

SPECIAL COMMUNICATION

Back to the Future: Reflections on the History of the Future of Family Medicine

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These are historic times for family medicine. The profession is moving beyond the visionary blueprint of the Future of Family Medicine (FFM) report while working to harness the momentum created by the FFM movement. Preparing for, and leading through, the next transformative wave of change (FFM version 2.0) will require the engagement of multigenerational and multidisciplinary visionaries who bring wisdom from diverse experiences. Active group reflection on the past will potentiate the collective work being done to best chart the future. Historical competency is critically important for family medicine's future. This article describes the historical context of the development and launch of the FFM report, emphasizing the professional activism that preceded and followed it. This article is intended to spark intergenerational dialog by providing a multigenerational reflection on the history of FFM and the evolution that has occurred in family medicine over the past decade. Such intergenerational conversations enable our elders to share wisdom with our youth, while allowing our discipline to visualize history through the eyes of future generations. (J Am Board Fam Med 2014;27:839–845.)

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There is an urgent need for a strong and sustainable US health care system. Family medicine is uniquely positioned to lead efforts to help our nation achieve the triple aim of better health care, improved population health, and lower health care costs.^{1–5} Reflections on the history of family medicine are central to our dialog about the future, including a critical review of key historical docu-

ments, such as the Future of Family Medicine (FFM 1.0) report.^{6–9} Reviewing the history surrounding the creation of the FFM 1.0 report will help our profession prepare for the next wave of transformative recommendations (FFM 2.0).¹⁰ This article presents a multigenerational perspective on the historical context of the development and the launch of the FFM 1.0 report, emphasizing the professional activism that preceded and followed it. It is intended to spark continued intergenerational dialog on the evolution that has occurred in family medicine over the past decade as well as to provide historical context for critically interpreting and building an action plan for FFM 2.0 recommendations. Effective change will require the engagement of multigenerational and multidisciplinary visionaries who bring wisdom from diverse experiences. Historical competency is imperative; active group reflection on the past will potentiate the collective work being done to best chart the future.

Historical Context, Development, and Launch of the FFM 1.0 Report

Family medicine derived from general practice. Before the 20th century, the standard medical practice

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was that of general practitioners making house calls for urgent illnesses. After World War II, outpatient offices were built near rapidly expanding hospitals funded by the Hill Burton Act. The future of general practice became uncertain as medical disciplines increasingly specialized in certain diseases and organ systems.^{11,12} Recognizing the need for physicians to care for the whole person and coordinate patient care, the 1966 Willard¹³ and Millis¹⁴ reports called for a new residency-trained specialty to replace general practice. To further support the need for comprehensive approaches to caring for individual and community health, the 1967 Folsom Report called for “communities of solution.”^{9,15} Founded as “family practice” in 1969, the specialty flourished in the 1970s.¹⁶ In addition to providing care for acute illnesses, family physicians were tasked with managing chronic health problems and navigating the emerging preventive health recommendations. The founders recognized that behavior drives health, and thus behavioral education and biopsychosocial models have been an integral part of family medicine training from the beginning.^{17,18}

By the late 20th century, family physicians were spending the majority of their time delivering episodic care in outpatient settings. Despite changes in the organization and financing of health care delivery, Green et al¹⁹ demonstrated in 2001 that the US “ecology of medical care” had not changed significantly from when it was first assessed by White et al²⁰ in 1961. Primary care was essential for the health of the nation; a majority of patients received medical care in primary care physician’s offices, and a majority of those office visits were provided by family physicians.¹⁹

In 1998, the Institute of Medicine Committee on the Quality of Care in America published an influential report: “Crossing the Quality Chasm: A New Health System for the 21st Century.”²¹ This report warned that the US health care system was fatally flawed and required a massive overhaul to shift from episodic office-based care to a continuous process of care between a team and a population of patients using advanced information systems. This new system should provide collaborative, patient-centered, evidence-based, high-value, equitable, and safe care.²¹

With the realization that radical changes were needed to propel the discipline of family medicine into the 21st century, family physician leaders gath-

ered (for the third time) in Keystone, Colorado, in 2000.²² In what became known as Keystone III, multigenerational representatives from the 7 family medicine organizations engaged in a “structured conversation about family practice in the United States” to “examine the soul of the discipline of family medicine” and “to take stock of the present and grapple with the future of family practice.”²³

Building on recommendations and discourse from Keystone III, the FFM Project was officially launched in 2002.²⁴ This historic project came at a time of increasing health care costs and diminishing care quality; health care disparities were worsening, delivery of evidence-based care was sporadic, and an increasing percentage of the population was uninsured.^{25–28} Fragmentation of care was predominant; few systems were organized, integrated, or coordinated to place patients at the true center of care.^{28,29} Widely considered to be a failure, the trial of managed care led to physicians’ demoralization and patients’ distrust in the system.³⁰ Family medicine was poorly understood by patients and family physicians were undervalued by payers and experienced a lack of prestige.³¹ This dire external view of family medicine was exacerbated by changes in the profession’s scope of practice and lack of consensus on professional priorities. At the same time, interest in primary care among medical students was plummeting.³²

FFM 1.0 leaders organized 5 task forces (later adding a sixth) with representatives from all 7 national family medicine organizations and other experts external to the field. Qualitative research involving interviews with “thought leaders” and focus groups of physicians and patients was performed by independent research firms.²⁴ They identified 5 key characteristics of family physicians and issued the following identity statement: “Family physicians are committed to fostering health and integrating health care for the whole person by humanizing medicine and providing science-based, high-quality care.”²⁴

The FFM 1.0 report called for major changes to family medicine and to the US health care system. Its principles were widely shared with the public and were featured by major media outlets. For family medicine to achieve excellence in delivering science-based, high-quality care for the whole person and to lead the transformation of primary care, the report recommended bringing about changes in 4 key areas: (1) the US health care system, (2)

clinical practice, (3) training and continuing development, and (4) leadership and communication.

The US Health Care System

The FFM 1.0 Report had 10 recommendations addressing the role of family medicine in improving US health care. A key recommendation described a “new model” of care entitled the patient-centered medical home (PCMH).²⁴ This concept, first described in the pediatric community in the 1960s,^{33–35} was seen as a transformational design for family medicine to address issues related to access to care and the quality and efficiency of patient care and to embed new and relevant technological advances into practice.³⁶ In 2005, Ostbye et al³⁷ estimated that a primary care physician without a team would need at least 18 hours per day to provide high-quality care to a panel of patients. Given this impossibility, the PCMH was envisioned to improve efficiency by relying on a team of caregivers all working to the highest level of their licenses.³⁸ The PCMH characteristics were further articulated in a document released in 2007 by the Robert Graham Center.^{36,39–41} The PCMH concept received significant positive attention by the media and the public and was embraced by many primary care stakeholders, payers, and politicians.⁴² However, the cost of building the required clinical office infrastructure has not been supported by current payment models,^{43–46} so the adoption of PCMHs within the primary care community has been slow, and the value and viability of the PCMH remains a concern.^{47,48}

The timeliness of the FFM 1.0 Report facilitated an opportunity to influence the Affordable Care Act (ACA)—the largest health reform legislation in more than 50 years; key concepts from the report were embedded in ACA legislation.⁴⁹ Fueled by the FFM 1.0 Report, the ACA developed policies to shift the US health care system toward a primary care–centered model intended to improve quality at decreased cost, with better systems for managing population health.⁵⁰ The FFM Report also laid important groundwork for the integration, implementation, and “meaningful use” of electronic health records into the health care system.^{51–53}

Clinical Practice

A goal of the FFM 1.0 process was to identify the core attributes of family physicians. FFM 1.0 outlined the vision for a scope of practice that encom-

passed a comprehensive approach to caring for the whole person and suggested operationalizing this vision through a “basket of services.” Over the past decade, studies have highlighted key areas within family medicine’s traditional scope with decreasing involvement by family physicians.⁵⁴ For example, the percentage of prenatal visits that were provided by family physicians decreased by 50% from 1995 to 2004, a decline that continued through 2010.^{55,56} Family physicians’ provision of care to children has similarly declined: One study reported a 33% decrease in the percentage of children’s office visits provided by family physicians and general practitioners between 1992 and 2002.⁵⁷ Another study reported a decrease in the percentage of family physicians providing children’s health care: from 78% to 68% between 2000 and 2009.⁵⁸ Some experts point to the fact that the number of pediatricians doubled from 1981 to 2004, while the birth rate decreased.⁵⁷ Further, the number of family physicians providing care in hospitals has steadily decreased; an increasing percentage of hospital care is now provided by hospitalists, only 10.5% of whom are family physicians.^{59,60} A similar trend toward outpatient-only practice has occurred among general internists.⁵⁷

A full basket of services and a broad scope of practice were envisioned by FFM 1.0, yet many family physicians have not maintained this traditional scope because of several factors, including malpractice insurance, reimbursement, lifestyle priorities, credentialing, and lack of support from other medical specialists.^{61–63} At the same time, an increasing percentage of family physicians are engaged in comprehensive prevention and chronic illness management for individuals, as well as in caring for communities and populations, demonstrating that family medicine has expanded in complexity, if not in scope.^{64,65}

Training and Continuing Development

Research informing FFM 1.0 revealed that family medicine training requirements were viewed as rigid and not well suited to meet the future needs of the health care system. The FFM 1.0 Report responded by calling for the Residency Review Committee (RRC) to enhance educational “flexibility and responsiveness, innovation and active experimentation, consistency and reliability, individualized to learner’s needs and the needs of communities.”²⁴ In turn, the RRC approved a key innovation

project in 2007: the Preparing the Personal Physician for Practice (P4) Initiative.⁶⁶ Administered by TransforMED, a clinical practice national support resource founded by the American Academy of Family Physicians (and also an FFM 1.0 recommendation), the project selected 14 residency programs to implement innovative changes, including duration of training and curriculum content.^{67,68} In 2013, the discipline launched a second pilot addressing duration of training and scope of practice. In 2014, the RRC revised the Accreditation Council for Graduate Medical Education core program requirements, stressing PCMH competencies, population health, and quality improvement training.⁶⁹ While longitudinal studies of these innovative projects will require years to complete, preliminary findings show improvements in care of chronic illnesses,⁶⁶ successful examples of practice transformation and improvement,^{67,70,71} and a new model for providing tailored residency education experiences.⁶⁸ One promising sign is that more US medical school seniors chose family medicine through the National Resident Matching Program in 2013 than in any year since 2002.^{72,73}

Beyond medical school education and residency training, FFM 1.0 recognized lifelong learning and career development for family physicians as critically important for the health of the profession. This recognition coincided with the creation of a process called Maintenance of Certification by the American Board of Medical Specialties, which was implemented by the American Board of Family Medicine⁷⁴. In 2010, 91% of all active, board-certified family physicians eligible for Maintenance of Certification were participating in this training, with demonstrated improvement in the quality of medical care delivered.^{75,76} This high level of engagement in career-long learning is seen as one of the top achievements of FFM 1.0 and has served as a model for other specialty boards.

Leadership and Communication

FFM 1.0 emphasized the need to strengthen the identity of family medicine by defining and promoting a public message via a combination of strategies aimed at communicating consistency and purpose. As part of this messaging, the name of the specialty, and of the certifying board, was officially changed from “family practice” to “family medicine.”

Research was identified as being critical to the profession; thus FFM 1.0 called for development of a collaborative research agenda for studying the origins of illness, improving care provision, and expanding traditional practice-based research. While a cohesive national family medicine research agenda remains only a recommendation, the Robert Graham Center in Washington, DC, has played a crucial role in informing ongoing FFM efforts and continues to evaluate progress toward its goals.

The FFM 1.0 Report recognized that the broad training and diverse vantage points of family physicians enable them to play a vital leadership role in the transformation of the US health care system. There was a call for an expansion in leadership training opportunities and for academic departments to develop programs to address this need. FFM 1.0 also called for the development of a leadership center for family medicine and primary care, which has yet to be fully realized.

Conclusions

Family medicine’s history of positive change and growth over the past decade is a testament to the vision and foresight of the founders of the specialty more than 40 years ago and, more recently, to that of the FFM 1.0 creators and contributors. FFM 1.0 was a critical first step toward ensuring that family physicians are equipped and positioned to drive the changes needed for the US health care system to achieve the triple aim, but more work is needed to realize all FFM 1.0 goals and to set FFM 2.0 goals.¹⁰ Family medicine must continue to transform at an accelerated pace to best meet the needs of patients and influence vital improvements in the US health care system. As the profession moves forward, continued study of the history of family medicine will help ensure that all family medicine learners and teachers know where we’ve been to better see where we are going, thereby building historical competency within the profession. For example, a group of young leaders revisited the historic Folsom Report and highlighted its relevance regarding communities of solutions for today’s complex health problems.^{9,15} Intergenerational dialog about how best to interpret and learn from this history will meaningfully inform the future. The future of family medicine as a profession and as an academic discipline will depend on effectively passing the baton from the current FFM leadership to the next generation.

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