Family Medicine Has a Second Chance to Make a First Impression

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The discussions in this supplement issue have provided us with a tremendous breadth of perspective and experience from participants in the development of family medicine during the last 40 years. I will not try to summarize the specific comments we have heard, but will seek to provide a synthesis of common threads of thought, significant findings, and implications for the discipline's future. I will focus these comments on 4 specific points:

1. the significance of disruptive innovations in changing complex systems;
2. the implications of choosing an operational philosophy of continuous quality improvement;
3. the difficulties—and opportunities—of a health care system which is a structural mismatch for the country's needs, and the strengths of family medicine; and
4. the possibility that we are currently involved in the early stages of a new "disruptive innovation" that could fundamentally change the structure of family medicine and the organization and effectiveness of the US health care system.

Significance of Disruptive Innovations in Changing Complex Systems

I suspect that the founders of the American Board of Family Practice (now American Board of Family Medicine [ABFM]) were not thinking in the context of "disruptive innovations" when they made their decision to initiate the ABFM as offering only a time-limited certificate, but this is exactly what they accomplished. The term "disruptive innovation"[1] was coined by Clayton Christiansen largely in the context of technology and business, but it described any new innovation which operated on such a different set of principles that it created not only a competitive advantage for the innovator, but forced other parties with which the innovator interacted to change their own strategies and practices.

When the ABFM declared in 1969 that they would use only time-limited certificates, it began a very gradual process of change within the medical profession that has forced all other boards to adopt this same policy. Even though this process has been slow—today probably fewer than 50% of American physicians have a time-limited certificate—it fundamentally changed the professional structure of certification and the responsibility of the boards to the American public.

Implications of Choosing an Operational Philosophy of Continuous Quality Improvement

A closely related change that followed this decision for time-limited certificates was the implicit commitment in family medicine to the principle of continuous quality improvement in both its educational and certification spheres. In a very fundamental way, this removes the ability of family medicine from ever establishing a finite boundary of "best quality." Instead, it makes it clear that the commitment of the individual family physician is not only to maintain their competency over time, but to continually measure and assess their clinical performance and to identify mechanisms by which any given status may be improved. This principle, therefore, has become a very subtle but substantive linkage between the innovation of time-limited certificates and the developing principles of the patient-centered medical home.

The Difficulties and Opportunities of a Health Care System

Throughout the history of its development, the discipline of Family Medicine has been constrained to function in an American health care system, the

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values and structures of which are at substantial variance with its own core principles. Simply stated, the American health care system, in its organization and financing, is structured to address medical problems based on a paradigm created 30 to 40 years ago, when the majority of problems were acute and immediate. However, the vast majority of the current needs of the American public are for chronic and continuous conditions. The discipline of Family Medicine has struggled throughout its development to build effective training programs and practices that could respond to the changing nature of the medical and health care needs of the American public but has had to work constantly against the strong countercurrent of a system organized by subspecialty and that largely focuses on current and acute conditions.

A New "Disruptive Innovation"

To provide a context for this point, and my closing comments, I would like to return to Gayle Stephens's[2] reminder about the substantial contribution to the formation and creation of the discipline of Family Medicine from 3 reports that were authored in the early to mid-1960s: the Willard Report,[3] the Millis Commission,[4] and the Folsom Report.[5] Most of us are familiar with the recommendations of both the Willard report and Millis commission because they provided a significant structure for the revised family medicine training programs in the 1970s. However, in many ways the Folsom Report had as important a message for the discipline. It articulated the need for the modern family physician, not just in terms of the different training and certification structure, but also the potential importance of such a physician in addressing the changing needs of patients' communities in the United States.

That is why, as my fourth point, I would suggest that we may be in the early stages of developing yet another "disruptive innovation" within the family medicine community: the patient-centered medical home. Although the movement toward this new structure and philosophy of practice is still in its relatively early stages, it seems that it may be entirely consistent with the principles articulated by Christiansen in that not only is it fundamentally changing the way family medicine practices are structured and how they perform, but it also has the potential to reshape the way the larger medical care system organizes health care services and reimburses for its care.

To be successful, the medical home requires practices to change not only the structure and processes of their daily work, but also fundamentally to alter the philosophy and the culture of their practice, placing patient care needs at the center and moving toward a team-based, proactive practice model in which continuous quality improvement is a central function. A successfully functioning patient-centered medical home will substantially improve patient involvement in maintaining their health status, coordination of their care, and interaction with subspecialty, inpatient, and long-term care facilities. Patients in successful patient-centered medical homes will have fewer hospitalizations and emergency department visits and better process and outcome markers for chronic conditions. Overall, the total cost for care in the medical home model will be decreased and quality of care and outcomes will be increased. Not surprisingly, just as in the early 1960s, substantial support for this transformation within family medicine comes from entities outside of the discipline who see the potential for the patient-centered medical home model to address many of the most pressing and problematic needs of the current US health care system.

So, in closing, I come back to where Gayle Stephens[2] and Larry Green[6] left us with their commentaries earlier in this issue. Larry noted that times have changed and instability brings anxiety, uncertainty, and impatience. Any of us involved in family medicine or the broader reform efforts taking place nationally can certainly identify experiencing a high degree of each of these emotions. And Gayle noted in his closing comments that we may have only partially fulfilled the expectations for the discipline when we began this journey in the 1960s. We have done a good job of implementing major elements of both the Willard and Millis commissions, but the Folsom vision of a community-based, patient-responsive, primary care profession, which is at the center of the needs of the US health care system, has only been partially recognized. This may be the second opportunity for family medicine to make a first impression. We can destabilize and change the system in a direction that is positive not only for the needs of the US public, but also the discipline of Family Medicine,

and we can do this just by living up to what we always said we wanted to be.

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