Family Practice Forum

Where Shall We Live and For Whom Shall We Care?

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There are ominous signs in the gas lines. These signs do not merely indicate that the fossil fuel based economy of the twentieth century is in trouble, but that the system of delivering services, including medical care, will undergo drastic change before the end of the century. And we in family practice may find ourselves in a quandary, somewhat of our own making.

A number of well-known figures have alluded to the urban/rural dialectic as central both to the emergence of family practice in the middle 1960s, and to its position as a method of health care delivery. Stephens[1] pointed to the influence of agrarianism on the continued role of family medicine as a reform movement. He reminds us of the love of the American spirit for the values of rural life, and the role of the land in American mythology and in the character of the American hero. The image of the pipe-smoking, horse-and-buggy family doctor trading flour and chickens for services and living the life of the committed citizen of small town America, is also central to many of us as we seek a place in a community, a place of dignity, a place of belonging.

That idyll of the small town family doctor was also, I am sure, in the minds of many legislators who were instrumental in the funding of family practice residency programs. There is a definite reassuring quality to the idea of family doctors infusing rural America with "high quality continuous medical care regardless of age, sex, or type of problem." It warmed the hearts of legislators, also, to see that, after the first few years of funding, graduates were predominantly settling in towns of less than 100,000 population and in significant numbers (52 percent) in towns under 25,000 population.[2] That trend has continued, without much deviation, to the present. In fact, the discipline of family medicine has been unique in medical education in recent years by showing a responsiveness to the expressed needs of people. We deserve to be proud of what we have achieved in producing physicians who have gone to areas where they are needed rather than creating fictitious needs through "medical center" types of clinics in rural areas, a la the brothers Mayo. Small communities do not need to be coerced to accept us, to accept the type of care we deliver nor the manner in which we deliver it. They have, in great part, given us the required support in the medical education community to get things underway in training programs in family practice, likely because they have memories of practicing general practitioners that are more recent and more vibrant than do urban Americans.

This happy fusion of rural needs and family practice education has even found support in the writings of traditionalists in the field of medical education.[3,4] However, there has been a tendency, which is somewhat more disconcerting, I must confess, for the advocates of primary care internists and pediatricians to "concede" the small towns to family physicians. This may be in part due to the notable lack of success of the pediatrician/internist model of primary care to be able to meet the dual needs of coverage and economic viability in small towns. It is easy for three family physicians to provide coverage, hence time off, and to make a living, while any combination of two internists and one pediatrician or the reverse provides neither coverage nor a comfortable living. Their "concession" may be based on reality.

While we revel in the success of the revival of the small town family physician and the ability of residency programs to attract and train family physicians competent to practice in such towns, there is another problem: urban America.

Since the Second World War, America has become more and more a series of towns con-

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nected by concrete to areas of industry and/or finance. The suburb is a mid-twentieth century phenomenon. The birth of the suburb was rapidly followed by the death, or relative decline, of the vital and stable life of the city. The ultimate desperation of the oppressed and dehumanized citizens of urban America became manifest in the late sixties as Detroit, Newark, Washington, DC, Los Angeles, and Chicago burned, and the heart of the city was fired with the rage and hopelessness of people destroying their homes and their businesses. The suburbs, the bedroom communities, seemed secure. The events of those times reinforced the image of cities as unsafe, unwholesome places which existed only because it was too expensive to relocate *all* the factories, banks, and financial markets. And also, let us not forget, we had spent billions of dollars building expressways to get to the cities from the suburbs. We can't ignore the expressways.

During the middle and late 1970s, we have witnessed two social forces in apposition, the movement of young people, primarily sons and daughters of the urban middle class, toward lives of self-sufficiency and conservation of resources in small communities and farms. (The population of Vermont, for example, reversed its decline and actually increased during the late 1970s.) The self-sufficiency movement in many ways is an attempt to make a political statement by living one's life in such a way as to ensure the possibility of a future for those who will live in the future.

The second force has been the increasing shortages of fossil fuels, particularly gasoline, and the impact that such shortages will have on the rebirth of the American city. What the increasing fluctuation in the availability and cost of gasoline may do to the face of this country may be, through some strange and bitter irony, to make a phoenix of the American city, forcing all of us who want to work in cities to live in them. The moonscapes of the South Bronx and the West Side of Chicago may become filled with new housing. What had previously been left to the "inner city" poor may now become prime condominium sites close to the rapid transit system, accessible to the workplace without an expensive and exhausting commute. To conserve what resources we have, the choice may be between living on a self-reliant and energy efficient rural farm or in an energy efficient, geographically central urban neighborhood. The suburb may well be the ghetto of the next century.

While family practice has chosen to emphasize, and be allowed to own as its "turf," the small town, the reality of the revitalization and repopulation of the city is a factor that must be included in future equations for health manpower needs and family physicians. America has been an urban culture and, for reasons I have outlined, we will continue to be, statistically at least, if not in our image of ourselves, an urban people. If family practice and its training programs do not begin to consider and train family physicians who will be capable of and interested in practicing in the cities as well as in the small towns, we may find ourselves geographically isolated and relegated to the vast tracts of rural America, while the cities have de facto become the land of the internist/pediatrician. If that has begun to happen already, it is because we have gone where we are comfortable and where people have expressed a desire to have us. But if the people of urban America do not cry out for family physicians, it is my contention that it is because many of them have had no direct experience with a family physician.

City people, particularly the urban poor, have come to regard Emergency Rooms and faceless clinics as their sources of primary care and regard promises of a personal physician as a cruel hoax. If we are really committed to bringing medical care to all the people of this country, we cannot ignore urban communities, or condemn them to episodic and impersonal care. If we believe that family physicians are the best providers of primary care, then we must address the need to train family physicians for cities. After the dust settles and the expressways have become examples of the extravagance of a time long gone, cities are where the greatest percentage of the people of this country will be living and where family physicians, through commitment and through imaginative and creative design, must be delivering the majority of care.

References

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