than in the past but a still-inadequate number of minority physicians. In contrast to the low proportion of minorities in the US physician workforce, women now comprise approximately half of medical students. A major economic trend affecting health care access in the United States is the lack of secure insurance coverage for 44 million people in 1998. Rates of no insurance are higher among minorities, households with no full-time worker, the near poor, and among persons with less education. Private charitable services, as well as the formal safety net systems, are experiencing financial pressure in the United States, further jeopardizing access to care for the uninsured. The average family in the United States is now working harder—but earning less money. The changing population mix, shifting gender balance, increasing proportion of elderly, and major socioeconomic trends and income disparities occurring in the United States today have shaped a practice environment that differs from what faced family physicians 30 years ago. Thus, a change in approach to training and practice is needed, while preserving the critical relationship we have with our patients and continuing to meet their needs.

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American society is constantly changing, and many of these changes affect health care and the practice of family medicine. In this paper, we focus on two broad trends in American society: changing demographics and changes in the economy.

Changing demographics involves the increasing racial and ethnic diversity of the United States, the changing role of women in society, and the aging of the population. Our discussion of changing demographics also includes an examination of the degree to which these demographic trends are reflected in the composition of the US physician workforce.

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Our review of changes in the economy focuses on the problem of the uninsured, ie, the millions of individuals in the United States who have no health insurance. We also discuss trends in the security and distribution of income.

Changing Demographics

Population Demographics

Changing Racial and Ethnic Diversity. US society has changed considerably in the 30 years since establishment of the first family practice residency programs. In particular, the nation has become more ethnically heterogeneous. Current estimates are that between the years 1994 to 2005, minorities will comprise 51% and women from all ethnic groups will comprise 62% of new entrants into the workforce.[1,2]

American children mirror the diversity of the general population. In 1999, those under 18 comprised 26% of the population (70.2 million children). Only 65% of

these children were non-Hispanic whites, 16% were Hispanics, 15% were non-Hispanic blacks, 4% were Asians or Pacific Islanders, and 1% were Native Americans or Alaskan Natives. The number of Hispanic children has increased faster than that of any other racial or ethnic group, growing from 9% of the child population in 1980 to 16% in 1999.[3]

There are major differences in mortality rates among the ethnic groups in the United States. African-Americans and American Indians have more than twice the mortality rate of white Americans from late adolescence to age 60. Hispanics have higher mortality rates from their teens to age 50. Only Asian-Pacific Americans have lower mortality than white Americans.

Recent research on access to medical care suggests that although minorities may have achieved improved equity of access during the 1980s, this improved access to care may now be declining.[4] About 21% of African-Americans and 32% of Hispanic-Americans lack health insurance, compared with only 14% of the general population. African-Americans and Hispanic-Americans are also less likely to see a physician than the general population (63% and 59% versus 71%). While less than 5% of the US population uses a hospital emergency department on a regular basis for medical care, 10% of Hispanic-Americans and 16% of African-Americans regularly use these hospital-based facilities for their medical needs.

Spirituality and faith have always been integral to racial and ethnic minority communities, and these factors will have a greater influence on society as these minority groups increase in numbers. Increasing evidence suggests an association between health and religious beliefs. Strong religious beliefs are known to provide comfort and an improved sense of well-being to those with illness.[5-8] This effect is seen across a variety of faiths, irrespective of race, and in all age groups.[9-11] For example, the negative effects of living in a dilapidated neighborhood are ameliorated over time for older adults who are deeply religious. Religious commitment seems to help people cope with mental and physical illness and facilitate recovery from illness.[12]

Increasing Numbers and Representation of Immigrants. Related to the changing racial and ethnic composition of the United States is the shifting pattern of immigration. During the 1970s and 1980s, the two largest groups entering North America were refugees from Southeast Asia and Central America. Many of these individuals immigrated to the United States to escape physical and emotional trauma related to unsettled political conditions or war in their countries of origin. Both children and adults manifest stress in similar fashion, especially when the stress involves exposure to violence against their nuclear family. Even when the nuclear family escapes injury, however, growing up in a war-affected community can promote emotional problems, including the development of aggression in children.

After a period of time, children and parents can heal from political abuse and the effects of war.[13-15] Those escaping physical privation seem to recover more rapidly and completely than those suffering from emotional trauma and loss.[13]

Despite this healing, however, the challenges of acculturation and poverty that accompany immigration can themselves precipitate significant psychological distress, especially depression, social withdrawal, "acting out," and school failure.[16,17] Experiences subsequent to immigration such as discrimination, loneliness, unemployment, and isolation from mainstream society also result in anxiety and depressive symptoms. Feeling accepted by the host society and being involved with Americans and US culture promotes better mental health.[18,19]

Some immigrants, especially those from non-European countries, have a longer life expectancy and more years of life without disability and dependency than do native-born citizens.[20] This improved longevity could relate to the "healthy immigrant effect," ie, those who migrate from abroad represent a healthier and more motivated segment of the population of origin. However, lifestyle also affects an immigrant's health. Heavy cigarette use, high alcohol intake, poor dietary intake, limited physical fitness, and crowded living conditions can all contribute to poor health in this population.[21]

Pregnant immigrant women are generally considered to be at risk for unfavorable pregnancy outcomes because of socioeconomic risk factors. In spite of this concern, however, evidence suggests that, for Hispanic immigrants, pregnancy outcomes are actually more favorable despite higher socioeconomic risks. The favorable pregnancy outcomes among Hispanic women have been termed the "Hispanic paradox" and have been associated with a protective sociocultural orientation and a strong family unit among this immigrant population.[22]

Finally, many immigrant populations rely heavily on their culture's traditional or folk remedies. Almost half of all Americans report using at least one alternative therapy, with prevalence rates ranging from 44% in Mexican-Americans to 78% of African-Americans.[23-25] When health care workers fail to understand or acknowledge these traditional remedies, it can result in negative interactions between patient and clinician. It can also cause misinterpretation of patients' symptoms and health care providers' recommendations.[22]

Changing Role of Women. Women constitute slightly more than half the total population of the United States. Women have a longer life expectancy than men, and more than three quarters of centenarians in the United States are women.[26]

The role of women in society has changed substantially since the specialty of family practice was established. More than two thirds of women are now working, and they account for 46% of the labor force—an increase of 17% since 1950. Even among women who recently gave birth to a child, participation in the work force is high, with about half of these women returning to work within 12 months of giving birth.[27] Women are also pursuing higher education in increasing numbers. In 1996, 42% of students enrolled in professional schools in the United States were female, compared with only 8.5% in 1970.

Changing Family Structure. Along with the racial, ethnic, and gender changes in the nation, there have also been profound changes in family structure. In 1970, 36% of African-American families, 22% of Hispanic families, and 14% of all US families were headed by a single parent.[28] By 1992, those figures had increased to 53%, 32%, and 27%, respectively.

Most single parent families were headed by a woman, and female-headed households made up 39% of the poor population in 1991. Half of African-American children and 40% of Hispanic children live in female-headed households.[28] Despite the predominance of female-headed households, it is notable that the percentage of children living with single fathers doubled between 1980 and 1999, from 2% to 4%.[3]

The Aging Population. An improved standard of living, advances in public health, and perhaps even the nation's much heralded medical care have contributed to a dramatic increase in life expectancy in the United States and an attendant growth in the number of elderly persons. Life expectancy at birth in the United States was 47 years in 1900, 68 years in 1950, and 76 years in 1991.[29] This amounts to an annual increase in life expectancy of .43 years. Although still short of the annual increase of 1.0 years that would confer immortality, this is an impressive rate of gain in life expectancy for the nation!

Persons over age 65 comprised 1 in 25 Americans in 1900 and 1 in 8 Americans in 1994. Even within this population of older Americans, major demographic shifts are occurring. Currently, 10% of those over 65 are now age 85 or older. By 2050, 25% will be age 85 or older. Sixty percent of these older Americans are women, who are three times more likely than elderly men to be widowed and to live alone.

With aging comes a greater prevalence of chronic disease. More than two thirds of older Americans have at least one chronic condition affecting their health. These chronic conditions result in an increased need for assistance with activities of daily living (ADLs), especially in the "oldest old"—those over 85. Whereas 10% of noninstitutionalized persons ages 65–74 need assistance with ADLs, half of those age 85 and over require such assistance.

Debate continues about whether the increasing life expectancy in the United States necessarily means that Americans will continue to spend periods of their lives living with chronic disease and dependency. Although some analysts contend that deferring mortality comes at the expense of a greater burden of morbidity, there is evidence that improvements in medical care and greater life expectancy may bring with it a "compression of morbidity," such that the onset of chronic illness occurs later in life.[30]

Finally, despite the existence of Medicare, a purportedly "universal" insurance program for persons age 65 and older, many elderly remain financially burdened by the costs of their health care. Out-of-pocket health care expenses consume 21% of the average elder's household income,[31] with the proportion of income going for health care expenses nearly twice this level for low-income seniors. One third of these expenses are for nursing home costs; Medicare provides limited skilled nursing facility benefits and excludes long-term care coverage.

Physician Demographics

With the US population changing in the many ways outlined above, one must ask whether these changes are mirrored by trends in the demographics of the physician workforce. During most of the 20th century, older white males dominated the medical profession, but as we enter the 21st century, there are now many more female physicians, and physicians are younger. Despite these changes in physician gender and age, however, a current assessment of the physician workforce reveals that it is not only the physicians' coats that have maintained the traditional color of white. In this section of the article, we examine trends in the racial/ethnic and gender composition of the nation's physician supply in more detail.

Physician Race and Ethnicity. Tables 1 and 2 indicate that in recent years, there has been some increased diversity in medical school classes compared to that of the overall pool of practicing physicians. Despite this, many racial and ethnic minority groups are still underrepresented in the health professions. African-Americans and Hispanics are particularly underrepresented relative to their share of the nation's population.[32]

The underrepresentation of minorities in the medical profession is concerning for two key reasons. First, it may be viewed as an indication of social injustice, in that there may be fewer opportunities for individuals

Table 1

Medical School Enrollment
by Student Race/Ethnicity, 1996–1997

Racial/Ethnic Group	*US Population 1996*	*Allopathic Medicine*	*Osteopathic Medicine*
Non-Hispanic white	72.3%	65.8%	79.8%
Non-Hispanic black	12.5%	8.0%	4.1%
Hispanic	10.6%	6.6%	3.8%
Native American	.9%	.8%	.9%
Asian	3.7%	17.6%	11.4%

Source: US Health Workforce Personnel Factbook, US DHHS-HRSA-BHPr.

from minority groups to advance in higher education and achieve entry into professional careers. Second, the lack of greater racial and ethnic diversity in the health professions is likely a factor in the poorer health status and access to health care experience by minority communities. Minority physicians are more likely to practice in underserved, minority communities and to care for uninsured and Medicaid patients.[33-35] There is also evidence that members of minority populations prefer to receive care from physicians of their own race/ethnicity and are more satisfied when care is provided by physicians of concordant race/ethnicity.[36-38] Thus, the underrepresentation of minorities is not simply a matter of fairness of opportunity for individuals desiring careers in the health professions. It is also an issue that may contribute to inequities in access to care and health outcomes for the growing proportion of minorities in the population as a whole.

The Association of American Medical Colleges (AAMC) implemented the "Project 3000 by 2000" program in 1991 to increase the number of underrepresented minorities matriculating in US medical schools.[39] This program consisted of efforts to create partnerships between academic medical centers and K–12 schools and colleges to better prepare minority students for careers in medicine. These efforts initially appeared to yield benefit, as reflected in an increase in underrepresented minority medical school matriculants from 1,470 in 1990 to 2,014 in 1994.[39] However, a political movement opposed to affirmative action coincided with a downturn in underrepresented minority enrollment in US medical schools in the late 1990s.[40] As described below, this political movement has resulted in court decisions and voter initiatives on local, state, and regional levels that have compromised the pipeline for minority students to enter careers in health care through institutions of higher education.

1. Court Decisions. The landmark *Regents of the University of California versus Bakke* decision in 1978 was the first court decision to hinder race-based admissions policies. Since the Bakke decision, the lower courts have offered differing guidance to institutions regarding the circumstances in which they can consider race and ethnicity in admissions. In 1994, the US Department of Education issued a policy endorsing appropriately crafted, minority-targeted student aid programs. However, that same year, the US Court of Appeals for the Fourth Circuit struck down a University of Maryland scholarship program for African-American undergraduates (*Podberesky versus Kirwan*) as a violation of the equal protection clause of the 14th Amendment. In 1996, the Fifth Circuit Court supported the lower-court ruling of *Hopwood versus Texas*, which held unconstitutional a University of Texas Law School admissions process that sought to enroll targeted percentages of Mexican-American and African-American students. The judiciary continues to confront similar issues in other cases.

2. Voter Initiatives. In addition to the rulings regarding affirmative action in the courts, voters in California and Washington adopted initiatives in 1997 and 1998, respectively, that bar affirmative action in public employment, public education, and public contracting. The Regents of the University of California voted to end selective admissions for racial/ethnic minorities in UC graduate schools beginning in 1997 and in undergraduate schools in 1998. The subsequent passage of the California Civil Rights Initiative (Proposition 209) in November 1996 perpetuated this trend. Initiative 200 passed in November 1998 in the State of Washington forbidding "discrimination" and "preferential treatment" by public institutions on the basis of race, ethnicity, national origin, sex, and other factors and took effect 2 months later.

3. Effect on Minority Enrollment**.** Following the aforementioned court decisions and voter initiatives, there has been a decline not only in the numbers of minority students admitted to medical schools in the states affected but also declines in the number of minority students applying to medical school. For example, the annual number of underrepresented minority (URM)

Table 2

Practicing Physicians by Physician
Race/Ethnicity,1998

Racial/Ethnic Group	*US Population 1996*	*Physicians*
Non-Hispanic white	72.3%	79.25%
Non-Hispanic black	12.5%	2.94%
Hispanic	10.6%	4.69%
Native American	.9%	.05%
Asian	3.7%	10.50%
Other	NA	2.56%

Source: American Medical Association, *Physician Characteristics and Distribution, 2000–2001*

admissions to all California medical schools dropped by 30% from its peak in 1993–1994 to 1998.[41] The drop in URM admissions in California beginning in 1994 was followed 2 years later by a drop in URM admissions in all US medical schools. URM admissions in US medical schools overall dropped 8% between 1995 and 1997—49% of which can be explained by drops in California, Texas, Louisiana, and Mississippi.[41]

If these trends continue, the number of minority physicians will fail not only to reach parity with their representation in the population but will steadily decline. Such a trend will likely have a negative effect on the already poor minority health status seen in the United States today.

Women in Medicine. In contrast with the lack of major improvement—and current deterioration—of the racial and ethnic diversity of the physician workforce, a marked shift has occurred over the past 3 decades in the gender composition of the medical profession. The proportion of women entering medical school increased from 11% of first-year enrollees in 1970 to 43% in 1997.[42] The increase in the number of women in medical school has resulted in an increased number of female physicians in the United States (from 7% of practicing physicians in 1970 to 20% in 1996).[43]

Female medical students are more likely than their male counterparts to select primary care, obstetrics and gynecology, and psychiatry as their specialties (Table 3). There are several reasons why women have historically gravitated to these specialties. One is that these specialties require fewer years of training than medical and surgical subspecialties and, therefore, primary care, obstetrics, and psychiatry may allow more flexibility in subsequent practice lifestyle.[42] Female medical students may also be more likely to receive advice from mentors to enter a primary care specialty.

1. Feminization of the Physician Workforce. The feminization of the physician workforce has several implications for the role and distribution of physicians. First, female physicians, including female family physicians, are also more likely to practice in urban rather than rural areas of the United States.[44] This choice of location may in part be due to concerns about quality of family life in rural areas, such as lack of job opportunities for spouses and school opportunities for children.[45]

Second, the feminization of the physician workforce may necessitate an adjustment of projections of physician supply to compensate for the possible lower productivity of female relative to male physicians.[42] Four times as many female physicians as male physicians are classified as "inactive" (ie, not currently practicing), likely due to women reducing their professional activities during their childbearing years.[43] Female physicians also are more likely to work part-time. In fact, a recent study of primary care physicians in one large health maintenance organization found that 58% of female physicians worked less than 90% time, compared with only 12% of male physicians.[46] Female physicians also tend to earn less money than male physicians, although some studies suggest that these differences may largely be accounted for by gender differences in specialties, practice settings, and work hours.[47]

Table 3

Women as a Percentage of Residents, by Specialty

	%
Overall	36
Family practice	45
Pediatrics	64
Internal medicine, general	44
Cardiology	15
Obstetrics-gynecology	63
Psychiatry	45
Anesthesiology	27
Radiology	26
Surgery, general	21
Orthopedic surgery	7
Otolaryngology	18

Third, female physicians tend to have a different style of practice than do male physicians. Female physicians tend to attract more female patients, and they deliver more preventive services than do male physicians.[48,49] Patients of female physicians may place more value on different aspects of the physician-patient relationship than do patients of male physicians.[48] For example, patients of female physicians tend to have a higher level of complex psychosocial problems, and they value more time with and explanations from their physicians.

Fourth, many female physicians experience gender discrimination, lack of role models, and role strain—all of which are interrelated. Role models are needed for both image and career development and provide examples of how women can function in a professional environment. Role strain develops from needing to choose between multiple demands—those arising from obligations as mother, wife, professional, and community participant. This strain is undoubtedly influenced by the fact that female physicians are more likely to marry another professional; more than 50% marry another physician.[50] Domestic responsibilities are rarely shared equally in such relationships, such that women experience more role strain in the areas of child care and household tasks. Bowman and Allen have suggested specific methods of stress reduction, including role cycling, adjusting expectations, developing support networks, and selecting creative practice styles.[51]

Economics

Insurance Coverage

Lack of secure medical insurance coverage for a large portion of the population is a major factor affecting medical practice in the United States. The United States is the only major Western industrialized nation without

some form of guaranteed universal health care coverage for all of its citizens.

The number of uninsured individuals in the United States has doubled since 1980. The number of uninsured increased by about 2.5 million between 1996 and 1998, to the point that more than 44 million people in the United States were uninsured for the entire year in 1998, representing 16.3% of the population.[52] Remarkably, the growth in the number of uninsured continues unabated in the United States despite the recent surge in the overall economy. In fact, despite declining rates of unemployment, fewer Americans have job-based private insurance (64% of non-elderly persons in 1996 versus 71% in 1987).[53] Compounding the decrease in private employment-based insurance has been a downturn in Medicaid coverage in the mid-to-late 1990s. This downturn has been attributed to welfare reform and the uncoupling of Medicaid eligibility from welfare cash assistance, as well as to enactment of policies restricting the eligibility of immigrants for Medicaid and public assistance.

One in five uninsured people in the United States is a child. Eleven million children (15% of all children) were uninsured in 1998.[52] The number of uninsured children has remained relatively constant in recent years despite enactment of programs such as the State Children's Health Insurance Program (SCHIP), designed to expand children's eligibility for publicly subsidized insurance. Rates of enrollment in SCHIP programs have lagged far behind expectations, despite the availability of substantial federal matching funds to support these state-administered programs.

Lack of medical insurance is common among minorities, households with no full-time worker, the near poor, and among persons with less education. However, the majority of uninsured persons are white and belong to households with a full-time worker.[52]

Implications of Lacking Health Insurance. Extensive research has documented that the uninsured, compared to the insured, have less access to care and suffer worse health outcomes. For example, 75% of uninsured persons with poor health reported a "problem getting needed care," compared with only 23% of insured persons in poor health. Furthermore, 55% of uninsured persons postponed seeking care in the prior year, compared with 12% of the insured. Uninsured persons are much less likely to receive preventive services such as mammograms and pap smears.[54] Uninsured women are also more likely to have breast cancer diagnosed at a later stage and to die sooner from that cancer.[55] Even uninsured newborns receive fewer hospital services and experience worse health outcomes than their insured counterparts.

Several factors are further jeopardizing access to care for uninsured and low-income individuals. For private practice physicians, financial pressure from managed care has resulted in a decreased ability to provide charity care to uninsured patients.[56] For health care systems, particularly the publicly funded safety net hospitals designed to care for underserved populations in the United States, financial pressures are threatening the ability to continue providing such care. A recent Institute of Medicine report highlighted the tenuous economic status of these safety net systems in the United States, such as community health centers and public hospitals, due to growing demands from uninsured patients and new restrictions on federal subsidies to these providers.[57]

Economic Security and Income Inequality

The persistent inequities of insurance coverage and access to care mirror broader inequities in the overall economy. Despite the recent robust economy in the United States, not all boats are rising on the nation's surging economic tide. In fact, poverty and income disparities are increasing in the United States.

A recent report from the Economic Policy Institute highlights the nation's growing economic divisions.[58] The average family in the United States is working harder, but earning less money, over time. The median family income in the United States decreased by $1,000 (in constant dollars) between 1989 and 1996, despite an increase in hours worked. In fact, the total hours worked per year in the median married household with children in the United States increased by 615 hours from 1979 to 1996, equivalent to 15 additional weeks of work per year, and the average annual hours of work in the United States far exceeds that of any other major industrialized nation. Despite this, and despite the fact that the unemployment rate in the United States is under 5%, 13.7% of persons in the United States have incomes below the poverty level. One in 5 children in the United States lives in poverty, with poverty rates for African-American and Hispanic children hovering around 40%.

Inequality in the distribution of income in the United States is growing. In 1989, the most affluent 1% of Americans held 37.4% of the nation's wealth; by 1997, the top 1% had 39.1% of the nation's wealth. The top 10% of households in the United States earned almost six times the income of the lowest 10% of households, a ratio that has grown over the past decades. In fact, the United States has the most inequitable income distribution of any major industrialized nation; the ratio of income for the top 10% to lowest 10% of the population in industrialized nations averages about 4. In contrast, the average chief executive officer (CEO) in the United States now makes 116 times the income of the average worker, and CEOs in the United States have incomes over twice that of CEOs in other industrialized nations. Much of the recent overall growth in incomes in the United States has been fueled by rising stock prices rather than by increases in wages, but fewer

than half of families in the United States own any type of stock, with stock investments largely concentrated in high-income households.

Implications of Income Inequality. These economic data portray a society in which working families are clocking longer hours to make ends meet, and basic economic security—not just security in health insurance coverage—is still elusive for many households. The data reveal a society with widening divisions in socioeconomic classes, where wealth is increasingly concentrated in the top tier of high-income households.

Research has documented that societies with greater income inequities tend to have worse overall population health outcomes.[59-61] Even in regions with an overall relatively high standard of living, wide disparities in income distribution are associated with lower life expectancy. Many social scientists have concluded that the "toxic" health effects of social inequality in developed nations result from the psychosocial stresses of social hierarchies and social oppression, not from material deprivation. As such, social inequality must be a public health concern in the United States.

Conclusions

The changing population mix, shifting gender balance, increasing proportion of elderly, and major socioeconomic trends and income disparities occurring in the United States today have shaped a practice environment that differs greatly from what faced family physicians 30 years ago. These changes necessitate a change in approach to training and practice. We recommend that family practice, as a specialty, consider adopting the following actions and attitudes.

First, advocate for a physician workforce that represents the population we serve. Major differences in health status, communication styles, and preferences for providers exist among our diverse patients. Both providers and patients are more likely to choose concordant therapeutic relationships. Family physicians may play a variety of roles in promoting a more racially and ethnically diverse medical profession, such as participating in medical school admissions committees and working with local school districts to enhance science education for disadvantaged students.

Second, it is important to recognize the disparity in numbers of minority providers compared to their representation in the population. Simultaneously, we need to become more competent in caring for culturally diverse patients and more forthright about recognizing the legacy of racism that continues to influence the relationship between patients, physicians, and the health care system.

Third, there should be closer linkages between practices, clinics, and academic health centers and the communities they serve. These entities should become partners in improving the total health of the community.

Fourth, it is essential to better integrate minorities and women already in the profession into the framework of decision making and promote equity and success for those individuals. Attention must be directed and solutions found to breaking the glass ceiling that exists to the advancement of both groups.

Fifth, we must become more knowledgeable about the needs and strengths of our elderly patients and colleagues. As the number of elderly grows, skill in managing patients with chronic illness will become an ever more important element of family practice. As the number of older physicians grows—a group with significant experience—they may be able to assist in addressing the needs of the underserved segments of the population.

Sixth, we should advocate for a system of universal health coverage in the United States so that the most basic component of health care justice is achieved. A publicly accountable, tax-financed system for all residents of the United States would be the most effective and equitable system.

Finally, we must appreciate the underlying social determinants of health and illness and work to reduce the socioeconomic disparities that are the breeding ground for premature morbidity and mortality.

Kenneth Pye emphasized our responsibilities as physicians when addressing a group of graduating medical students. He said:

> All professions have a privileged status in American society, and the profession of medicine is more privileged than most. Special privileges are always vulnerable . . . but never more so than when people become dissatisfied with a condition which they associate . . . with those to whom special privileges have been granted.

Our goal as family physicians must be to work to preserve the important relationship we have had with our patients. We must assure our patients that we will strive to understand and meet their needs and the needs of their communities.

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