



Family Medicine for America's Health and Escape Velocity

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When a confluence of economic and political pressures combine with capable leadership, history has demonstrated that things can take a radically different trajectory. But achieving a new orbit requires a great deal of energy. Over the past 115 years there has been a series of transformational moments in American medicine. The Pure Food and Drug Act in 1906 helped establish the role of public health,¹ the Flexner report in 1910 codified medical education,² and Medicare in 1965 broadened coverage but also contributed to an unprecedented increase of wealth and costs in medical care. The country may be at that point again.

Other changes, such as the creation of a generalist specialty like family medicine, emerge from the large societal changes. Unfortunately, instead of helping bring about a cohesive health system, the establishment of family medicine was followed by 50 years of increasing fragmentation of the physician workforce and exorbitant rises in costs that have brought medicine to its present state. Despite the energy and innovation that has grown family medicine as a discipline, transforming health as well as health care in America has not yet achieved liftoff.³

In this special issue of *Family Medicine*, six position papers outline the Family Medicine for America's Health (FMAHealth) agenda for substantive change in America. In past decades, strategy and tactics that relied on well-crafted, thoughtful, and empirically based reports to make the case for primary care have repeatedly collided with the famous opening phrase of *The Social Transformation of*

American Medicine: "The dream of reason did not take power into account."⁴ Starr was not calling for the abandonment of dreams or reason but suggesting that reason must confront power with new tactics or will suffer the same disappointment. While the dream of creating a new discipline took a decade, the dream of a transformed health system faces larger forces with a great deal more power and money. A question for the FMAHealth project is whether the tactics they propose are indeed different enough to have a greater chance of success. Even if they are, to escape the pull of gravity, family medicine needs a more powerful engine.

One does not have to be a disciple of either Karl Marx or Milton Friedman to accept the reality that economic forces drive changes in culture, politics, and education. The unwillingness to change payment and care models from the shopkeeper mentality of the middle 20th century based on throughput and production has helped create multi-billion dollar "shops" where buildings full of people illuminated by computer screens comprise the power that will resist any change. The work of reform is heavy lifting. The Affordable Care Act should be the economic driver of changes in clinical care and medical education. It has the potential to be the engine that helps the transformational potential of primary care to gain escape velocity, but it remains to be seen if this will be the case.

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Experience from countries with universal coverage and strong primary care shows that economic reform preceded educational reform. The United Kingdom, Canada, Japan, and most European countries set principles for covering all members of those societies and the methods to pay for it. Defining the role of generalists and their education came later, often much later.^{5,6} The primary focus of FMAHealth and all other primary care disciplines must be to change to a population- and team-oriented payment model, driven by quality and outcomes.⁷ Financial reform is a prerequisite for the changes in education, technological creativity, innovative practice reform, and research in health and health care. It is undoubtedly the most difficult aspect of medicine to change but is the most essential; otherwise change will remain incremental, unsatisfying, and ultimately unsuccessful.

As an example, while workforce reform has been the subject of intense interest to family medicine educators for decades, countless reports and articles advocating major redirection have had mixed results. In the 15 years since the Future of Family Medicine project, the last major effort to bring large changes to family medicine, US medical graduates have increased by over 4,000⁸ while US graduates entering family medicine residencies in the past decade have increased by only 300.⁹ Canadian medical schools have pledged to be socially accountable to the people of Canada, including providing an appropriate workforce, in part because of economic reforms in health care that assured universal coverage. US academic health centers have remained essentially unchanged in their lack of accountability to the public to train an appropriate workforce, and much of their reluctance can be traced to economic incentives that are built into the current graduate medical education structure.^{10,11}

In a ubiquitous world, as Phillips and colleagues¹² point out, strategies to make technology meet its potential in health care can be a wicked problem, described by Camillus¹³ as one with “innumerable causes, is tough to describe, and doesn’t have a right answer,” and may require wicked solutions. The end result of technology should be to improve lives, simplify the experiences of health and illness, and offer help to patients and doctors. However, medical technology is still a long way from the tipping point of benefit versus burden.¹² Oversight and compliance masquerading as safety and a focus on measuring production rather than health has sucked the air out of the room,

leaving creative clinicians with little time or energy to try new ideas.

All the articles in this special issue are well researched, thoughtfully written, and capture the central challenges in health care reform in 2015. They are documents worth keeping and re-reading. However, if they are to serve as guidelines for the fundamental reform of education, research, technology, patient engagement, and payment reform, each needs to have agreed upon messages and strategies that can be used by the public trying to push for the care it needs and by clinicians pushing for economic and structural reforms that will help those needs be met.

I offer some observations for helping communicate such strategies:

- Primary care needs to speak with a single voice. The fragmentation of generalists into different tribes may be important to academics and clinicians but it is not to the public. Too many voices create cacophony.

- There has to be a change in “us,” not just “them.” One can’t expect radical changes in others while remaining an island of incrementalism.

- Universal coverage must be the stated goal of generalists and agreed upon as essential to meeting the Triple Aim.

- The demand for payment reform away from piecemeal and toward payment for populations has to be consistent, forceful, and based on economic models that are clear and understandable. Mixed models should be a transition, not the end point.

- The campaign to educate the public about economic and educational reform starts with neighborhoods, communities, and local officials, not boardrooms. Community engagement happens in communities, not hospitals and medical offices.

- Changes in medical education will come from outside academic health centers, driven by economic changes, but being inside to help speed change when it does happen is essential and valuable. Creative anticipation is crucial.

- Embracing and using technology is the only way to find solutions that work, but technology requires active engagement that makes it the servant, not the master, of doctors and patients.

- Speak of shareholders rather than stakeholders. Respect patients by asking their collective advice about how to improve the functioning and health of medical homes. Patients should be treated like trusted partners, not simply with their own information but

with the struggles that their doctors face in trying to improve care for everyone.

Finally, all change is not successful, and learning from failure is where real innovation originates. Honesty and transparency about what works and what doesn't should move clinical systems from competitors to collaborators. And of course, primary care must lead change, not simply be reactive to it. With the power of the ACA to drive economic change, this may finally be the time reform takes off.

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