Over the past few years, as the inevitability of major changes in an unsustainable health care system becomes clearer to everyone, the definition of change has become the central argument. With the exception of modern-day Rip Van Winkles, no one argues for the status quo. That would be like believing that you can buy a million dollar house on a $50,000 income with no down payment and a floating mortgage rate.

Taft and colleagues (Consequences of uninsurance in Wisconsin. WMJ. 2009;108(6):297-301) bring moving personal perceptions about the need for change from a spectrum of citizens interviewed, ranging from those with no health insurance to those who are insured. If there is any doubt, from the perspective of neighborhoods and families, that something must be done now, I encourage you to read this article. Remarkably, the interview subjects from west-central Wisconsin agreed on the components of reform long before the language of current legislation was crafted. The people of the state seem to know what is needed.

The physician voice is certainly not monolithic when change in health care is concerned. Getzin and colleagues (Wisconsin physician opinions on health care reform. WMJ. 2009;108(6):302-309) surveyed a representative group of Wisconsin physicians and found, in contrast to the citizens in Taft’s study, that half of physicians don’t see a problem, which in itself is a surprise. As a group, we seem to recognize the dilemma in having large numbers of our neighbors without health insurance and support universal coverage and other changes to improve quality. However, in contrast to national samples, Wisconsin physicians don’t opt for large-scale change to solve the problem. Where physicians agree is the place to start. But we should have started years ago. There is a public agenda for medicine in this state.

Not surprisingly, Getzin found a substantial split between primary care physicians and specialists about how well things currently work and whether we should continue to rely on market forces to drive change. Generalists experience the day-to-day constraints on patients and families that the subjects in Taft’s study discuss. As a result, generalists are more likely to see the current system as broken and therefore favor a national or statewide solution.

Two other articles point out issues relating to primary care. Giriappa and Sullivan (Career satisfaction and retention risk among Wisconsin internists. WMJ. 2009;108(6):316-320) describe the precarious nature of general internists in the state, with most respondents liking where they live but, nevertheless, almost a quarter of them considering either leaving their practice or leaving medicine. Couple these data with the precipitous decline in medical students choosing careers in general internal medicine or family medicine and one could conclude that generalists should join the whooping crane on the endangered species list.

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Rakel’s essay on the irrationality of the current payment system (Show health the money. *WJM*. 2009;108(6):295) also supports another dilemma posed by Giriyappa and Sullivan. Physicians in Wisconsin work predominantly in large multispecialty group practices. More than half of the physicians in this state work in 16 groups. The general internists in Giriyappa and Sullivan’s study said that the biggest negative for their overall satisfaction was the group practice in which they work. This should give every physician in the state pause. Respecting and valuing each other is the greatest factor in successful group function. National studies have listed “cultural conflict” as the chief reason for physicians leaving groups. Whether compensation feels adequate or not, respect and value are more important overall to both satisfaction and retention of generalists. Not to attend to issues of value and respect will not only cost groups large amounts of money to recruit replacement physicians, it is a recipe for disaster for our state.

Health care reform nationally places a high value on primary care and is proposing increased compensation and movement away from fee-for-service and toward salary for population care. If this can’t be done in Wisconsin, with its considerable resources and large, well-financed groups, then we will suffer the consequences. Unfortunately, our communities will bear the cost of our dithering, since general medical care would be delivered by “a panoply of competent specialists,” the recipe for primary care outlined by the late Franz Ingelfinger, editor of the *New England Journal of Medicine* in the 1970s. It didn’t work for him and it won’t work for Wisconsin.

**References**

The mission of the Wisconsin Medical Journal is to provide a vehicle for professional communication and continuing education of Wisconsin physicians.

The Wisconsin Medical Journal (ISSN 1098-1861) is the official publication of the Wisconsin Medical Society and is devoted to the interests of the medical profession and health care in Wisconsin. The managing editor is responsible for overseeing the production, business operation and contents of Wisconsin Medical Journal. The editorial board, chaired by the medical editor, solicits and peer reviews all scientific articles; it does not screen public health, socioeconomic or organizational articles. Although letters to the editor are reviewed by the medical editor, all signed expressions of opinion belong to the author(s) for which neither the Wisconsin Medical Journal nor the Society take responsibility. The Wisconsin Medical Journal is indexed in Index Medicus, Hospital Literature Index and Cambridge Scientific Abstracts.

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