President’s Column

Thoughts for a New Year

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The beginning of the new year is a time to assess our progress and look to the future. Like Janus, the Roman God, it is important to examine where we have been as we look forward to a new year. I believe 2004 will be a critical year for family medicine.

Let us review some major challenges affecting health care in the United States in 2003. The United States had $1.6 trillion in health care expenditures in 2003, yet many of our citizens continue to lack access to basic health care, and others get suboptimal care. Emergency rooms continue to be overcrowded in major metropolitan areas. Changes in Medicare will allow a drug benefit for the elderly, but it remains to be seen who will benefit the most, the elderly or health maintenance organizations and multinational pharmaceutical corporations. In the past year, SARS impacted us although no cases were reported in the United States. We continue to worrying about the safety of our food supply. Bovine spongiform encephalopathy (mad cow disease) has now occurred in the United States. Environmental toxins, such as mercury in fish, continue affecting our food supply. The leading causes of death continue to be related to cardiovascular disease, unintentional trauma, and the results of smoking tobacco. The immunization rates in some of our largest cities are at abysmally low levels. Overuse of antibiotics continues to be a problem. Emerging infections continue to be a problem. Health terrorism with biological agents such as anthrax or cyanide continues to worry us. We should be angry that, given the wealth of this country, not more is done to protect the health of the American people.

More people continue to die from their excesses in smoking, alcohol consumption, and caloric intake than from terrorism. I have heard it said that in the United States, food is a weapon of mass destruction. Obesity is now occurring in epidemic rates in this country. The occurrence of Type II diabetes among obese teenagers and young adults portends badly for the future. In the coming decades, the cost of caring for the young Type II diabetics will compete with the rising health care cost of aging baby boomers.

We live in a fragile balance. At any given time, any one of our support systems may be weakened or lost. When one system of support is lost, stress is placed on the remaining units of the network, and adjustments are needed to maintain homeostasis. Too frequently, in family medicine, our support systems are being challenged. The continued stress can lead to collapse of the entire system. This collapse can occur in families, and it can occur in complex organizational systems.

In family medicine, we have survived another year with funding from the Health Resources and Services Administration (HRSA) although the cuts continue. Medicare payment to primary care physicians has gone up slightly, but support for graduate medical education trends downward. Residency programs have implemented the 80-hour work week and the 24+6 rule. Over the past 2 years, family medicine residency training programs have closed. Student interest in family medicine continues to wane, and fewer US graduates chose family medicine for postgraduate specialty training than in the past 20 years.1 Perhaps we are back to the baseline interest in training in family medicine. At the same time, some academic departments continue to increase their clinical revenues. Some departments continue to increase research support. We are in the same boat but seem to be on different decks.

In any given year, we can have a bad residency Match. We may be unable to find residents for our programs. Our hospitals may question their support for our residency programs. Many of our states face continued financial crises. These financial stresses lead to fiscal cutbacks for higher education, including our medical school departments. If our clinical practice plans lose a major managed care contract or if our payor mix changes the financial well-being of our department or residency program, we can become at risk. We know that the well-being of our patients is partially dependent on the degree of social support that exists for them in time of need. We must ask ourselves, “How robust are our support systems? How much more stress can the discipline of family medicine take? As a consequence, we need to be ever vigilant in the development of our support networks.

We are once again struggling with the issue of physician workforce. Past predictions for oversupply of physicians have not occurred. The maldistribution of physicians, both by specialty and

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geographic location, continues. A rational national policy for physician workforce needs to be implemented. The forces driving the selection of family medicine as a specialty choice are multifactorial. As Josh Freeman, MD, said in a recent Association of Departments of Family Medicine list serve posting, we are the only country that leaves the health workforce decisions in the hands of privileged 25 year olds.

As the number of residency programs that close continues to rise, we need to concentrate on quality instead of quantity. Programs started with the idea that one could get cheap labor from housestaff while profiting from Medicare IME and DME funds now have too small a margin to justify training physicians. Residency programs without a tradition of education have increasing difficulty justifying maintaining family medicine training programs.

The nation once again is confusing its priorities. President Bush is proposing spending money on going to Mars instead of taking care of the basic health needs of our citizens. Health care is no longer a priority in this country. It seems that, barring a major national health care disaster or epidemic, the federal government will not put additional funds into health care. A large infectious disease outbreak or a national disaster require additional funding, but providing funding for prevention seems to be off the radar screen. We should all be angry. Perhaps it is up to us, the generalist on the front line, the family physician, to cry loudly for change and push for even stronger preventative services. If not us, who will take up the cry? If someone else succeeds in making prevention a major issue, we will once again be left on the sidelines.

As a country, we face the dilemma of providing expenditures for creatively expanding the envelope with scientific advances while needing to provide basic health needs to our citizens. Balancing the need of funding for caring for the sick today with the need for making scientific advances that may save lives in the future is tricky indeed.

The resilience of family medicine will allow us to survive. The loyalty of our patients is directly dependent on our providing them the services they want at a reasonable cost. Our ability to serve as generalists is both a weakness and a strength. Our ability to collaborate with others will allow us to get into new ground. We cannot become so territorial that we are cut off from positive changes occurring around us.

Academic departments have to push for excellence in all of their academic programs, their research endeavors, and their community service. We must provide the evidence that we can provide health care across many conditions, across a wide spectrum of ages. That evidence needs to be measured in outcomes, patient satisfaction, and cost savings. It is hubris to depend on just thinking we are right. Each of the Society of Teachers of Family Medicine task forces, committees, and groups should combine excellence with evidence in taking action or making decisions for the improvement of the discipline and the organization.

Social change generally occurs as a result of the actions of a few. There are many of us who entered family medicine because we saw it as an avenue for change, not just social change, but for political change and as a way to change the health care system. If the Majority Leader in the US Senate can be a cardiothoracic surgeon, why can't he or she be a family physician? If we want to effect change, we have to become increasingly politically active.

Perhaps we need to develop new health initiatives that target adolescents and young adults. We spend much of our energy caring for the consequences of preventable problems. We should be doing the things that matter—getting patients to eat healthy, lose weight, exercise, quit smoking. There is no magic or glory in taking these actions, but if we do it frequently and we do it well while documenting our successes, we will be credited for the positive changes that occur.

A new year should make us think of new beginnings. Putting aside past problems or putting them into perspective is a healthy start. Break down any town-grown problems that may exist in your region. Territoriality only increases mistrust. If we are to thrive, we must work together with our colleagues in practice.

The health care system continues to fragment and become multi-tiered. Family medicine needs to be at the forefront in pushing to prioritize health care for all citizens in the United States. Family medicine needs to step forward and propose meaningful change for the improvement of health care for all the American people. Since it is an election year, we are sure to hear promises of what might be, but we need to insist that Congress and the president propose changes that will benefit all of the American people and not get caught in the traditional partisan squabbles.

Physicians can have a powerful voice in the political arena as long as they are not perceived to be acting only in their self-interest. Physicians can encourage their patients to register to vote and remind them to vote on Election Day. We should all be angry at the current situation. We need to channel our anger into effective action.

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