

The Americanization of Family Medicine: Contradictions, Challenges, and Change, 1969–2000

Rosemary A. Stevens, PhD, MPH

Family practice became the 20th medical specialty in 1969, identified by its leaders as a harbinger of health care reform, as well as practice excellence, and with expectations of continuing government support of its purpose and role. Since that time, the cultural and political environments have changed significantly in some ways, and not changed in others as initially expected, thus challenging the new specialty with pressures for reinvention with respect to its identity, function, and prestige. The most important impediment to a clear-cut role for family practice has been the lack of a formal administrative structure for primary care practice on a nationwide basis in the United States. Differentiation of the field from all other parts of medicine was also difficult because of the identification of family practice with the professional accoutrements of a specialty, parallel to other specialist fields. Family practice moved from an outsider role in medicine to a position of entrenchment in the medical establishment, including hospitals and academic medical centers. And, family practice became one of several overlapping and competing primary care fields. The role of family practice in US culture is now less clear than the potential role envisioned for it in 1969. Its multiple and not always well-defined roles in medicine may make it difficult to establish a clear identity for the specialty in the future. If it is to be successful, family practice must develop allies and work aggressively to establish its role in primary care. It must also work to institute primary care in the US medical system and act politically (as in the 1960s), taking advantage of current cultural trends, notably the information revolution and the growth of biomedical research.

(Fam Med 2001;33(4):232-43.)

The American Board of Family Practice (ABFP) was established in 1969 under the umbrella of the American Board of Medical Specialties (ABMS), thus legitimizing family practice as a specialty within the established hierarchy of the US medical profession. Family practice became the 20th ABMS-approved specialty certifying board (there are now 24). For family practice's founders and supporters, this was a time of jubilation. A new type of generalist would replace the old-style, aging cadre of general practitioners (GPs). The Board's symbol, a shield, included the image of a phoenix rising from the flames. The motto below the shield proclaimed (in Latin), "Let him bear the palm who has earned it."¹

Happily for the new field, the rhetoric of change in the general culture promised an increased societal commitment to personal and/or community medicine. Medicare and Medicaid, legislated 4 years earlier, demonstrated a national commitment to the elderly and poor, with the dollars to back it up. Community health was on the national agenda. According to the widely distributed Folsom report (1966), every individual should have a personal physician, of a status and income comparable to other specialists, and money must be made available to carry out this goal. "The dollars required to produce these personal physicians," the report proclaimed, "will be comparable in magnitude to that which expanded medical research in the past 2 decades."²

By the mid-1960s, state, private foundation, and federal funding supported comprehensive care programs in an array of university medical centers, providing the basis for education and training, for example, at the Universities of Kentucky, Oklahoma, and North Carolina.³ While such programs were not typically at the most specialized, urban, research-oriented medical

From the Department of History and Sociology of Science, University of Pennsylvania.

schools, the rhetoric of the time promised changes here too. Common wisdom suggested that personal or family doctors were needed (and demanded by the public) to overcome the “dislocations wrought by science,” that is, to temper US medicine’s thrust toward specialism.⁴ By 1969, 77% of active doctors claimed to practice as full-time specialists, up from 36% in 1949.⁵ National health insurance seemed just around the corner, and workforce projections suggested the need for a major reorientation toward first-contact physicians if such a measure were to succeed.

Looking forward from the euphoria of 1969, family physicians could see themselves as both future participants in a new, well-funded health care mainstream, based on community health, personal physicians, continuing responsibility for individuals and families, and national health insurance, and as revolutionaries in the house of medicine, taking on the power of the medical elite. “There is a kind of arrogance in specialized medicine,” the Millis Commission on graduate medical education had declared in 1966, stressing instead the high calling of comprehensive health care and the need for a new body of knowledge for what that report called primary physicians.⁶ Signs from many different directions pointed toward success for the new field of family practice, which by its institutional incorporation might capture the associated concepts of the personal physician, community medicine, comprehensive health, and primary care.

What happened since then? My purpose in this paper is twofold. I hope, first, to analyze and reflect on the past 3 decades in ways that will be useful when thinking about the present and future of family practice and, second, to show the sheer “American-ness” of this history. Both the successes and the dilemmas that have faced family practice illustrate wider themes in the recent history of US medicine and, of course, of US culture at large. Others have looked at specific institutions and aspects of the history of family practice in its various contexts since 1969.^{7,8}

I will focus on five themes of particular relevance to health and medical policy in the early years of the 21st century, as we try to tie together the experiences of the past 3 decades and look toward the future. By “we,” I mean not only those of us who are interested in history but also physicians and their organizations concerned about the present and critics and reformers of the health care system. These themes include (1) lack of acceptable formal structures for primary care in the United States, (2) the implications of characterizing family practice as a specialty in the US system, (3) assumptions about what the public wants, (4) the tendency to create historical myths, which may or may not be useful in the present, and (5) the multiple images of family practice, related to competing claims to primary care, and the nature and boundaries of the field. I will conclude by suggesting possible actions for the future.

Formal Structures for Primary Care

The single biggest question in considering family practice as a US medical field is the lack of a formal administrative structure for primary care. In Britain, for example, GPs have had a long history as first-contact doctors. Professional etiquette, crystallized in the early 20th century, dictated a division of roles between the GP and the consultant or specialist, with the generalist providing first-line care to patients, referring to specialists as necessary, and receiving the patient back once specialist care was complete. British specialists are called consultants to this day. At the same time, British GPs largely ceded hospital practice to the specialists. Each branch of medicine in Britain has its own sphere. National health insurance (1911) and the National Health Service (1946) confirmed and strengthened these separate spheres.⁹ In short, the basic role of GPs in health care has been a given. When the ABFP was established in 1969, British practitioners were enjoying the fruits of a new Family Doctors Charter, designed to improve their status and their income. Basic questions for family practice in Britain centered on strengthening general practice as a clinical field, respecifying its content to respond to the changing technologies of medicine and patient expectations, and reorienting professional education.¹⁰ Though many problems still remain, the shift from general practice to family practice was a relatively simple matter of transition.

The United States, in contrast, was the home of the specialist system. Well before the famous Flexner report of 1910 energized the modern medical school around ideals of biomedical science, physicians competed against each other in an open market for the patronage of patients. There was no clear specification of the role and function of the GP, even at the beginning of the 20th century. General practice was becoming a residual field, both in substance and in income, distinguished by what remained after various specialists had taken their cut. Patients who could afford it were enthusiastic, paying consumers of surgery and prescribed drugs, flocking to specialists in their private offices in the burgeoning cities and into the private suites of newly built hospitals. Americans, said a professor of surgery in 1906, in words that echo through the present, paid for medicine, not words, and would be insulted if the doctor charged for “mere advice.”¹¹ There were neither effective professional rules nor organized payment systems to protect a first-line, primary care role or to privilege advice over technique; specialization was economically advantageous and prestige driven. There were no effective mechanisms to dissuade Americans from seeking out specialists unnecessarily or receiving care from the ill-trained and little or no coordination among the various doctors who might be involved in a single case. In a health care market where every doctor competed with the next, generalists were disadvantaged by not having a recognized niche.

In theory, a formal role for primary care in the United States, with patient access to specialists channeled through generalists (and patients happy with this arrangement), might have been incorporated years ago into multi-specialist practice groups or mandated by single-payer insurance. It is worth emphasizing, though, that Americans chose not to take this approach. By the 1960s, two formative assumptions marked health policy in the United States as it affected the role of GPs. First, patients had learned to cherish direct access to specialists as a seemingly natural exercise of freedom of choice in the United States. Second, national health care policy was implemented in the private sector as a matter of course, not through the force of government *fiat*. Even Medicare, a national insurance program of massive scope, allowed patients direct access to specialists and subspecialists.

In the 1990s, the managed care movement was to throw decisions about primary care and medical organization in the United States into the tumultuous, profit-oriented health care marketplace. However, this was a scenario that could not have been envisaged in the 1960s, when federal solutions to social problems, negotiated among private interests and implemented through tax support, seemed the natural and obvious path to change.

For GPs, there were more immediate problems, from the 1960s on, than long-term political scenarios. The American Academy of General Practice (now the American Academy of Family Physicians [AAFP]), formed in 1947, represented the practical concerns of a diverse professional group who felt happy with fee-for-service private practice, some of it subsidized by Medicare and Medicaid. But their numbers were falling, and many felt besieged by a growing cadre of specialists whose claims to expertise were eating into general practice and lowering its status and who were challenging the right for generalists to have hospital (particularly surgical) privileges.

The new, self-designated leaders of family medicine in the 1960s and 1970s saw the necessity of defining themselves as specialists in America's specialty-defined health care system and of gaining public funds for training. But, the structural issues remained. Without a formally defined role as a primary practitioner outside of the hospital, US generalists, unlike their British counterparts, held tenaciously to the right to perform inpatient surgery and to cherish hospital admitting privileges. Clashes with surgeons, obstetricians, and other specialists were foreordained. Over and above the vexed question of defining family practice through conflict and negotiation in the United States, the new specialty had to establish itself as worthy of a place among the specialties and to market itself to a choice-conscious public. Family medicine had "arrived" professionally, but boundary issues would continue to be fiercely contested.

For a variety of reasons, then, cultural, political, and professional, the option of a seamless transition from general to family practice in the 1960s and 1970s was effectively foreclosed in the United States. The pattern of 20th century medicine continued to encourage patients to seek direct access to specialists, bypassing the GP or family physician. For a while, from the late 1980s through the 1990s, it looked as if managed care would sweep in a formal primary care structure through designating primary care gatekeepers to manage individual patient care and requiring them to approve referrals to specialists. Reactions by both patients and professional groups were intense: gatekeepers were criticized for rationing care inappropriately (ie, limiting access to promising techniques), for being agents of managed care corporations rather than their patients, and for putting their own economic self-interests first. Responding to market signals, direct access to specialists has become a new selling point for managed care. Another result of managed care was to bring out rival specialist claimants to primary care, from internists, pediatricians, and obstetricians through psychiatrists. The lack of a sustaining administrative structure for family practice or even for a more widely conceived primary care (supported by financial incentives, professional rules, or external regulation) remains a stumbling block for family practice as a field in the United States. Instead of being able to claim a monopoly function in health care, family physicians have tended to tout their mission—as well-trained, dedicated doctors with a sense of higher calling. The structure of primary care has to be an agenda item for the future.

Characterizing Family Practice as a Specialty

In the absence of role definition through clinical service structures in the United States, credentials have taken on enormous significance in defining the formal structure of the medical profession. Family practice entered a world of intense intraprofessional competition for new credentials, each of which carries monetary significance in the private health care marketplace. Certification signals a professional group's authority, autonomy, and prestige. This is so because professional identities are determined by brand names (specialties) or niches, not only in the professional marketplace for referrals or university positions but also in fee schedules and in insurers' approval of specialist procedures.

The establishment of family practice as a specialty marked the routinization of medical specialization in the United States. All doctors might now expect to take a residency in an area approved for a designated specialty field and take the appropriate examinations for certification in that field. Almost 90% of US physicians are now board certified. Thus, approval of new fields takes place in a more or less closed system. Since certification as a specialist or subspecialist stakes a territorial claim, there are constant skirmishes at the

borders of and across different fields and negotiations between competing claimants. In entering the board system and becoming a full-fledged specialty in US professional terms, family practice had no choice but to relate to other specialties according to the latter's ground rules: showing one's caliber as an academic discipline, being rated by other departments in the prestige structure of medical schools, and developing hospital-based residency training.

The formidable battery of expectations and institutions vested in (and by) specialized medicine meant that new fields had to incorporate themselves either into an entrenched culture of technique or (perhaps buoyed by a swell of public demand for a new field) in powerful opposition to it. Family practice tried both strategies in 1969. The first strategy was to show the legitimacy of the field by gaining approval from the Liaison Committee for Specialty Boards (LCSB) and then the ABMS. Historian David Adams has described the intense political negotiations that were necessary to reach this point among the major organizations and leaders in general practice and family practice and the awareness of the power of the preexisting specialty elite as they "tailored their application to the model that the LCSB demanded."^{7(p45)} Residency training was to be for 3 years, equal to the length of training for general internal medicine and general pediatrics, thus sending a message of equal status. As with other specialties, training was hospital based but with emphasis on continuity and ambulatory care. An intraprofessional specialty network for family practice was created, paralleling those of other fields.

By the mid-1980s, there were almost 400 residency programs in family practice, diverse in focus and content though they were, and more than 7,000 residents in training.¹² The first certification examinations were given in 1970, and by mid-1971, several thousand family physicians had been certified. To demonstrate to other specialties, as well as to themselves, that family practice was a new field, there was no grandfathering in of GPs without examination. The initial candidates had to show evidence of approved education or experience as specified by the board. Certification was also to have time limitations, with mandatory recertification, a higher standard than then imposed by any other specialty board.

Taken together, these measures showed substantial success in institutionalizing family practice along traditional specialty lines. "The bureaucracies of family practice are now firmly established," wrote G. Gayle Stephens, MD, in 1987; the field was a "*fait accompli*".¹³ Looking back from the mid-1990s, Board leader Paul Young, MD, claimed a double accomplishment for the new Board's actions: the separation of family practice from general practice and the differentiation of family practice from other specialties.¹⁴ The unusual, dual terminology of this new general specialty—both

family practice and *family medicine*—reflected these distinctions: family practice in contrast to general practice, family medicine distinct from internal medicine, its closest rival in the field of primary care.

By entering the lines of established specialties—becoming an established specialty itself—family practice joined the turf battles of the specialties, as each attempted to adjust to, manage, and receive advantages from changes in biotechnology, science, and socioeconomic conditions, including research funding and money flows in the health care system. Playing the game of specialization within the rivalry of the board system led family practice into competitive subspecialization. Before 1970, the ABMS had approved a total of 10 subspecialties (in the Boards of internal medicine, pathology, pediatrics, psychiatry, and neurology). In the 1970s alone, the American Board of Internal Medicine added six subspecialties, obstetrics and gynecology—three, pathology—two, pediatrics—four, and dermatology, radiology, and surgery—one each. There are now some 80 approved subspecialties, and more are in the wings (personal communication, ABMS). The ABFP was swept up in this exuberance, with its attendant threats to status and to territory. In 1985, the ABMS approved a subspecialty in geriatric medicine for both family practice and internal medicine after years of debate as to its validity as a field (validated in part by the establishment of the National Institute on Aging in 1974). The American Board of Psychiatry and Neurology followed with geriatric psychiatry in 1986. The ABMS approved sports medicine for family practice in 1989 and in 1992 for internal medicine, emergency medicine, and pediatrics. The American Board of Pediatrics instituted a subspecialty of adolescent medicine in 1991. Not to be outdone, internal medicine added adolescent medicine in 1992, and family practice did so in 2000. Thus, family practice now has three subspecialties. Other fields may appear in the future, as family medicine protects its turf and extends its range.

Subspecialization in family practice highlighted the difficulties of defining family practice as a field. There were both advantages and costs to becoming a specialty. On the success side, specialty status conferred privilege on interlocking professional and extra-professional networks, which in turn reinforce the specialty. They include the recognition of designated specialty departments or divisions in medical schools and in hospitals, a right of place of the specialty in the undergraduate medical curriculum, and residency programs and residency review committees in the field. The ABFP is now the second largest board in terms of diplomas granted (after internal medicine), and the specialty also has the largest specialist delegation to the American Medical Association (AMA). In the 10 years from 1989–1998, the Board issued 26,490 general certificates, out of a total of 227,022 for all ABMS-approved specialties or about one out of eight.¹⁵ AMA figures show a total of

66,564 self-reported family physicians in 1998, of whom 9,329 were residents or fellows. Of the 57,235 not in training, 43,298 were board certified.¹⁶ The AAFP assured its public in the year 2000 that the demand for family physicians “far surpasses the demand for all other specialties” and noted that average net income was competitive with other primary care fields at \$110,000 per year, and 61% of physicians worked in group practice (only 3% were in academia).¹⁷

By bending to fit the prevailing notion of a specialty, family practice became more like internal medicine than general practice. While the push toward a board for family practice made good, practical sense for establishing a new academic and practice field, thousands of GPs were excluded from the board process. Only 8% of family physicians or GPs were board certified in 1972 (compared, for example, with 81% of pediatricians¹⁸), although to some extent this was a temporary problem, since every year older GPs would retire, and younger family physicians, with approved training, might take their place. Besides the obvious grievances from those excluded, and perhaps of greater long-term importance, the exclusion marred the image of family medicine leaders as social reformers seeking access to care for all Americans and confirmed the focus on professional education and training.

A more critical question for the long term was the viability of family medicine in America’s premier research-based universities. Traditional general practice was not a focused research discipline but a field with a central commitment to service. While the research portfolios of many specialties are broad rather than focused, family practice has been vulnerable to criticism by medical faculties outside of family medicine with respect to the specialty’s intellectual base, research funding, and research productivity. There has been relatively little support from outside the medical profession, compared with other developing fields. Historian Bruce Fye, for example, has described the interlocking efforts of the American Heart Association, the American College of Cardiology, and the American Heart Institute in the growth of cardiology over the past 50 years.¹⁹ Other historians have explored the alliance of the National Cancer Institute with a growing private health lobby for cancer care from the 1950s (including, notably, the American Cancer Society), unleashing federal funds for research and thus legitimating oncology as a field.²⁰⁻²² Family practice has not had an equivalent professional or public network to press successfully for a National Institute of Family Medicine. These were significant handicaps in a medical culture distinguished by jockeying for power in medical schools and teaching hospitals and by fights for federal funds that were justified in Congress by a commitment to building America’s science base.

Family medicine’s strongest academic bases have tended to be in state universities with significant rural

populations and supportive state legislatures, and its leaders and major supporters in other fields have been disproportionately drawn from these states. By my count, 18 of the 97 members of the Board of Directors of the ABFP who served between 1969 and 1998 came from Kansas, North Carolina, and Kentucky (six each). In the hierarchical power system of US medicine, dominated by an urban elite and measured by the level of funding for research, how is family practice going to define its power base in the future?

Whose Culture? What Does the Public Want?

Like emergency medicine, family practice was jump-started by widespread public concerns about services to the population—about accessibility to services and to primary care in the 1960s and emergency services in the 1970s. In his presentation to the Society of Teachers of Family Medicine in 1979, Dr Stephens stressed to teachers of the new specialty, many of whom were confused and conflicted about its place in the hierarchy of US medicine, that the flowering of family practice stemmed in large part from the convergence of forces, “over most of which we had (and have) very little control.” These included forces fundamental to broader social reforms in the 1960s: idealism, feminism, consumerism, egalitarianism, the willingness to fight, and a renewed sense of service. In a powerful phrase, Dr Stephens identified family medicine leaders with the 1960s counterculture; they too, like other social evangelists, were informal, egalitarian, and “certainly propertyless” and critical of the dominant culture. The family practice movement of the past decade succeeded, Dr Stephens claimed, “because we were identified with reforms that are more pervasive and powerful than ourselves.”²³

By the late 1970s, the social tide had turned away from reform toward fiscal and cultural conservatism. Family practice was becoming incorporated into the dominant culture of medicine, to which it was supposedly ideologically opposed. Had the public (or at least the counterculture) abandoned family medicine, or had family medicine abandoned the public? In some ways, the answer to both questions was yes. In 1989, in a coda to his earlier remarks, Dr Stephens emphasized his underlying theme: “We have expended our energy on professional legitimation and enfranchisement rather than reform.”²⁴ Nevertheless, it is doubtful how far the fledgling specialty could have achieved major reforms in health care without broad public support. It was difficult to proclaim the message that, “People are ill as wholes, not as parts”²⁵ and that many, if not most, health problems require social, environmental, or psychological approaches rather than technological solutions, when medical schools and hospitals were divided along specialist and subspecialist lines, justified by biotechnology and biomedical science and buttressed by established money streams.

At the same time, it was difficult in the 1970s, as it is now, to establish a unique public persona for family practice within more general debates about primary care. Significantly, the report of the influential Graduate Medical Education National Advisory Committee (GMENAC) in 1976 did not single out family practice for special consideration. The report noted that primary care was an evolving concept in the United States and that it “means different things to different people.”^{26(p27)} General internal medicine and general pediatrics had staked their own claims, independently, to primary care. In 1967, the American Boards of Internal Medicine and Pediatrics had agreed on joint certification in those fields. Internal medicine training grew rapidly from the late 1960s, representing almost 28% of first-year residency positions in 1976, compared with only 9% for family practice.^{26(p48)}

The tensions of identity, as well as purpose, thus dogged family medicine’s history. Borne along by forces in US culture, family physicians retained the sense that they were properly still reformers, even after those forces had diminished. But how was reform to be measured? Was it to be measured in demonstrable improvements in access and quality of care to all Americans, in education and the quality of learning in the field, or in the moral character of physicians? A legacy of ambiguity about the political agendas of family medicine/family practice thus accompanied its growth. Were the agendas of family practice (the clinicians) and family medicine (the academics) even the same? To the observer, the answers are not at all clear. Probably, there are multiple agendas across both groups, masked by an overriding commitment to unity for the field. The concept of family medicine as a force for reform may help cement this unity.

What the public actually wants is a tricky question to address because in US health care, social preferences are expressed indirectly, through the availability of money for specific purposes, rather than via direct or overarching government policy making. The history of family medicine must therefore include the impact of larger monetary decisions on the field. Of more importance than the fact that the counterculture went away as a force for social change in the 1970s, social preferences favoring family practice as the center of health services were not recognized or adequately implemented through financial investment in the field.

Medicare funds followed dominant patterns of clinical practice from the late 1960s, giving no special advantage to family physicians over internists or other personal physicians. Federally funded comprehensive health centers, which might have provided a model for mainstream comprehensive care, based on family practice, were limited to services for the poverty population and lacked strong lobbyists outside of poverty reformers to sustain them; by the 1980s, the primary policy concern was their cost.²⁷

On the other side of the ledger in the 1970s, there was particular political concern about the physician workforce, physician shortage areas, and inadequacies in primary care. Federal government support of primary care training led to grants for family medicine education, appropriated in 1972 in the midst of national debate over the distribution of doctors by specialty across the United States. The US Congress funded Area Health Education Centers in 1972 to address what was then called specialty maldistribution, particular in rural areas, and in 1976, the Health Professions Education Assistance Act increased primary care support. However, reductions in federal support in the 1980s, for these and other programs, cast blight on future prospects.²⁸ State support of family medicine education has been, and continues to be, critical to the establishment and continuation of teaching programs, but, according to the AAFP, the heyday of such support was between 1968 and 1977—leading to constant efforts by the Academy’s state constituent chapters to lobby state legislatures to at least maintain state support.²⁹ The Academy also keeps a watching brief over federal and state funding that may impact on family medicine, such as Medicare funding for graduate medical education and state subsidies of family practice training.

As interest by medical students in all aspects of primary care dropped in the 1980s, money continued to flow into more specialized research programs and fellowships, and patients called on an increasing array of specialists and subspecialists, paid for through Medicare and private health insurance. Strong cultural (or public) preferences toward specialism, rather than primary care, were expressed in these major money streams. In this context, family physicians continued to feel ideologically different and professionally distinct from other specialties of medicine in the 1980s and 1990s.

The Family Physician as Hero in a Myth

In this context, too, leaders of family medicine have focused to a remarkable degree on the historical image of the family physician as a hero. Board founder Nicholas Pisacano, MD, may have begun the mythic framework in his declaration in 1964 that the GP was “all but extinct,”³⁰ thus setting the stage for inventing a new field and for suggesting that evolution seemed to call for a new species and the times for powerful leaders.

The language of family practice as a heroic struggle for identity continues through the present. The Board’s submission to the current ABMS *Directory* describes its establishment as a “fascinating saga of travails, with frustrations and impediments punctuating its formative days” and suggests a sage, rational group of “founding fathers.”³¹ Though opposed by powerful forces, the specialty finally achieved victory and “began to make slow progress toward infiltration and modification of venerable academic fortresses.”³² In the foundation myth,

purity of heart and mind distinguish the early warriors, with their "prophetic words,"³³ for only they could perceive what was right for patients in a technologically driven health care system. The continuing use of the term *counterculture* carries some of these emotive themes.

The claim to being part of a counterculture that has rung, nostalgically, through the history of family medicine over the past 30 years, suggests noble goals, paths abandoned, and lost heroes. Jane Murray, MD, of the University of Kansas, recently wrote eloquently on this theme, reviewing her career in family medicine over the 20 years following Dr Stephens' counterculture speech. She listed the evident successes of family practice as a specialty by the year 2000, including academic departments in almost all medical schools, primary care experiences built into undergraduate medical education, 447 family practice residency programs, and a growing research agenda. "But something is still missing," she went on to say, describing her own "inner discord and disenfranchisement with myself and with our specialty." Her conclusion was that the field should reclaim the spirit (if not necessarily the political successes) of reform: "If we decide to become reformers, mavericks, activists countering the mainstream, we might reclaim our own professional sanity and regain, too, respect from the public, which modern doctors have largely lost."³³

Good myths are usually based on fact, and the demonstrable idealism of early leaders is part of the history of the specialty and a reason for its success. Family medicine educator F. Marian Bishop, PhD, who was on the faculty of community health and medical practice at the University of Missouri-Columbia in the late 1960s, said later:

I had never met a group of people who were more enthusiastic, more excited about what they were doing, with a sort of missionary zeal. Here was this young group of thin, trim, lean-and-mean fighting (physicians) who were really going to change the world.³⁴

It took courage, persistence, negotiating skills, and great efforts to establish the board in the face of opposition, not only by other specialties but initially also by many GPs and their Academy. As Dr Pisacano observed, those who favored a board were criticized for "seeking only prestige."³⁰ Today, the AAFP, like the major associations of other specialties, works hard to develop the prestige and institutions of family medicine necessary to its sustenance and lobbies for training and research funds. To some extent, the creation of a history of family medicine based on heroes and unselfishness has served to mask the fact that specialization is an intensely political process in any field of medicine and that it both creates and ratifies vested interests.

The practical, organizational advantage of the myth in the past was to create a sense of group identity for the new field. But the myth also sets up family physicians in the present for not measuring up to the heroic exploits of its early leaders, as Dr Murray's words suggest. Relatively small declines in the residency Match are seen as major failures in the field as a whole. Realistically, though, the heroes of family medicine were unable to revolutionize US medicine in the 1970s because times changed, not because of moral failings in their successors.

In our current unsettled environment, in both practice and academia, this may be a good time for family medicine to relegate the old myths to the past and create new explanatory narratives for the future. Before considering what these might be, though, it is worth asking if the mythical rhetoric also masks conflicts, confusion, and uncertainty as to what, exactly, family practice now is. Differentiation of family practice from general internal medicine on some difficult-to-specify moral grounds is a difficult posture to sustain in the early 2000s. Each field is trying to make primary care more effective and visible, each feels under duress from the impact of managed care insurance, and each feels competitive pressures from subspecialists.

Multiple Images, Boundaries, and Claims

What is family practice? The AAFP, in a rather vague statement adopted in 1993, says the field provides "continuing and comprehensive health care;" is a "specialty in breadth" that integrates biological, clinical, and behavioral sciences; encompasses all ages and disease entities; and is "uniquely defined within the family context."³⁵

The journal literature presents multiple images—literary, moral, and scientific. The literary image draws on the idea of the doctor-patient encounter as a discourse, with the construction and analysis of the patient (or family) text. The office visit becomes a drama, whose outcomes may be life-altering decisions. The doctor may act as interpreter, umpire, or narrator or, alternatively, the patient may be seen as author, with the doctor as the critic.^{36,37} Focus on the family cries out for narrative interpretations and analysis of behavior in the light of circumstances, the very stuff of literature. Such observation may also be the basis for research based on analysis of typical encounters or critical incidents—the field of "insider practitioner research," as developed, for example, by Della Fish and Colin Coles in England.³⁸

A central focus on family medicine as a literary discipline is, however, only part of the story—and a difficult claim to make, anyway, in US medical schools, which measure their organizational success by successes in biomedical research. The linked claims of technology and science continue to measure relative

prestige among medical fields in academic medical centers. Proving the field as scientifically legitimate, in relatively narrow terms, has become a major job of university family medicine leaders. "Strangers in a strange land" is how one professor of family medicine recently described the roles of both family practice and general internal medicine as primary care fields in the academic center.³⁹

Over the past 30 years, claims have been made for family medicine as a biopsychosocial science and as a field drawing from family dynamics. Thus, the book *Family Medicine: The Maturing of a Discipline* was published as a volume of *Marriage and Family Review* in 1987. Contributors couched the history in terms such as sibling rivalry (conflict with other specialties), transition from the biomedical to the biopsychosocial model, and socializing the next generation.⁴⁰

Nevertheless, from the perspective of the year 2000, whatever the rhetoric of the term *family* in US politics and culture, family-based research and practice does not seem to be central to family practice as a field. According to the North American Primary Care Research Group, reporting this year, the rate of taking family histories during office visits is low and is also variable from physician to physician.⁴¹ Sociology and other behavioral sciences are regarded as important, legitimate aspects of family medicine education. However, here too there is not a recognizable (or publicized) body of academic work that defines family practice as a field. A major problem here has been in the social sciences themselves, which since the 1960s have grown away from applied clinical studies, observational research, and descriptive analysis. There has also been relatively little research funding in such areas.

For whatever reasons, to the observer, the science of family medicine is not explicit. There is tentativeness about it and slipperiness. True, other specialties have ambiguous definitions too, in terms both of role and of research. Marjorie Bowman, MD, MPA, pointed out that internal medicine deals with adults but not all adult issues; obstetrics and gynecology with women but not all women's medical questions; and orthopedics with bone, muscle, and connective tissue but not all connective tissue and not all diseases of the three. Further, the research definitions of these three specialties, to take but these as examples, are no clearer than that of family practice. So why make a fuss about lack of clarity in family practice? The short answer is political: no one is questioning those specialties because it is assumed (however erroneously) that they represent logical entities. Family practice is still young enough to have to justify its place.

General internal medicine, which has some of the same needs as family practice to justify its existence in the medical hierarchy, has laid claims to the science of clinical decision analysis, using methods drawn from management science and exploiting internal medicine's

historical strength as the specialty of diagnosis. This route at least gives that field a topic with identifiable research funding and organized investigator groups. (The more cynically inclined might also observe that this is research methodology that may not be readily understood by other medical specialties, one definition, perhaps, of science as a bankable commodity in the hierarchical prestige system).

Family medicine has claimed no such major core. Instead, it embraces many actual and potential research fields, from the psychology or sociology of the doctor-patient relationship to epidemiological studies done in community practice research networks. Research breadth may be a great strength for family medicine in the future. That is not the problem. Rather, the specialty seems unwilling or unable to express its philosophy as a field of knowledge.

For example, if family practice is a field in which "the patient defines the problem," as suggested by McWhinney,²⁵ does this mean there is (or should be) no standardized science for family medicine? If it stands in opposition to an overemphasis on high technology, what is the technology of family medicine? If family practice is comprehensive in its scope, as the AAFP guidelines suggest, does this mean that family medicine faculty are gadflies who can pick and choose from any research field in medicine? Or is there a science of comprehensiveness? A case can be made for each of these positions. My reading suggests that such questions need to be asked and answered confidently by family physicians and family medicine faculty in this decade, to develop strong family practice research networks, to protect professional turf, to increase National Institutes of Health and other research funding, and to inform outside observers (the public).

Competing claims to primary care from internists, pediatricians, and others, from the 1970s on, make such questions more urgent than they were 30 years ago. The boundaries between family practice and other specialties are fuzzier than they were. But, the nature of family practice itself is indeterminate. Howard Stein, PhD, set out some basic problems in 1981: the tension between the goals of being a meta-specialty, transcending the boundaries of other fields, and the wish to be a clearly defined, if limited, specialty, which is complementary to other fields and works in parallel to them.⁴²

There are costs in taking either position too far, as Dr Stein pointed out, though the idea of a meta-specialty seems less of an option today than in the 1980s. Current concerns focus, rather, on whether any form of true medical generalist can (or should) survive a combination of recent onslaughts: consumers informed about disease and disease management via the Internet and the widespread distribution of subspecialists and nonphysician generalists such as nurse practitioners. Nevertheless, the claim to an overarching portfolio of skills remains an important part

of the ethos of family medicine in general and may be essential to the daily work of those in rural areas.

Defining what family practice is, through studying what family physicians do, has been an ongoing task for the specialty board, which has to define to examine candidates. Despite great variation across practices and across the country, 30 areas of practice appear to account for 90% of what family physicians do (personal communication, ABFP). Yet, specific questions remain about how skilled family physicians should be in areas such as obstetrics, surgery of all kinds, and behavioral health, including personal and family therapy. The acceptance of board certification and recertification (now called maintenance of certification) assumes common national standards, and there will be continuing debates over what these should include for all family physicians and what discretionary options should be made available.

The water has become muddied, however, with respect to one large group of patients, the elderly, because of the existence of geriatric medicine as a subspecialty. Clinical guidelines promulgated by specialty groups, and evidence-based medicine, developed by a variety of researchers, may muddy the water further. Nevertheless, a body of knowledge is slowly being created as a descriptor of practice, if not (yet) related to a defined research agenda in academic family medicine.

Dr Stein's second warning was to avoid overspecialization, and this concern remains in the form of overinsistence on the uniqueness of family medicine, in terms of both outlook and field, in comparison with other primary care specialties. Claims to uniqueness are of course part of the baggage of any form of specialization, but they can be confusing and may stand in the way of creative strategies for the future. For example, the AAFP official definition claims that family practice is "uniquely defined within the family context." While this may be code for practice that includes both child and adult care, it would be clearer if this were directly stated.

Meanwhile, those outside the specialty, including patients, may have little knowledge about or even interest in whether their personal physician is a family physician, an internist, jointly trained in internal medicine and pediatrics, or trained in some other field. The American Boards of Family Practice and Internal Medicine issued a joint statement early in 1994, at the time of intense discussion of the Clinton Administration's health reform proposals, which might, if successful, have substantially built and solidified primary care. The statement is a masterpiece of a cooperative statement that also tries to perpetuate distinctions. The two boards "accept their respective roles" in what is to come; they have agreed on the concept of a generalist physician (with internists serving adults and family physicians serving all ages); they call for more such individuals,

who would work in teams with nonphysician professionals (both policies presumably jump-started with funding and/or regulation); they approve sharing training opportunities between the two specialties, including dual certification; and they urge joint participation in "rigorous health services research."⁴³ Despite the failure of the Clinton legislation in 1994, the case for collaboration and cooperation between the primary care medical specialties (and their non-medical counterparts) continues.

Perhaps general internists have more to gain as a specialist field by such cooperation, for their specialty board is dominated by powerful groups of subspecialists. General internists also seem to lack the sense of confidence or even hubris that distinguishes family medicine and is one of its continuing strengths. Seeking to explore differences in the core values of the two fields, John Saultz, MD, of Oregon Health Sciences University, concluded that internists in academic settings "may underestimate the degree of nonconformity and rebellion required of US medical students who entered family medicine in the 1970s and 1980s," individuals who are today's family medicine faculty.⁴⁴ Among other differences, Dr Saultz continued, for the family physician but not the internist, continuity of care is a multigenerational concept, where (ideally) the physician cares for families as groups. Moreover, internists are taught to approach clinical problems through the method of differential diagnosis based on classic deductive reasoning, whereas family physicians tend to draw on a more empiric approach based in clinical epidemiology. It is not clear to this observer whether (or why) such differences are mutually exclusive; which approach leads to better results, under what circumstances; nor even how far such distinctions are real, rather than part of the cherished dogma of each field. Like many others, Dr Saultz was identifying differences to identify common ground.

For family medicine, institutionalized with its own board, university departments, and residencies, claims for common ground with (at least) general internal medicine, may seem to threaten the hard-won independence of the field. If so, one logical, if defensive, response is for a clearer separation of family practice from other specialties. This is difficult to achieve without formal structures for primary care practice buttressed by major money streams and is made even more so in the absence of incontrovertible evidence about the social utilities of different specialties. Even if such structures are made available in the future, there is no guarantee that family physicians would be privileged over other primary care physicians. Signs in the environment suggest the reverse.

A major report on primary care from the Institute of Medicine (IOM) in 1996 lumped different primary care providers together, physicians and nonphysicians, thus

defining primary care by its generic nature rather than by specialty—the provision of a sustained personal relationship between clinician and patient and the inclusion of both mental and physical health, as well as health promotion and disease prevention. This tactic suggested that the successes of family practice had not entered mainstream policy making—indeed, that the role of primary care was still in its infancy. For the IOM committee, chaired by Professor of Medicine Neal A. Vanselow of Tulane, primary care “represents a largely uncharted frontier awaiting discovery and exploration.”⁴⁵

Conclusions: A Force for Change in the Future?

My reading of the history of family practice since 1969 is of a specialty that is at the end of one period (successful institutionalization) and is uncertain about what to do next. There may be a natural wish to rest on well-earned laurels and celebrate a heroic past.

The cultural/socioeconomic environment of the early 2000s does not offer the same opportunities for advancement as did the 1960s—the forces bigger than ourselves that swept family medicine to success as an approved specialty, and provided tax funds for family practice education—and for continuing subsidies for family medicine departments in some states. These are not rebellious times for the culture at large. The urge to differentiate the specialty within the medical profession by high standards for certification and high moral tone may serve the field well (and stimulate similar efforts among other specialties), but these do not necessarily translate to the cutthroat world of insurance contracts or national policy making. It is easy to fall into the trap of defining family practice, as general practice was once defined, in terms of what it is not, rather than what it is. Here I will shift to exhortatory mode and offer eight positive suggestions for family practice to consider in its next stage of development.

Be Aggressive

Family practice is an established field in a health system demonstrably in flux. Recognize the power of numbers and work pragmatically from within the realities of today's health care system. Rather than think in terms of yesterday's counterculture, build on moral leadership from inside elite medicine. As in the 1960s, this means exerting political pressure—in the political arena, in the marketplace, and within the culture of medicine. Since, as a specialty group, family physicians probably encompass more diverse roles and functions than any other specialty, from isolated rural practice to group practices in suburban and inner-city areas, family physicians have much to offer in redefining primary care for the future. Cooperation with other primary care clinicians, including nonphysicians, will produce the strongest (unified) political voice for change.

Work to Institutionalize Primary Care

Single-payer insurance systems with strengthened primary care could rapidly expand the number and centrality of family physicians in the US health care system. Such moves would have to convince the US public that this would result in better care than shopping for care from subspecialists. Build the necessary research base in family medicine. It would be helpful to patients to have reliable data about outcomes, experiences, prescribing patterns, and error rates among family physicians, multi-professional family practice teams, or family physicians as a group. For adults, what are the measurable costs and benefits of choosing a family physician over an internist and for children, over a pediatrician? Since most individuals are well most of the time, can it be shown that family physicians add specific value in preventing disease and disability? Do empirical data yet exist on the relative skill of recognizing clinical problems among different primary care clinicians? If family physicians have a greater scope of work in rural than urban areas, what are the implications of each pattern in the actual care of patients—or to the stress levels, knowledge base, and job satisfaction of physicians? Many other examples could be added.

Take Advantage of Current Cultural Movements

Just as family medicine's leaders did in the 1960s, today's leaders must take advantage of current cultural movements. These movements include publicity and concern about medical errors, recognition that there is too little scientific knowledge about primary care, widespread interest in quality measurements, and the huge market for and use of alternative medicine. In the political context, the movement toward patient's rights legislation shows new connections between medical groups, state legislatures, and federal representatives, while the likely inclusion of prescription drugs in Medicare stimulates questions about pharmaceutical use and patient compliance as natural topics for family medicine leadership.

Embrace the Information Revolution

Patients are both blessed and frustrated by available information on the Web. The physician has a potentially enhanced role as an interpreter and guide for the patient. Family physicians can lead medicine in general in sophisticated use of information as part of good practice. Common data systems can also make it possible for family physicians to control their own practice information and analyze it, for personal, professional, and policy uses, rather than ceding the role of analysis to insurers and investigators.

Market the Value of Applied and Clinical Research

Family physicians can exploit the fact that they are responsible, collectively, for large groups of patients. Research using data drawn from patient networks is a promising source of clinical and behavioral information for the future. Here is a definite opportunity to rephrase the agenda of counterculture and produce new science.

Identify Allies

The history of family practice, like that of other specialties in the United States, is a political history, if one uses the term to encompass negotiations, power plays, and bargains with both public and private groups. Allies in primary care have been noted. But there may be other arenas where family practice might usefully seek common cause: for example, preventive medicine, which also has its own specialty certifying board. If family practice is to take a strong stand in preventive medicine in the future, it might make sense to establish at least joint research endeavors. Another example is behavioral medicine. A group of private organizations have linked, for public communications purposes, into the Behavioral Health Alliance, run through the Center for Advancement of Health in Washington, DC. There is no sign of family medicine in the group. Is this because family medicine feels it is sufficiently served by its single-specialty institutions? Has it lost interest in behavioral health? Strategic alliances may be valuable with a variety of groups.

Stress the Intellectual Interest of Family Practice/ Family Medicine

By distinguishing practice from the dominance of mainstream biomedicine, the counterculture ideology has hovered on the brink of being anti-intellectual. Yet, obviously, family practice is (or ought to be) engaging and interesting, in whatever terms it is conceived.

Take Risks in Conceptualizing Family Practice for the Future

Presumably the specialty has two sets of goals in 2000: to protect its hard-won institutions and the practitioners and academics these represent and to improve health care for Americans. The first is the professional, the second the reform agenda. These do not necessarily conflict, but they are not the same. As reformers, today's leaders might examine potential pathways for change based on the null hypothesis that family practice, the institutionalized specialty, ceased to exist. For a nation apparently committed to consumer choice, technological solutions, widespread availability of information, and direct access to specialists, it is possible to conceive a health care system without designated primary care physicians at all. One might also conceive direct access by patients to diagnostic tests.

What would be the implications of this, positive and negative?

Alternatively, protecting the demonstrated success of the institutionalized specialty might lead to change without major reform, in the time-honored American political tradition. The goal might be to maintain family practice as a brand name separate from internal medicine or pediatrics or to ally with them into a single field of primary care, exerting the greater force of numbers. Such pathways might benefit patients or might be less beneficial than other approaches. Either way, the primary agenda would be maintenance of a hard-won professional position.

Final Thoughts

This observer will watch the specialty's next steps with interest. Is the family physician of the future to be primarily a crack diagnostician for all diseases and age groups, a health adviser to (generally healthy) parents and their children, a gateway to pharmaceutical prescriptions, an expert in chronic conditions, a translator and arbiter of knowledge brought in by patients, a manager of a multi-professional team, or what? Is family practice sustainable as one field, or will it become the umbrella for many? Will family practice take the offense or defense in defining its future? Will its positions be clear and realistic? What will its agendas be? Will these be made, and implemented, by the specialty or by others?

Given the mixed messages of its history to date, will family practice, as it now is in the United States, prosper, stagnate, or decline? That each of these fates is possible reminds us that the continuing history of family medicine, as of other histories, is contingent on cultural movements, available institutions, and individuals who can seize the opportunities of the moment.

Acknowledgments: Research work for this paper was funded under an Investigator Award in Health Policy Research, funded by the Robert Wood Johnson Foundation. An earlier version of this paper was presented at the Society of Teachers of Family Medicine 2000 Annual Spring Conference in Orlando, Fla.

Correspondence: Address correspondence to Dr Stevens, University of Pennsylvania, Department of History and Sociology of Science, 249 South 36th Street, Philadelphia, PA 19104-6304. 215-898-7601. rstevens@sas.upenn.edu.

REFERENCES

1. American Board of Family Practice. The specialty of family practice. Lexington, Ky: American Board of Family Practice, 1994;August.
2. Folsom MB, chair. National Commission on Community Health Services. Health is a community affair. Cambridge, Mass: Harvard University Press, 1966:26.
3. Snoke PS, Weinerman ER. Comprehensive care programs in university medical centers. *J Med Educ* 1965;40:625-57.
4. Bower AD. General practice—an analysis and some suggestions. In: DeGroot LJ, ed. Medical care: social and organizational aspects. Springfield, Ill: Charles C. Thomas, 1966:234.

5. Stevens R. American medicine and the public interest: a history of specialization. Berkeley, Calif: University of California Press, 1998:81. Original edition 1971.
6. Millis JS, chair. Citizens Commission on Graduate Medical Education. The graduate education of physicians. Chicago: American Medical Association, 1966:38-9.
7. Adams DP. American Board of Family Practice: a history. Lexington, Ky: American Board of Family Practice, 1999.
8. Doherty WJ, Christianson CE, Sussman MB, eds. Family medicine: the maturing of a discipline. New York: The Haworth Press, 1987.
9. Stevens R. Medical practice in modern England: the impact of specialization and state medicine. New Haven, Conn: Yale University Press, 1966.
10. Loudon I, Horder J, Webster C, eds. General practice under the National Health Service, 1948–1997. New York: Oxford University Press, 1998.
11. Lanphear E. Should a specialist pay a “commission” to or divide a fee with the general practitioner (sic)? *American Journal of Clinical Medicine* 1906;13:22-6.
12. Massad RJ, Schorow M. Family practice residency training: do we know what we want? In: Doherty WJ, Christianson CE, Sussman MB, eds. *Family medicine: the maturing of a discipline*. New York: The Haworth Press, 1987:109-27.
13. Stephens GG. Developmental assessment of family practice: an insider’s view. In: Doherty WJ, Christianson CE, Sussman MB, eds. *Family medicine: the maturing of a discipline*. New York: The Haworth Press, 1987:9.
14. Young PR. A brief history of the American Board of Family Practice: the second annual Nicholas J. Pisacano, MD, memorial lecture. *J Am Board Fam Pract* 1996;9:109-13.
15. American Board of Medical Specialties Research and Education Foundation. 1999 annual report and reference handbook. Evanston, Ill: American Board of Medical Specialties Research and Education Foundation, 1999:101.
16. American Medical Association, Department of Practice and Communications Information, Division of Survey and Data Resources. Physician characteristics and distribution in the US, 2000–2001 edition. Chicago: American Medical Association, 2000:23,303.
17. American Academy of Family Physicians. Facts about the AAFP and family practice. www.aafp.org. Accessed 4-19-2000.
18. American Board of Medical Specialties. Annual report 1973. Evanston, Ill: American Board of Medical Specialties, 1974:11.
19. Fye B. American cardiology: the history of a specialty and its college. Baltimore: Johns Hopkins University Press, 1996.
20. Erdey NC. Armor of patience: the National Cancer Institute and the development of medical research policy in the United States, 1937–1971. PhD dissertation, Department of History, Case Western Reserve University. Ann Arbor, Mich: UMI Dissertation Services, 1995.
21. Patterson JT. The dread disease: cancer and modern American culture. Cambridge, Mass: Harvard University Press, 1987.
22. Proctor R. Cancer wars: how politics shapes what we know and don’t know about cancer. New York: Basic Books, 1995.
23. Stephens GG. Family medicine as counterculture. *Family Medicine Teacher* 1979;11(5):14-8.
24. Stephens GG. Family medicine as counterculture. *Fam Med* 1998;30(9):629-36.
25. McWhinney IR. Family medicine in perspective. *N Engl J Med* 1975; 293:176-81.
26. Graduate Medical Education National Advisory Committee. Interim report. DHEW publication no. (HRA) 79-63. Washington, DC: US Department of Health, Education, and Welfare, 1979:27.
27. Sardell A. The US experiment in social medicine: the community health center program, 1965–1986. Pittsburgh, Pa: University of Pittsburgh Press, 1988.
28. Politzer RM, Harris D, Gaston MH, Mullan F. Primary care physician supply and the medically underserved: a status report and recommendations. *JAMA* 1991;266:104-14.
29. American Academy of Family Physicians. State legislation and funding of family practice programs. www.aafp.org. Accessed 4-19-2000.
30. Pisacano NJ. General practice: a eulogy. *GP* 1964;19:173-81.
31. The American Board of Family Practice. In: The official ABMS directory of board-certified medical specialties 2000, 32nd edition. New Providence, NJ: Marquis Who’s Who, 1999;1:947.
32. Young P. Family practice: birth and development of a specialty. *Am Fam Physician* 1997;56(3):725.
33. Murray JL. Family medicine: return to counterculture? *Fam Med* 2000; 32(2):129-30.
34. Advanced Forum in Family Medicine, September 23–28, 1984. The intellectual basis of family medicine revisited. Reprinted in the special series “Classics in Family Medicine.” *Fam Med* 1998;30:648.
35. American Academy of Family Physicians. AAFP official definitions of “family practice” and “family physician.” www.aafp.org. Accessed 4-19-2000.
36. Sorum PC. Patient as author, physician as critic: insights from contemporary literary theory. *Arch Fam Med* 1994;3:549-56.
37. Daniel SL. The patient as text: a model of clinical hermeneutics. *Theor Med* 1986;7:195-210.
38. Fish D, Coles C. Developing professional judgement in health care: learning through the critical appreciation of practice. Oxford, UK: Butterworth-Heinemann, 1998.
39. Schwenk TL. Strangers in a strange land: primary care physicians in academic medical centers. *J Gen Intern Med* 1998;13:216-7.
40. Family medicine: the maturing of a discipline. *Marriage and Family Review* 1987;10, numbers 3 and 4.
41. Unsigned report. Frequency of obtaining family history varies in family practice. *Am Fam Physician* 2000;61(Feb):1007.
42. McWhinney IR. Family medicine in perspective. *N Engl J Med* 1975; 293:176-81.
43. Stein HF. Family medicine as a meta-specialty—and the dangers of overdefinition. Reprinted in *Fam Med* 1998;30:637-41.
44. Kimball HR, Young PR. A statement on the generalist physician from the American Boards of Family Practice and Internal Medicine. *JAMA* 1994;271:315-6.
45. Saultz JW. Reflections on internal medicine and family medicine. *Ann Intern Med* 1996;124:600-3.
46. Donaldson MS, Yordy KD, Lohr KN, Vanselow NA, eds. Primary care: America’s health in a new era. Summary. Washington, DC: National Academy Press, 1996:6.