Family Practice and Social and Political Change

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Reform in US medicine has been a longstanding process, and it has always been intertwined with politics and social issues. So-called organized medicine has often resisted reform, but despite this resistance, many changes took place in the US medical system in the 1960s. The establishment of the specialty of family practice coincided with these changes. Although family practice was established with many goals in mind, many of the goals did not match the public's perceived needs, and there is still much unfinished business. One of family practice's current tasks is to examine its accountability to the public and decide what it can provide for the public good.

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Thesis

Family practice, in its advocacy for distributive justice in medical care that is humane, merciful, moral, personal, and cost-effective, has a necessary relationship to politics, economics, ethics, and social change. This relationship derives from family practice's unique traditional role in the medical care system of providing universal access to health care for any person, regardless of age, gender, social status, medical condition, or ability to pay. This relationship has undergone fragmentation and attrition, due in large part to unremitting and inimical flaws in the US medical care system.

Therefore, family physicians have a legitimate and obligatory interest in working for reform of the system on behalf of patients, medicine as a whole, and themselves.

What is Reform?

Reform is a process by which societies attempt to achieve their best ideals for the welfare of their citizens. In nations with representative and democratic governments, this process is predominantly peaceful and depends on formation of public opinion, education, debate, politics, legislation, and adjudication.

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There always are gaps, of course, between the best ideals and their fulfillment in reality. The best ideals are usually stated in key historical documents (eg, the Declaration of Independence, the Constitution and Bill of Rights, the Gettysburg Address) or dramatized by the actions of exemplary and heroic individuals. Such documents and actions do not fulfill themselves except through conflict, refinement, reinterpretation, and reconciliation. Grievances, flaws, and inequities are identified, abuses of power are rooted out, and values are reaffirmed.

In the United States, reform began at the beginning of nationhood, but many issues from that time have remained on our agenda over the ensuing 200 years. These include issues such as federalism versus states' rights, taxation, church-state relationships, foreign policies, suffrage, agrarian versus mercantile interests, prison reforms and the death penalty, public welfare, and civil rights. Physicians have often participated in reform, and many physicians identify Benjamin Rush as a prototype physician-reformer. Rush worked tirelessly from 1780 toward enlightened and benevolent views on liberty, slavery, capital punishment, alcohol abuse, mental illness, and the duties of physicians.

The contemporary entanglements of medical care with politics, economics, and social change are not historical aberrations. Those who imagine golden eras when virtuous physicians practiced their humane arts

in peace and prosperity, unencumbered by conflicts and outside interference, do not take historical facts into account. Even the tradition of merciful care initiated by monastic orders was mired in the politics and carnage of the Crusades. Galenic and Hippocratic systems of medicine foundered in the urban environments that produced the successive waves of plague and their accompanying civil disorders. In reality, Western physicians are descendants of heroes and hoodlums, savants and scoundrels, and gentlemen and peasants who quarreled with each other and with civil and ecclesiastical authorities for 300 years to create the foundations of medical orthodoxy.

A Brief, Brutish Bio of the American Medical Association

James Burrow and Paul Starr tell the story of US medicine's social and political evolution from sectarian schisms in the 19th century to the creation of a dominant scientific orthodoxy in the 20th. That dominant orthodoxy was embedded within a "sovereign profession"[1] which, after a burst of progressive energy culminating in the Pure Food and Drug Act (1906), turned fractiously resistant to further social legislation. It perished at its Battle of Armageddon in 1965, when the US Congress enacted the Medicare and Medicaid Amendments.

What perished at Armageddon was the American Medical Association's (AMA) 45-year-old strategy of effective resistance to state medicine and socialized medicine, and the myths that undergirded this strategy. This resistance began with opposition to the World War I Veteran's Act and subsequently to the Sheppard-Towner Acts for federal subsidies to states for mothers and infants, the New Deal's programs, the Wagner-Murray-Dingell Bills for compulsory health insurance, and finally to the bitter defeat of Truman's Health Proposals in 1949. In resistance to all of these measures, organized medicine defended itself against "political crackpots, the yearners for political power, the enemies of freedom, and the importers of alien philosophies of government . . . "[2]

The passage of Medicare and Medicaid called the AMA's bluff about socialized medicine as a British failure and a Communist plot, demolished the AMA's credentials as a dependable interpreter of the nation's health needs, ruined its reputation as a forecaster of doom, and subverted its "contract" with the public. The organization never recovered its status as the monolithic voice of American medicine.

Since Armageddon, which we all know did not usher in a thousand-year reign of righteousness, US medicine capitalized on its defeat by exploiting what it previously opposed. It transformed itself under the unwatchful eye of *laissez-faire* federal health policies into a booming growth industry that features all of the vices and few of the virtues of the *status quo ante*. Everything changed but the problems.

Enter Family Practice

Prior to 1965, US general practitioners were not politically distinguishable from their mainstream colleagues, and there was nothing about them to suggest that they might become the beneficiaries of social, political, and educational reforms that appeared on the US national agenda in the 1960s. The medical care system then came under attack because of perceived flaws, deficiencies, and excesses. These included (1) an unmet need for services, (2) health manpower shortages, (3) escalating costs, (4) increased complexity of medical care, (5) outdated arrangements for practice (the cottage industry), (6) embarrassing indices of public health, compared with other nations, and (7) the need for better distribution of knowledge derived from new research.

A spate of publications—committee and commission reports and books by academicians and politicians—exposed these problems, energized public and legislative debate, and set in motion new programs, laws, and funding. Decades of accommodation between the public and its health professionals were put in disarray, and a new equilibrium has yet to be found. The major changes put into place in the 1960s, along with their consequences, some of which were enormous, are shown in Table 1.

Table 1

Changes in the US Health Care System in the 1960s and Their Consequences

Changes
- Medicare and Medicaid, 1965
- Regional medical programs for heart, cancer, and stroke, 1968
- Regional health planning
- Area health education programs
- HMO enabling legislation
- Emergency care reorganization

Consequences
- Increased number of US medical schools from about 90 to 124
- Doubled entering class size of medical schools from 9,000 to 17,000
- Doubled accredited residency positions from 35,000 to 75,000
- Doubled number of licensed MDs from 350,000 to 700,000
- Ten-fold increase in national health expenditures from $100 billion to $1 trillion
- Adoption of competition as a national policy for cost control
- Entry of corporate capitalism as majority owner of health care industry

Whether by design or circumstance, family practice, by its appearance in 1969, chose a propitious time in the history of US medicine to reprofessionalize the field of general practice. It was perhaps the only time in the 20th century when this could have occurred. We discovered a remarkable conjunction, to borrow an astrological metaphor, between our traditional ideals of medical practice and the reform ethos of the 1960s, and we seized the opportunity to identify ourselves as relevant to alleviating some of the most urgent problems in medical care delivery that critics were exposing.

Family practice set about to establish the legitimacy of a generalist vocation in medicine, serving underserved populations, especially in smaller towns, rural areas, and inner cities and coordinating medical care through comprehensiveness and continuity. Family practice had a focus on families and communities. It emphasized personalizing and humanizing medical care and stressed cost-effectiveness. In these respects, we were in touch with the deepest roots of reform that scholars have identified in US history—distributive justice, individualism, humanism, agrarianism, the search for order, and feminism.

Unfinished Business

Reform is always an item of unfinished business because further change is inevitable, irresistible, imminent, and produces unexpected consequences. What gets pushed out the door often returns by the window.

Thus, despite the immense and unimaginable changes in medical practice during the last 30 years, many of the fundamental problems highlighted in the 1960s remain unresolved, some are worse, and new ones have emerged. The politics of scarcity have been replaced by the politics of abundance, but distributive justice in medical services remains an elusive goal. Medical science has advanced, but people do not seem noticeably less terrorized by the prospect of cancer and other catastrophic diseases. Medical care efficiency and, presumably, competency have increased, but so have medical harm and professional liability litigation. Moreover, many people are voting with their feet to seek medical care outside the mainstream, dramatizing that something is missing from ordinary medical care.

Among the lessons that ought to have been learned during the last 30 years is that the natural evolution of change is not necessarily in the public interest. We've also learned that the *bete noir* of change is not necessarily socialized medicine, as the AMA tirelessly warned us for decades—compared to the draconian intrusions of industrialized medicine on free choice and privacy. Further, we've discovered that organized medicine, hospitals, and medical schools are not dependable fountains of wisdom and leadership in the midst of change. Our so-called expert institutions and organizations have exposed themselves as bastions of resistance, self-interest, and exploiters of the public purse. More than anything else, they resemble the medieval clergy in maintaining their death grip on privilege, power, and self-aggrandizement.

Why Family Practice?

We have to ask ourselves what qualifies family practice for a continuing role in the reform of medical care. What legitimizes our claims for continued public funding of our residencies and departments? What is the basis of our appeal to medical students to join our ranks? What is the current status of our vision for medical care, and is it sufficiently distinctive to make a difference?

The short answer to these questions is the outrageously presumptuous and provocative assertion that we hold the public interest in medical care above our narrow professional self-interest. Can this possibly be true? When we first made this claim in the late 1960s, it was probably more absurd than now, but we discovered a reservoir of public credibility and financial support that lent validity to our claim. Not only did we believe it ourselves, but we discovered that others believed it, too. When the Millis Commission, among other things, called for a "new kind of doctor" and described the desiderata for a "primary physician," it did not have existing general practitioners in mind, but when we raised our hands and claimed that role, we were believed.

Now, after 30 years, we have to ask ourselves whether we still believe it and are still committed to it. One of our tasks is to examine our accountability and decide again what we can provide that counts for the public good.

On balance, I judge that we have squandered some public credibility in our evolution despite our success in having created a specialty. We probably confused the public early on when we changed our name from general practice to family practice, and we confused ourselves in drawing finer distinctions with the addition of family medicine, community medicine, and primary care. We all know the reasons for these name changes, but they held no interest for the public, conveyed no weight of meaning, and sometimes allowed us to mistake the cart for the horse.

In retrospect, our preoccupation with defining family medicine as an academic discipline was probably excessive. Some of the perceived need to do this was inflicted on us politically by other specialty boards whose members controlled the club we wished to join—the American Board of Medical Specialties. Indeed, William Ruhe, executive director of the AMA's Council of Medical Education, who was privy to the negotiations for approval of the American Board of Family Practice, once acknowledged that we were subject to greater demands for definition than any other specialty board. But, most of the pressure was self-inflicted

by our earnest desires to become legitimate in a way that general practice never was.

Our debates about the family as a unit of care, the role of behavioral sciences in medical practice, and the meaning of community medicine led us down some blind alleys that have not stood the test of time. Ed Pellegrino, a friendly critic, once called us "mutants," meaning that we created a package of services that was more than the public wanted, needed, or understood. The public wanted accessibility to ordinary services at reasonable cost, but we wanted utopia. In some respects, we have recapitulated the dysfunctional phylogeny of mainstream medicine by fragmenting our basic role into niche jobs and subspecialization that subverts continuity and comprehensiveness of medical care. We took a hit to our public credibility when we were suckered into gatekeeping by managed care organizations. We ought to have nurtured our main asset better and demanded from our educational settings the permissions and wherewithal to prepare students and residents forfull-service practice in communities of need.

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