A brief editorial on the state of family medicine in the US

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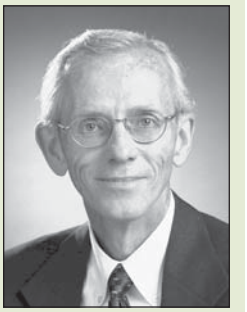

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Transformative change is the daily fare for family physicians in the United States. It is not a tweeking that is underway, but a remake. There are a number of reasons why.

The US has passed the $2 trillion/year milestone for spending on health care. All projections yield a conclusion of unsustainability, while providers demand more revenue. The underperformance of the health care system is well-advertised and common knowledge. There is much complaining by the public about difficulties getting the care they seek and how expensive it is, while the nation's love affair with technology and miracles runs ahead, unabated. The evidence about the salutary effects of primary care is resurfacing, garnering the attention of government, employers, and anyone responsible for paying for health care services. The appropriate roles and relationships amongst generalists and subspecialists remain contested. The lack of national standards, sunk costs in legacy computer systems, and privacy concerns thwart the establishment of a nationwide health information architecture capable of handling interoperable, electronic health records. Every aspiring presidential candidate is elevating health care reform back on to the nation's agenda.

The Future of Family Medicine report created and published at the beginning of the 21st century has been scrutinised for a few years and is still standing. Its basic findings concurred with the US Institute of Medicine's quality studies and concluded that family medicine might not have a future without substantial changes within the specialty and also with the health care system overall. Sufficient consensus has been established to proceed with pioneering efforts to redesign family practices and the way family physicians work. These efforts have as their 'pole stars' the new, modern medical home and personal doctoring. A wave of early adopters have set about revising their practices to use advanced scheduling techniques, incorporate electronic health records and patient registries, incorporate asynchronous care via email and websites, revise the work of staff into vibrant teams, incorporate patient safety and quality improvement as part of daily routines, and more. Each component, taken separately, has been demonstrated, but the operating characteristics of the comprehensive 're-make' is just emerging, with strong leadership from TransforMED, Inc., a new practice assistance organisation recommended by the entire family of family medicine organisations and created by the American Academy of Family Physicians.

Despite considerable uncertainty and recognition that there is much yet to be learned about the new model of family practice, US family medicine residencies are initiating the first serious revision of the structure and content of training for family physicians since the advent of the specialty in 1969. For example, 'Preparing the Personal Physician for Practice' is a national effort initiated by the Association of Family Medicine Residency Directors and the American Board of Family Medicine that is launching educational experiments this month with multi-method, comparative case studies to guide new training requirements forecast for 2012.

The long-articulated notion that being a physician is a life-long jour-

ney of learning is also finding new expression in revisions of the processes practising family physicians follow to be board certified specialists. No longer is taking a test sufficient. Indeed, examining one's practice and making efforts to improve it measurably are now embedded into 10 year cycles of self study and practice improvement.

There are different types and 'sizes' of change, and this one is a big, transformative one for family medicine in the United States. Core values about the centrality of relationship between a personal physician and another human being who becomes a patient, and the receptivity of family physicians to people of any age with any problem are enduring and continuing into the new model of care. But much is going to be different. Perhaps the most critical skill for family physicians in the next decade, after superior clinical competence, will be the ability to lead and manage change.

Performance as never before by family physicians to make a difference in premature death and avoidable suffering is within reach. Not yet pervasive, still emerging, is a renewed sense of purpose and excitement amongst family physicians. The next version of family medicine is just ahead – personal doctoring in a medical home where people of all walks of life with any type of health problem can come and expect integrated, best care from 'my doctor'. This redesign is not easy, but it is necessary. For the frontline family physician, it is a bit like building an airplane while flying it. It is important work, worthy of physicians and their partners and allies, destined to be of great benefit to people.

Competing interests

Dr Green has received travel support from TransforMED, Inc., a division of the American Academy of Family Physicians, to attend and speak at conferences.

The demise of the blockbuster?

'When Pfizer announced that it was halting clinical testing of its new cholesterol drug, torcetrapib, the company's market value fell by $21 billion overnight. Ten thousand job cuts followed. The ongoing promise of nearly $3 billion in annual sales vanished when Merck pulled Vioxx (rofecoxib) from the shelves, and the company's market value fell by $25 billion.'

Cutler DM. The demise of the blockbuster? N Engl J Med 2007; 356:1292–1293.