The Evolution of Family Medicine in the United States

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INTRODUCTION

IN JULY 1979, the American University of Beirut Medical School established a residency training program in the new discipline of family medicine. Two months later Bahrain initiated the first such program in the Arabian Gulf. This specialty is generating increasing interest among medical educators, students and government officials. If this attraction continues, neighbouring countries are also likely to start family medicine residencies. These developments would have considerable influence upon the quality of medicine and the health of people living in this region. Therefore, this is an appropriate time to review the collective experiences in the United States and other countries working toward similar goals. Hopefully, this historical analysis will enhance the family medicine movement in the Middle East by providing a perspective from which recent developments and plans for the future can be evaluated.

DECLINE OF GENERAL PRACTICE

In 1931, general practitioners dominated the American health scene making up 83% of all practicing physicians. This figure dropped rapidly over the next 40 years. By 1970, only one out of five physicians in private practice was a general practitioner.[1] Forty per cent of these physicians were over 55 years and their median age had increased to 50 [2,3]. There was little hope for replacing these aging physicians because less than 8% of medical school graduates were entering general practice.[4] Furthermore, general practitioners were gradually losing many of their hospital privileges. It appeared that they would soon be excluded from effective involvement in the hospital care of their patients.[5] In fact, by 1970 the Joint Commission on Accreditation of Hospitals had limited hospital departments of general practice solely to organizational functions.[6] It was necessary to obtain clinical privilegs from each specialty department. The situation was critical; some thought hopeless.

Although general practitioners often worked longer and more irregular hours than their specialty counterparts and received less pay,[7–10] there were more fundamental reasons for their declining status. This trend was established during World War II when the United States mobilized medical manpower along specialty lines. Those going into specialty training were often deferred from serving in the armed forces. Better assignments and higher ranks went to specialists rather than general practitioners [11]. Following World War II medical knowledge expanded rapidly, there were remarkable technological advances and research was subsidized heavily through federal and private agencies [7–9]. In-depth investigation of specific areas of medicine stimulated by funding incentives led naturally to emphasis on training highly specialized physicians. White et. al. described the effect of these changes on medical education in a classic article concerning the provision of health care to adults in the United States [12]. The authors concluded that University hospitals, in which medical students received most of their training, reflected an atypical spectrum of illness. Patients who had rare diseases were referred to these medical training centres while those with more common problems remained in the community. Neither student nor teacher received adequate exposure to frequently occuring illnesses and diseases were seldom viewed in relation to their early natural history. Because patients were seen outside the context of their home environment, there was little appreciation of how their health was affected by socioeconomic circumstances or cultural background. Familial influences and phychosocial variables were often neglected. Teachers became experts in highly specialized areas of medicine and students were stimulated to emulate their mentors in subspecialization and research. The generalist clinician was no longer present or respected as a role model in academic centres [9]. Indeed, many educators believed it was not possible to train physicians to care for a wide variety of disorders, all of which appeared to be so complex.

As the trend of specialization continued, medicine progressed in many areas such as cardiovascular surgery and infectious diseases.

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Yet something was missing. Patients had difficulty finding the right physician for their particular disorder. Often it was necessary for them to consult several physicians if their problems involved more than one organ system or specialty. Their care was becoming fragmented, depersonalized and costly. Even though opinion studies demonstrated that the majority of people called a general practitioner first when family members were ill [7-11] these physicians were harder to locate with each subsequent year. Whereas in 1931, there was approximately one general physician for every 1000 citizens, by 1970 there were over four times as many people for each general practitioner [1]. Many communities were gradually depleted of physicians. Rural areas and poorer sections of the cities were affected most because specialists tended to congregate in the more affluent metropolitan locations.

A COUNTER TREND LEADING TO CERTIFICATION

In spite of specialization's preeminence, the ideal of a well trained physician capable of caring for the majority of common illnesses persisted. Some medical spokesmen also emphasized that physicians should be trained to care for the whole patient within the family context [7—9, 12]. This private concern was evident at the organizational level as well. In 1945, the American Medical Association formed a section on general practice. Two years later efforts by leaders in several states culminated in the formation of a national organization, the American Academy of General Practice. (Subsequently, the name was changed to the American Academy of Family Physicians.) In order to retain their membership it was necessary for general practitioners to attend at least 50 hours of continuing education each year. Although general practice was in a precarious position, the AAGP was the first medical organization in the United States to require continuing education. This emphasis on quality was a forerunner of future developments in the family medicine movement. General practitioners' insistence on self-imposed high standards tended to enhance respect for this discipline from society and physician colleagues in the other specialties.

During these years the American Medical Association made efforts to combat the dwindling number of general practitioners. For instance, the AMA House of delegates appointed several committees to study the causes of this decline and propose solutions. In 1956, one such committee recommended the establishment of two-year training programs in general practice for medical school graduates. Fourteen such pilot programs developed over the next few years. In addition, traditional one-year rotating internships were available, as well as a few two-year rotating internships. Also a number of two-year general practice residencies were offered for physicians who had completed a one-year rotating internship [13].

None of these routes to general practice succeeded and few students were attracted [6—8, 12—15]. Most programs failed to provide high quality educational experiences. They were poorly coordinated and lacked thorough planning while service often took priority over teaching. General practice continued its precipitous decline.

Although advocated in the past by a few, more leaders now became convinced that specialty status along with certification examinations and well planned residencies were the only way to attract medical students and assure quality in their training. [7, 8, 12, 15].

These physicians spoke repeatedly of the need for specialty recognition with the House of Delegates of the American Medical Association. They met strong opposition from representatives of many specialties who wondered, "How can a doctor be all things to all people? How is it possible to train physicians to be competent in so many different fields and with patients of all ages?" Vigorous debates centered around whether obstetrics and surgery should be included as integral components of family practice. Others were concerned about increased competition from the proposed new specialty. Even general practitioners were opposed. Some did not see the value of extra training. Many older practitioners believed this development would be unfair to them, and that their reputations might suffer in comparison with the younger physicians who would now be certified as specialists.

Arguments continued back and forth in private and in various committees of the AMA and the American Academy of General Practice. Nevertheless, the shortage of general practitioners became more serious each year. A turning point occurred in the middle 1960's, however, when several studies were undertaken concerning the health needs of the citizens of the United States. Perhaps the two most influential studies were those commissioned by the American Medical Association.

In August 1966, the Citizens Commission on Graduate Medical Education chaired by John S. Millis, P.H.D., published its recommendations [16]. This commission observed that the rapid rise in