ON TRACK

The Future of Family Medicine? Reflections from the Front Lines Reveal Frustration and Opportunity

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THE FUTURE OF FAMILY MEDICINE

The Future of Family Medicine (FFM) project aims to launch efforts "to transform and renew the discipline of family medicine to meet the needs of patients in a changing health care environment."[1] Table 1 below depicts some of the early themes apparent in the ongoing discussion about the project's report, which was published as a supplement to the previous issue of *Annals*.[2] By the time this On TRACK feature is published, the ongoing discussion will likely reflect additional ideas on the future of family medicine. We encourage readers to participate and invite diverse others to join in at http://www.annfammed.org. Invite patients, people without access to becoming patients, other health care professionals, policy makers, and others to bring their voices and insights.

The early online TRACK discussion personalizes the sense of frustration on the front lines of a dysfunctional, imploding health care system. The assessment of many is succinctly summarized by Douglas W. Morrell, a family physician from Rushville, Ind,[3] "the article 'The Future of Family Medicine'... is a great idea, but the reality is that it just can't happen without great changes in the American health care system." A number of TRACK discussants (including Dr. Morrell) identify survival strategies in the current system.

The discussion also suggests helpful frameworks and some innovative approaches for pursuing practice change. At the same time, it calls for a crusade to reform the larger health care system.

The early discussion leaves us with at least 3 overarching questions and many subquestions that call for further debate, and ultimately, action. We invite readers to weigh in and to pose other questions:

1. How do we move from our current frustration to a better place for patients, family physicians, and the larger health care system?
   - What will it take for us to change this situation?
   - What does each of us want to do?
   - How do we want to work together?
   - What support do we each need?
   - How could we organize ourselves locally and nationally?
2. How can the larger health care system be reformed?
   - How can the energy from the current pain, frustration, and anger be channeled toward finding solutions?
   - How do we move the discussion from being just about family medicine to focusing on equity, accessibility, affordability, personalization, and quality of health care for all people?
   - What is an emerging and essential role for family medicine in this larger vision?
   - Who are potential allies? The family medicine organizations and their members? Others engaged in providing and paying for health care? Policy makers who can envision primary care as essential? The community of those who need health care?. How can they be engaged?
   - How do we build resilience and capacity for when the current "system" collapses?
3. What do we do in the short term and at the local level, while advocating for long-term and macro-level solutions?
   - How can we get just a bit of slack—to move from day-to-day survival in a painfully dysfunctional system to a place where we can start to imagine and implement a better way?
   - What short-term sacrifices will we have to consider to see a brighter future?
   - What will leadership—organizational, individual, grass roots—look like for these efforts?
   - To what degree do things have to get worse, if they are to get better in the end?
   - Can an appreciative inquiry approach[4] engage diverse

Table 1. Themes from the Early Future of Family Medicine Online Discussion*

Times are changing[1]	
Change and the current health care reality is causing great frustration	Among family physicians, patients, others
	Loss of relationships, system fragmentation
	Financial crisis, malpractice crisis
	Pain from being part of a dysfunctional system
	Distress is an impetus for calls for retrenchment or further change
	Some feel isolated from the report and its proponent organizations; some are energized
	A sense that the reports, and therefore the organizations, in trying to see beyond the current frustration, are not adequately acknowledging the current reality
The call is about something larger, a crusade about which family medicine is only a part	Restructuring and greater equity in health care financing and reimbursement
	Health care for all
	A medical home for high-quality, integrated medical care
Diverse strategies are emerging	Local practice and system innovation
	Appreciative medicine[2]
	A viable economic model can provide "breathing space" to pursue innovation, but with current financing, this can involve sacrificing access for all to primary care
	Concierge practice
	Safety-net projects
	National advocacy and partnerships for health care, financial and tort reform
Frameworks for understanding and fostering change	Return to old values and approaches
	Retain some core values and develop new approaches
	Take the offensive based on the unique and valuable generalist role[3]
	A complexity science perspective[4]
	Anticipate nonlinear results and unintended consequences
	Well-planned social interaction can result in a partial agreement
	Initial conditions and evolving relationships are key
Challenges for individuals and organizations	Adapting to (and thus enabling) a dysfunctional system while working to change the system
	Engaging and activating traditional and new partners
	Being true to core ideals AND open to new ideas
	Getting enough margin to make proactive changes
	Costs (eg, electronic health record) of transition to any new model
	To be effective in fostering the big changes their members need, organizations need to engage outside groups that are not sympathetic to the financial concerns of doctors, while not losing the support of their members
	Managing the short term, in which things might have to get worse before they get better

* An earlier version of this table was posted in TRACK on April 26, 2004. The author is grateful to the many discussants who provided helpful feedback for its revision.

References

1. Hashim MJ. Future trends in primary care: lessons for family medicine [eletter]. http://www.annfammed.org/cgi/eletters/2/suppl_1/s3#592, 20 April 2004.
2. Franklin TL. A truly new approach to family medicine [eletter]. http://www.annfammed.org/cgi/eletters/2/suppl_1/s3#575, 20 April 2004.
3. Starfield B. Whither family medicine [eletter]? http://www.annfammed.org/cgi/eletters/2/suppl_1/s3#483, 6 April 2004.
4. Lamberts H. Complexity and benificence [eletter]. http://www.annfammed.org/cgi/eletters/2/suppl_1/s3#478, 6 April 2004.

potential partners around an important common goal? How can we *discover* that which gives meaning, life and joy, *dream* what might be, *design* together what should be, and then make our *destiny* together by working on our own part of the solution?

- What changes do we want? What comes to mind when you think of practicing family medicine happily? What is the meaning of family medicine in your life? What 3 or 4 things do you like best about family medicine and shouldn't be lost? What do you do for joy?

Please continue to use the *Annals* TRACK forum to share your insights, frustrations, and joys. Give the Web address to others and invite patients, policy makers, health care professionals in other fields, payers, and other potential partners and antagonists to enrich the debate and action.

TRACK DISCUSSION OF RESEARCH REPORTS

The discussion of the research articles in the March/April, 2004 issue of *Annals* also was vigorous. Community-oriented primary care (COPC) generated great enthusiasm as a model for integrating public health and primary medical care to solve population health ills and health disparities. Commenters on the study by Plescia and Groblewski[5] and the editorial by Williams[6] described their own experience and identified the challenges of applying this appealing model within the current system.[7-13] We encourage others with real-world experience with COPC application to share the process and outcome.

The authors of the natural history study of asthma[14] provide a thoughtful response[15] to questions about the diagnostic criteria[16,17] and data sources[18] for their primary care cohort study. The study identifies a positive prognosis for primary care practice patients with an initial diagnosis of asthma and a lack of predictive value for bronchial hyperresponsiveness testing.

The study of management of hepatitis C patients[19] brought calls for advocacy and safety nets to facilitate care[20,21] and useful additional clinical information for increasing our awareness and efficacy in case finding in primary care.[22,23]

The study of medical errors by Elder et al[23] spawned a research agenda[24] and an articulation of the challenges of measuring errors of omission.[25,26] The need for a clas-

sification system and definitions for errors in the outpatient setting was identified by several discussants.[27-29] The authors' response,[30] and the tenor of the discussion show that there is a highly engaged group of critical thinkers openly sharing new knowledge in this nascent but rapidly emerging field of inquiry. A cluster of papers in a forthcoming issue of *Annals* will further this discussion, and we encourage readers to continue sharing ideas online.

The study finding low levels of reported physician effectiveness in screening for inherited cancer risk[31] brought a reflective commentary on why we don't consistently do what we are "supposed" to do.[32] Two family physician genetics researchers urge us either to seize the "teachable moment" to incorporate genetics into our practices[33] or to do more research to understand how to do this effectively.[34]

The related studies that identify mortality risk from elevated serum transferrin saturation[35] and dietary iron intake[36] brought important perspectives from an advocacy group[37,38] questioning the practice of iron fortification of foods. In addition, researchers identify a possibly related gene locus[39] and free radicals as a likely causal pathway for the observed association.[40] The *Annals*' statistical editor points to these studies as examples of the fruitful hypothesis-driven analysis of nationally representative data to answer an important clinical question.[41]

The novel and intriguing finding by Keeley et al[42] that a specific combination of parental attitudes is a predictor of birth weight is supported by French,[43] who raises additional questions for further research.

Gask's study of powerlessness among HMO-based family physicians[44] generated a call for team approaches to practice,[45] and the hypothesis that the younger generation of physicians may have a different experience.[46] Another writer hypothesized that it would be valuable to bring some aspects of decision making back to the physician "connected to the ground level practice realities of caring for patients."[47]

Comments on the US Preventive Services Task Force finding of insufficient evidence to support screening for intimate partner violence[48] reflected frustration with the limited evidence identified by this systematic review and recommendation. Observations included a call for additional questioning and research,[49] the presentation of emerging data on terrorism and other disasters as a risk factor for intimate partner violence,[50] and questioning the methods and data used for the systematic review and recommendation.[51,52]

In critiquing the meta-analysis that failed to show value to partner support in increasing smoking cessation,[53] McIlvain[54] wonders whether the question is too broad. Because there is such diversity in "partners" and in the meaning and quality of such relationships, she concludes that without further definition, the answer is likely to remain "it depends."

The very personal story shared by Rosenblatt[55] generated intellectual and personal responses[56,57] but a lack of surprise at the impersonal care he received. What are others' experiences and expectations of health "care"?

In addition to these postings related to the last issue of *Annals*, thoughtful commentary continued on articles in previous issues, including a critique[58] of the immunization study by Schillaci,[59] and author response to previous and continuing[60,61] critique of the study on religion, spirituality, and health status in geriatric patients.[62] Jerant responded to critique[63] of his TLC model of palliative care in the elderly.[64] A retired public health physician[65] provided some thought-provoking (if speculative) data on the magnitude of iatrogenic risk for mortality.

Finally, the *Annals* Open Forum was used to introduce the "Campaign to Revitalise Academic Medicine," offering an option for readers to contribute their views on this international effort.[66] Previously, the Open Forum generated a spirited international discussion of the importance of classification systems relevant to primary care. This discussion was in response to posting of the Banff Declaration on this topic.[67]

We thank you for your thoughtful engagement.

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References

1. Future of Family Medicine Project Leadership Committee. The future of family medicine: a collaborative project of the family medicine community [online]. *Ann Fam Med.* 2004;2(Suppl 1). Available at: http://www.annfammed.org/cgi/content/full/2/suppl_1/S3.
2. Discuss an article. TRACK comments published the past 120 days [*Annals of Family Medicine* Web site]. Available at: http://www.annfammed.org/cgi/eletters?lookup=by_date&days=120.
3. Morrell DW. Great concept but incompatible with reality. http://www.annfammed.org/cgi/eletters/2/suppl_1/s3#578, 20 April 2004.
4. Cooperrider DL, Sorensen PF, Yaeger TF, Whitney D. *Appreciative Inquiry: An Emerging Direction for Organization Development*. Champaign: Stipes; 2001
5. Plescia M, Groblewski M. A community-oriented primary care demonstration project: refining interventions for cardiovascular disease and diabetes. *Ann Fam Med.* 2004;2:103-109.
6. Williams RL. Motherhood, apple pie, and COPC. *Ann Fam Med.* 2004;2:100-102.
7. Smith DR. When all else fails [eletter]. http://www.annfammed.org/cgi/eletters/2/2/100#596, 22 April 2004.
8. Like RC. Whither COPC and family medicine practice-based research [eletter]? http://www.annfammed.org/cgi/eletters/2/2/100#521, 11 April 2004.
9. Kaufman A. Commentary of Dr. Williams' editorial [eletter]. http://www.annfammed.org/cgi/eletters/2/2/100#469, 3 April 2004.
10. Farley T. Conundrum [eletter]. http://www.annfammed.org/cgi/eletters/2/2/100#464, 2 April 2004.
11. Pathman DE. The strengths and challenges of excellence in COPC [eletter]. http://www.annfammed.org/cgi/eletters/2/2/103#523, 12 April 2004.
12. Murray SA. Rapid appraisal as a participatory approach to Community Orientated Primary Care (COPC) [eletter]. http://www.annfammed.org/cgi/eletters/2/2/103#506, 10 April 2004.

13. Bettigole CA. Structural barriers to health and the COPC model [eletter]. http://www.annfammed.org/cgi/eletters/2/2/103#416, 31 March 2004.
14. WinklerPrins V, van den Nieuwenhof L, van den Hoogen H, Bor H, van Weel C. The natural history of asthma in a primary care cohort. *Ann Fam Med.* 2004;2:110-115.
15. van den Nieuwenhof L, van Weel C. The natural history of asthma in a primary care cohort [eletter]. http://www.annfammed.org/cgi/eletters/2/2/110#665 , 29 April 2004.
16. Jackson EA. The natural history of asthma in a primary care cohort [eletter]. http://www.annfammed.org/cgi/eletters/2/2/110#481, 6 April 2004.
17. Thomas M. Asthma natural history and diagnosis [eletter]. http://www.annfammed.org/cgi/eletters/2/2/110#542, 15 April 2004.
18. Fardy HJ. The natural history of asthma in a primary care cohort [eletter]. http://www.annfammed.org/cgi/eletters/2/2/110#554, 16 April 2004.
19. Rocca LG, Yawn BP, Wollan P, Kim WR. Management of patients with hepatitis C in a community population: diagnosis, discussions, and decisions to treat. *Ann Fam Med.* 2004;2:116-124.
20. Sandt L, St. John TM. Repairing the holes in the HCV safety net [eletter]. http://www.annfammed.org/cgi/eletters/2/2/116#429, 31 March 2004.
21. Bauman KA. Management of hepatitis C in a very high risk population: corrections [eletter]. http://www.annfammed.org/cgi/eletters/2/2/116#440, 31 March 2004.
22. Herrine SK. View from a hepatologist [eletter]. http://www.annfammed.org/cgi/eletters/2/2/116#531, 12 April 2004.
23. Elder NC, Vonder Meulen MB, Cassedy A. The identification of medical errors by family physicians during outpatient visits. *Ann Fam Med.* 2004;2:125-129.
24. Galliher JM. Comment on "The identification of medical errors by family physicians during outpatient visits" [eletter]. http://www.annfammed.org/cgi/eletters/2/2/125#405, 31 March 2004.
25. Fetters MD. Errors in primary care: what's on the radar screen [eletter]? http://www.annfammed.org/cgi/eletters/2/2/125#407, 31 March 2004.
26. Scott-Cawiezell JR. Seeking to further understand "real" medication error rates in primary care [eletter]. http://www.annfammed.org/cgi/eletters/2/2/125#446, 1 April 2004.
27. Kuzel AJ. Physician reports, and terminology, and the notion of harm [eletter]. http://www.annfammed.org/cgi/eletters/2/2/125#486, 6 April 2004.
28. Main DS. Just the tip of the iceberg - Comment on Elder et al [eletter]. http://www.annfammed.org/cgi/eletters/2/2/125#503, 8 April 2004.
29. Riley RJ. Family medicine must do better [eletter]. http://www.annfammed.org/cgi/eletters/2/2/125#618, 26 April 2004.
30. Elder NC. Response from the author [eletter]. http://www.annfammed.org/cgi/eletters/2/2/125#614, 24 April 2004.
31. Gramling R, Nash J, Siren K, Eaton C, Culpepper L. Family physician self-efficacy with screening for inherited cancer risk. *Ann Fam Med.* 2004;2:130-132.
32. Ewigman B. Family history in practice [eletter]. http://www.annfammed.org/cgi/eletters/2/2/130#573, 19 April 2004.
33. David SP. Teachable moments for genetics in family medicine [eletter]. http://www.annfammed.org/cgi/eletters/2/2/130#529, 12 April 2004.
34. Carroll JC. Family physicians and the "new" genetics [eletter]. http://www.annfammed.org/cgi/eletters/2/2/130#489, 7 April 2004.
35. Mainous AG III, Gill JM, Carek PJ. Elevated serum transferrin saturation and mortality. *Ann Fam Med.* 2004;2:133-138.
36. Mainous AG III, Wells B, Carek PJ, Gill JM, Geesey ME. The mortality risk of elevated serum transferrin saturation and consumption of dietary iron. *Ann Fam Med.* 2004;2:139-144.
37. Alexander RS. Professional and patient perspective [eletter]. http://www.annfammed.org/cgi/eletters/2/2/133#551, 15 April 2004.
38. Weinberg E. Tsat% and mortality [eletter]. http://www.annfammed.org/cgi/eletters/2/2/133#546 15, April 2004.
39. Billings PR. Iron revisited [eletter]. http://www.annfammed.org/cgi/eletters/2/2/139#535, 13 April 2004.
40. Anderson GJ, Frazer DM. Iron and mortality [eletter]. http://www.annfammed.org/cgi/eletters/2/2/139#549, 15 April 2004.
41. Zyzanski SJ. Potential and added value of secondary data analysis [eletter]. http://www.annfammed.org/cgi/eletters/2/2/139#451, 1 April 2004.
42. Keeley RD, Birchard A, Dickinson P, et al. Parental attitudes about a pregnancy predict birth weight in a low-income population. *Ann Fam Med.* 2004;2:145-149.
43. French LM. An intriguing idea [eletter]. http://www.annfammed.org/cgi/eletters/2/2/145#497, 8 April 2004.
44. Gask L. Powerlessness, control, and complexity: the experience of family physicians in a group model HMO. *Ann Fam Med.* 2004;2:150-155.
45. Price DW. Powerlessness, frustration, and control -- so what do we do now [eletter]? http://www.annfammed.org/cgi/eletters/2/2/150#513, 11 April 2004.
46. Scherger JE. Family physician morale in practice -- larger groups [eletter]. http://www.annfammed.org/cgi/eletters/2/2/150#444, 1 April 2004.
47. Baird MA. Local vs. central control: one issue that might influence powerlessness [eletter]. http://www.annfammed.org/cgi/eletters/2/2/150#414, 31 March 2004.
48. U.S. Preventive Services Task Force. Screening for family and intimate partner violence: recommendation statement. *Ann Fam Med.* 2004;2:156-160.
49. Elliott BA. Thoughts from another perspective [eletter]. http://www.annfammed.org/cgi/eletters/2/2/156#473, 4 April 2004.
50. Heldring MB. Screening for family and intimate partner violence: a new risk factor for future analysis [eletter]? http://www.annfammed.org/cgi/eletters/2/2/156#454, 2 April 2004.
51. Alexander RC. Looking forward in dealing with child abuse [eletter]. http://www.annfammed.org/cgi/eletters/2/2/161#460, 1 April 2004.
52. Flaherty EG. Screening children for violence [eletter]. http://www.annfammed.org/cgi/eletters/2/2/161#475, 4 April 2004.
53. Park E-W, Tudiver F, Schultz JK, Campbell T. Does enhancing partner support and interaction improve smoking cessation? A meta-analysis. *Ann Fam Med.* 2004;2:170-174.
54. McIlvain HE. The thorny problem of the influence of partner support in smoking cessation [eletter]. http://www.annfammed.org/cgi/eletters/2/2/170#458, 1 April 2004.
55. Rosenblatt RA. Getting the news. *Ann Fam Med.* 2004;2:175-176.
56. Kohrs FP. Does it have to be this way [eletter]? http://www.annfammed.org/cgi/eletters/2/2/175#421, 31 March 2004.
57. Scott JG. Treating without caring [eletter]. http://www.annfammed.org/cgi/eletters/2/2/175#412, 31 March 2004.
58. Smith PJ. Comment on "Immunization coverage and medicaid managed care in New Mexico: a multimethod assessment" by Schillaci et al [eletter]. http://www.annfammed.org/cgi/eletters/2/1/13#378, 5 March 2004.
59. Schillaci MA, Waitzkin H, Carson EA, López CM, Boehm DA, López LA, Mahoney SF. Immunization coverage and medicaid managed care in New Mexico: a multimethod assessment. *Ann Fam Med.* 2004;2:13-21.
60. Moberg DO. Epistemological issues in measuring spirituality [eletter]. http://www.annfammed.org/cgi/eletters/2/1/49#386, 16 March 2004.
61. Hummel LM, Vollman M. Re: Response to Daaleman and colleagues' article [eletter]. http://www.annfammed.org/cgi/eletters/2/1/49#335, 16 February 2004.
62. Daaleman TP. Author response [eletter]. http://www.annfammed.org/cgi/eletters/2/1/49#395, 30 March 2004.
63. Mehr DR. Will better assessment enhance end-of-life care [eletter]? http://www.annfammed.org/cgi/eletters/2/1/54#345, 24 February 2004.
64. Jerant AF. One small step toward a comprehensive approach to palliative care in the elderly [eletter]. http://www.annfammed.org/cgi/eletters/2/1/54#358, 2 March 2004.
65. Biek RW. Iatrogenic benefits and risks [eletter]. http://www.annfammed.org/cgi/eletters/1/1/44#391, 21 March 2004.
66. Tugwell P. The campaign to revitalise academic medicine kicks off [eletter]. http://www.annfammed.org/cgi/eletters?lookup=by_date&days=120#504, 8 April 2004.
67. Okkes IM. The Banff Declaration and the information needs of primary care and family medicine in the USA [eletter]. http://www.annfammed.org/cgi/qa-display/short/annalsfm_el;48#175, 17 December 2003.
68. Stange KC. Editor's questions and further synthesis [eletter]. http://www.annfammed.org/cgi/eletters/2/suppl_1/s3#689, 5 May 2004.