

**The History of Family Medicine and Its
Impact in US Health Care Delivery**

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ABSTRACT:

Data from the last five years show a decline in the number of students choosing Family Medicine; no doubt the reasons are multi-factorial and complex. We believe that one major factor is the disapproval often experienced by students expressing their interest in Family Medicine. This disapproval is based largely on a misunderstanding of Family Medicine's importance in the United States' health care delivery. Hence, a better understanding of our past and present role in the U.S. might stimulate interest in Family Medicine as a career choice. We present a brief history of Family Medicine in the context of the history of US medicine. We demonstrate the fundamental role of Family Medicine in U.S. healthcare, and examine future challenges: from Keystone III to the Future of Family Medicine Project.

INTRODUCTION

Most of us go through training and practicing medicine without receiving any formal education about the history of medicine in the US, much less about the history of Family Medicine: Where do we come from? What forces and people have influenced our specialty? What struggles, accomplishments, and disappointments has the discipline faced? How have we contributed to the development of medicine and to the delivery of health care in this country? This paper traces our history from the mid-1800s to the present time, looks at our history in the context of the development of medicine and medical education in the US, as well as the social forces and significant historical events in our society. We are the product of that history and we stand on the shoulders of many who made Family Medicine possible. History does not just explain the past but also, by providing the framework for understanding the present, helps us to move forward. As Dr. Stephens, the great founder of our specialty said: “Medicine is always the child of its time and cannot escape being influenced and shaped by contemporary ideas and social trends” (1)

We will look at the birth and growth of Family Medicine, the triumphs, the dreams, some of the obstacles and challenges found along the path as well as at the hopes and strategies for the future. We hope to help strengthen our identity as Family Physicians; to stimulate students to learn more about Family Medicine as a career choice; to learn more about the fundamental role of Family Medicine in health care delivery in this country and to promote personal commitment to promoting our specialty in all aspects of our work.

PART I HISTORY OF FAMILY MEDICINE

II A HISTORICAL PERSPECTIVE

The 1800s

The US population was still settled in small towns, and farming and production of goods were the major foundation of the economy. Health care was unstructured; the doctor often visited his patients in a horse and buggy. Most doctors did not have formal training; some learned the job as apprentices working with older physicians, or attending small courses and workshops. There were no medical schools, no organized training nor organized medicine and no system to ensure quality of care. (2,3)

Most of the time, the doctor went to visit patients and took care of all members of the family. He knew his patients very well, he delivered babies, set fractures, treated a multitude of illnesses, helped those dying, and some did surgery and took care of trauma. Many were astute clinicians, with great knowledge and capabilities; they were very committed to serving their people. The payment was fee for service, and often goods were brought to doctors as payment. Although many doctors were outstanding physicians, there were also many who claimed incredible healing powers; there was a lot of “quackery” and no standards of care to which doctors were held. (3,4,5)

As cities grew, physicians began to see the need for organization and got together to address on a larger scale the needs of the growing society. The need to establish formal medical education and standards were recognized as a priority. The AMA was established in 1846 with a major aim being to organize and regulate medical education. JAMA was founded in 1882.

By 1900, the AMA's objectives were to:

- Purify the profession from quackery
- Establish an orthodox medical education based on natural science
- Promote standards for public health (sanitation, food and drugs)
- Standardize medical education

The Beginning of a New Century:

As the new century began, there was a strong sense that medical practices were far behind from those of European countries, particularly England and Germany.

Concerned about the state of medical education, the AMA sought support from the Carnegie Foundation for the Advancement of Teaching, to study the medical schools of the nation. Abraham Flexner led the project and the results of the study were the first critical event to influence the development of medical education. The findings were published in the Flexner Report, 1910 (6). As a result of the recommendations of the Flexner Report major changes were implemented:

- Pre-medical requirements were established with strong basis in science
- Medical curriculum was standardized (strongly based on science)
- Full-time faculty were dedicated to teaching and research
- The medical schools were attached to universities

The Flexner Report provided the basis for the development of medicine and the environment for the subsequent growth and development of specialties as the basis for the delivery of health care. Specialties flourished and began to dominate medicine. In the 1900s the American Boards emerged in an effort by physicians to organize medicine into subspecialties, to define a body of knowledge and to create specific requirements for membership. The first American Board was Ophthalmology in 1917 followed by Otolaryngology 1924, thirteen more followed by 1930 and four more by 1940. (3)

The AMA prospered and gained professional and academic control of sub-specialization through the American Boards. The Boards' responsibility was to prepare and administer professional certifying examinations for individuals in their fields.

One important fact as US medicine is that the medical bureaucracy evolved toward specialization and institutionalization but not toward nationalizing medicine. Four areas of control were established:

- The universities control the MD degree

- The state controls licensing to practice medicine
- The AMA controls graduate medical education through the Council of Medical Education and the Residency Review Committees
- The American Boards control certification of specialists

By 1935 the major changes to medical education were:

- Standardization of pre-doctoral medical education awarding all physicians the same medical degree
- Specialization based on extended graduate education; i.e. Residency
- Specialist control over the location and use of technology. Hospitals became the major place where medicine and technology reside and are developed
- Medicine became institutionalized, based in medical schools and city/county hospitals

As a result of these changes the cost of medical education increased and medicine became a profession of the upper class. Specialization was emphasized and highly valued while GPs became lower rank, smaller in numbers and aging. There was a lot of animosity between the specialists and the GPs. GPs continued to lose ground as they were prevented from hospital work, procedures and other activities.

In the 1940s, and particularly during WW II, the US recognized the superiority of Germany and England in regard to scientific and technological advances. The war led to

an intense push toward scientific and technological advances in all fields. The Federal government invested substantial resources into the development of science and America fell in love with science and technology. Just to point out some critical developments: Enrico Fermi demonstrated the atomic reaction. The Germans had the knowledge and likely the capability to develop an atomic bomb. World War II was followed by the Cold War with scientific knowledge and technological achievement at the center of the race for power. The National Science Foundation was established in 1950. The Soviets demonstrated their technological superiority by putting the first satellite into orbit, Sputnik in 1957. NASA was founded in 1958 and only eleven years later, Apollo XI landed on the moon.

In spite of all these changes, from 1920 to 1960 neither medical schools nor the enrollment of students grew considerably, while the population continued to increase. Eventually this created a shortage of physicians. In the 1960s the public began to express their dissatisfaction with the state of medicine, mainly:

- The shortage of physicians
- The inaccessibility of health care in rural areas and inner cities
- The high cost of medical care
- The increased depersonalization of medicine
- The fragmentation of care

In response to public concerns and outcry the AMA responded by

1. Increasing and extending direct federal support to medical schools through the Health Profession Education Assistance Act and by creating
2. The Citizen's Commission on Graduate Medical Education which resulted in the Millis Report of 1966 (7)

The winds were right for change, and 1966 marked the high point for the drive for a new specialty as three independent and important documents were published: The Millis Report, The Folsom Report and the Willard Report. (7,8,9)

The Millis Commission: The Citizens Commission on Graduate Medical Education. It was an external body requested by the AMA to study Family Medicine. The report called for:

“A physician who focuses not upon individual organs and systems but upon the whole man, who lives in a complex setting... knows that diagnosis or treatment of a part often overlooks major causative factors and therapeutic opportunities.” (7)

The Folsom Report: The National Commission of Community Health Services, established by the American Public Health Association and the National Health Council.

The report stated:

“Every individual should have a personal physician who is the central point for integration and continuity of all medical services to his patient. Such physician will

emphasize the practice of preventive medicine... He will be aware of the many and varied social, emotional and environmental factors that influence the health of his patient and his family... His concern will be for the patient as a whole, and his relationship with the patient must be a continuity one” (8)

The Willard Committee: an Ad Hoc Committee on Education for Family Practice. This commission was appointed by the AMA Council on Medical Education to study family medicine training and stated:

“The American public does want and need large numbers of qualified Family Physicians” (9).

Indeed the 1960s brought a sense of social responsibility: The Civil Rights Movement, the peace movement, the Vietnam War Protests, etc. The 60s brought the appropriate social forces and the right environment for Family Medicine to be born as a new specialty. In fact many people see Family Medicine as one outgrowth of the “Counterculture movement”, perhaps as a child of the sixties (10,11,12,13).

In 1969 the specialty American Boards approved Family Practice as a new specialty. In 1970 the ABFP offered the first certification exam and the mandate-required re-certification every 7 years. In 1971 the AAGP became the AAFP (3).

Who is a Family Physician and what is the scope of a Family Physician's practice?

“Family Physician: The family physician is a physician who is educated and trained in family practice -- a broadly encompassing medical specialty.

Family physicians possess unique attitudes, skills, and knowledge which qualify them to provide continuing and comprehensive medical care, health maintenance and preventive services to each member of the family regardless of sex, age or type of problem, be it biological, behavioral, or social. These specialists, because of their background and interactions with the family, are best qualified to serve as each patient's advocate in all health-related matters, including the appropriate use of consultants, health services, and community resources” (14)

“Family Practice: Family practice is the medical specialty which provides continuing and comprehensive health care for the individual and family. It is the specialty in breadth, which integrates the biological, clinical, and behavioral sciences. The scope of family practice encompasses all ages, both sexes, each organ system, and every disease entity.” (14)

Family Medicine grew and flourished through the 70s, 80s and mid-90s. Residencies grew; graduates and diplomates increased in number and it appeared that FM was set to make major leaps toward becoming a strong force within medicine. The ABFP is now the second largest board and the specialty has the largest delegation to the AMA. (10)

PART II: The IMPACT OF FAMILY MEDICINE IN THE US HEALTH CARE DELIVERY

III THE IMPACT OF FAMILY MEDICINE IN THE US HEALTH CARE

How important is Family Medicine today? For most of us the answer is clear: Family Physicians play a fundamental role in the care of the US population. But numbers speak louder than words, particularly when lobbying and promoting primary care in the US. Perhaps no group has dedicated so much of its work to providing this evidence as the Robert Graham Center in Washington DC. (15).

The best way to start is to go back to a seminal paper published in The NEJM in 1961 on the Ecology of Medical Care by White et al (16). The authors presented a fundamental concept that 40 years later, remains valid. The concept of ecology of medicine translates into the relationship between people and the environments in which they receive health care. In 1961, if one were to take 1,000 adults at risk, 750 of them reported an illness and/or injury each month. Of this 750 only 250 consulted a physician (at least once). Of them only 3 people were ill enough to require admission to the hospital, 5 were referred to another physician and only one individual was referred to a university medical center. The paper demonstrates a fundamental reality: The bulk of health care delivery occurs in the community, in the offices of physicians. In 2000, Dr. Larry Green revisited this model and found that the ecology model remains useful in spite of 40 years of changes in medicine (Medicare, Medicaid, Physician assistants, Nurse

Practitioners, Managed Care and impressive technological advances) (17). The bulk of health care continues to be delivered in the community; this is true for those with and without insurance, regardless of whether or not they have a usual source of care. The relevance of this concept is that access to health care and its delivery in the community setting are fundamental to promoting the well being of all people.

What is the contribution of Family Physicians to the care of the US population?

The best way to answer this question is to present some of the outstanding work done by the Robert Graham Center. (15). Different perspectives can be use to demonstrate the fundamental contribution of Family Physicians: the number of office based visit to US physicians; the proportion of visits to GP/FP for selected problems; the number of number of visits to FP for the eight top Health Priority Conditions; and the distribution of family physicians across the country in areas designated as Primary Care Health Personnel Shortage Areas (PC-HPSA).

Looking at data on office-based visits to US physicians, we find that family physicians see a large number of patients, Table 1 (15). In fact, family physicians see more patients than any other primary care specialty.

According to the National Ambulatory Medical Center Survey, NAMCS, analysis of office visits to Family Physicians and General Practitioners by selected problems also

demonstrates an important contribution to the delivery of health care in physician's offices. Table 2 (15).

Another perspective is to look at visits for Priority Health Conditions, diseases of great prevalence in the population which cause significant morbidity and mortality, such as: Heart Disease, Stroke, HTN, Diabetes, Cancer, Emphysema and Bronchitis, Asthma and Anxiety/Depression. Comparing the portion of visits to different types of physicians, we find that family physicians care for large numbers of patients with priority health conditions, Table 3 (15).

Perhaps the most dramatic way to demonstrate the fundamental role of Family medicine is to look at what would happen if Family Medicine were to disappear. Many US counties are designated as Primary Care Health Personal Shortage areas or PC-HPSA Fig.3 (18). These are counties where there is less than 1 primary care physician per 3,500 people in the designated area. Data from 1995 indicate that there were 2,298 counties not designated as PC-HPSAs. If family physicians were to disappear, 1,332 counties or 58% of these counties would become PC-HPSAs compared to 45 (2%) for general internists, 11 counties (0.5%) for pediatricians and 9 counties (0.4%) for OB-Gynecologists. Figs: 4,5,6 (15) and 7 (19). These data demonstrate without doubt that the United States depends on family physicians more than any other specialty to deliver care to its population.

IV: FAMILY MEDICINE IN THE NEW MILLENNIUM

In spite of the significant improvements of the last 30 years, many of the fundamental issues of 1969 remain unchanged; others have worsened and new challenges have emerged. Family Medicine was born at a time of great social awareness and with great expectations of making radical changes in society. As a specialty, we have walked a rough, steep road and accomplished a great deal; however, many dreams and goals remain unfulfilled. History teaches us over and over that our social evolution is the result of the economic, social and cultural forces of the times, and that they are all interrelated. For example: we cannot separate the economic forces that determine the financial support for health care from their effect on the patient-doctor relationship; or their effect on medical education. We cannot ignore the social and cultural changes in our society and their impact on how and where health care is delivered. We cannot ignore the effect of the growth of knowledge and availability of information on the patient's expectations and desires. We cannot be oblivious to the effect that the accelerated growth of knowledge has on how we practice Family Medicine and on the feasibility of maintaining competency as generalists.

Keystone III

In October 2000 members of the family of Family Medicine gathered to have a heart to heart discussion about the specialty in a landmark meeting known as Keystone III.

Family physicians from different generations looked at the past, reflected on the present

and looked into future. But Keystone's goal was not to provide or determine a plan of action for the future. The full report from K III is worthwhile reading and was published in the Journal of the Society of Teachers of Family Medicine in April 2001 (20). We will limit our discussion to some of the highlights of the meeting as they help bring into focus some of the fundamental challenges that our discipline faces today.

The Erosion of the Patient-Doctor Relationship

One of the core values of FM is the long-term relationship and partnership developed between the doctor and the patient. In the era of Managed Care, market forces constantly erode this foundation of our clinical practice. As employers change insurance systems to minimize cost, a large number of people are forced to change insurance plans and thus doctors. How can a partnership develop if the relationship is constantly broken? In addition to the financial strains, mobility of both patients and doctors also contributes to the loss of continuity, decreased quality and inefficiency of care (10,12,13).

Lack of Insurance Coverage

Today ~ 40 millions Americans have no medical insurance and another large percentage is underinsured. The number of uninsured persons has doubled since 1980 and one in five of the uninsured are children. Unfortunately, the uninsured population often waits until serious illness manifests itself to seek medical care, often presenting with increased morbidity and mortality. There is no doubt that the most fundamental factor that affects the development and growth of Family Medicine is the lack of an infrastructure that supports primary care as the basis for delivering health care. The good news is that

because of our fundamental role and contributions, we are in a unique position to promote primary care and to improve health outcomes for all people (11,21).

The Boundaries of the Specialty:

The overwhelming explosion of knowledge and information available has created new demands and expectations for patients and doctors. Many physicians worry about the feasibility of keeping up with the advances in medical knowledge. In response to this concern, many family physicians search for a niche, practicing a more limited scope of medicine, hoping to remain proficient and competent in specific areas of interest. For example: many have given up practicing obstetrics, some give up hospital work or the care of the elderly or the dying patient (10). In addition, economic pressures to be more cost effective and efficient strongly drive our practices. The development of the “hospitalist system” incorporated, and at times mandated, by insurance companies threatens this area of practice for our specialty as more often internists assume this role. Are the boundaries of the specialty getting fuzzier? Are we losing our identity as generalists? Is it realistic to remain generalists in a world of accelerated growth of knowledge and technology? (22,23,24,25). The answers to these questions are complex and controversial and represent a real challenge to our identity.

Demographics, Ethnic diversity and the constantly evolving concept of “family”

The US population is growing old, projections for 2050 estimate that 25% of the population will be > 85 year old. With the growing number of elderly, medical practice will shift toward the management of more chronic diseases. The impact of this change is

becoming evident as the viability of present programs to support the elderly are threatened and the utilization of limited resources is questioned (22,23,24,25).

The face of America is also changing:

The increasing ethnic diversity continues to add to the cultural richness of our society while bringing unique cultural challenges to patient care. Current estimates are that by the year 2005, minorities will compose 51% of the population. How can we develop “cultural competency” to address the unique problems of our diverse population?

(10,23,24)

Changes in Family Structure:

Since the 1960s the structure of families has changed significantly. We now see single parent households, couples raising children without marriage; families made of two or more different nuclei, step fathers/mothers and step-siblings are common and some families are made of partners of the same sex. In addition, the role of women in society has profoundly affected the dynamics of the family. Today women make up ~ 45% of the labor force; more women are getting higher education; more women go back to work soon after having children. Women in medicine have significantly increased in numbers, particularly in primary care, and we begin to see new and inventive ways in which some physicians share practices; however, professional barriers are still significant for women

(13,24,25)

The Price of Isolation:

The birth and growth of Family Medicine was the result of the work of many generous physicians who worked tirelessly and sacrificed a lot in the process. To some degree many of the old conflicts and distrust are still part of our experience. As Dr Geyman states: “ The three primary care specialties remain distinct tribes on parallel but separate courses” (26). The conflicts between generalists and specialists in regard to “turf battles” and the economic disparity in reimbursement between specialists and generalists continue to prevent us from achieving a bigger and more fundamental goal: to provide affordable, high quality and personalized health care to all people. We must overcome old conflicts and resentments within primary care and with our specialist colleagues. We all have an important role to play in taking care of our people. We need to begin to break walls and barriers and work together toward this common goal (11, 26).

V. MEDICAL EDUCATION, MEDICARE AND MANAGED CARE

In the absence of a national health care policy and lack of a coherent system to finance medical education, Medicare has served to support general public health and medical education for ~ 30 years. In 1965, the Medicare program was enacted and the federal government began to subsidize medical education. Medicare provided payments for direct and indirect costs of medical education and covered teaching overhead. In addition, it provided extra payments to hospitals with a disproportionate share of high cost cases (DISH). Prior to 1965, medical schools and teaching hospitals were funded through tuition revenues, private donors, endowments, and some state and local government funds. The contribution from clinical practice was minimal and the core of academic medicine was teaching and research. However, in response to the increasing cost of health care, Medicare switched its funding from open ended payments to prospective payments. Hospitals were to be paid by diagnosis rather than by treatment, and soon after, insurance companies followed along. This shift resulted in a significant loss in reimbursement and a decrease in funding to support medical education. In academic centers, faculties were pressed to bring clinical revenue to subsidize their institutions. According to the American Association of Medical Colleges, the revenue from family physicians' clinical practices used to subsidize teaching centers has increased from 5% in 1960 to 50% in 2000. Another setback to medical education came in the form of the Balanced Budget act of 1997 whose goal was to reduce payments by 5.6 billion dollars over a 5 year period by decreasing payments to all hospitals for patient care and capital, and by decreasing the DISH payments, as well as subsidies for teaching.

The overall effect on teaching and patient care has been profoundly deleterious, limiting the amount of time devoted to teaching, the quality of teaching, and the ability to adequately provide high quality patient care (27,28,29).

The growth of Managed Care (MC) in the late 1980's and through the 90's has deeply influenced the delivery of health care and the doctor-patient relationship. MC emerged in an attempt to control health care costs and with the goal of providing coordinated and rational health care. Although it seemed that MC would be the force to promote primary care, serious adverse side effects came with it. The concept of "gatekeeper" introduced by MC negatively impacted the patient-doctor relationship. The general public perceived this role as one of rationing and limiting access to medical care. Physicians often experience MC as a limitation on their freedom to practice medicine and as a system with increased rules, regulations and need for documentation in order to be reimbursed for services provided, regardless of the benefit to patients. MC also has forced medicine into a profit-oriented health care market and with this emphasis, many physicians feel a conflict of interest: on one hand to be patients' advocates and on the other being pressured to cut the cost of care (28,29,30).

Traditionally, the role of an academic center is to generate new knowledge through research, to transmit knowledge through teaching, and in the case of medicine, to take care of patients through clinical services. These missions are equally important and fundamental, as they benefit society at large. The latest changes in medical care and teaching reimbursement have negatively affected patient care and the teaching mission in

our institutions. We would like to argue that in the same way as scientific progress in the form of research and technology is funded by society through grants, education and health care need to be a societal responsibility. All education is fundamental to the democratic process; it is the force for social progress. If we view education generally as a worthwhile endeavor, then it only follows that the education and training of physicians is no different. If society benefits from the education of future physicians, then its financial support needs to be borne by all and must be protected from the pressures of for profit economy (28,30,31).

VI. THE FUTURE OF FAMILY MEDICINE PROJECT

Keystone III was a time for self-reflection as a specialty, but reflecting is only beneficial if it serves as a force to develop new strategies for growth and improvement. To determine a strategic plan, the AAFP has engaged in an ambitious task: the “Future of Family Medicine Project.” Its goal is to “Develop a strategy to transform and renew the specialty of family practice to meet the needs of the people and society in a changing environment” (32). The project is a joint effort of the American Academy of Family Practice, the American Academy of Family Physicians Foundation, the American Board of Family Practice, the Association of Departments of Family Medicine, the Association of Family Practice Residency Directors, the North American Primary Care Research Group and the Society of Teachers of Family Medicine. In order to achieve this goal, five task forces have been created to answer five fundamental questions:

Task Force #1. What are the core attributes of family practice, how can family physicians best meet the consumer’s expectations, and what systems of care should be delivered by Family Practice?

Task Force # 2. What is the training needed for family physicians to deliver core attributes and system services expected by consumers and the health care system?

Identifying the training needs will allow making recommendations to the RRC/ACGME on the changes needed in residency training to promote the attributes of family

physicians. To identify the barriers to reaching medical students, to understand the issues they face and to develop strategies to address them.

Task Force # 3 How to ensure that Family Physicians deliver core attributes and system services throughout their careers. Its task is to establish strategies to enhance FM Core attitudes and to enhance maintenance of certification.

Task # 4: What strategies should be employed to communicate the role of family physicians within medicine and health care, as well as to purchasers and consumers?

Task # 5. What is Family Practice's leadership role in shaping the future health care delivery system?

These are very challenging questions to answer so the project has sought help from a consulting firm, Siegelgale of New York to do qualitative and quantitative research to help answer a fundamental question: What do people want and expect from health professionals in the health care delivery system and what is the role that family physicians should play. In order to answer this question, Siegelgale will survey a wide spectrum of individuals and organizations including: People who receive their care from family physicians; people who receive care from other physicians; consumer advocate groups; family physicians in academia, family physicians working in the community, and other physicians; non-physician health care providers; employers, other payors and government; residents and medical students. It is expected that by October 2003 the

project will be concluded, that the final approval and recommendations will be available in fall of 2003 and that implementation will under way by January 2004.

VII. CONCLUSION

Family Medicine has accomplished a great deal and grown significantly since its birth. The strongest proof of our importance and contribution to health care is demonstrated by looking at how strongly the US depends on family physicians. We are a fundamental force and as such, we are in a unique position to influence much-needed changes in health care. Other countries and systems have already taught us that people do better when they have a strong, structured primary care system, accessible and affordable to provide at least some minimum level of care. We also need to work at securing the means to educate future physicians in an environment that does not compromise quality of patient care and teaching in exchange for profit making. We are important but we also need to recognize the importance of other specialties, we cannot neglect nor minimize their contributions and importance. We need ophthalmologists, dermatologists, orthopedists, ER physicians, cardiologists, etc. A good analogy is that of music. Music achieves its maximal beauty and full expression when all musicians work together to bring out the essence of the piece. Medicine is like a great symphony. At times, the music calls for an exceptional violinist, some other times for a cellist, a flutist, or pianist. The magnificence of Itzhak Perlman, Yoyo Ma, Jean Pierre Rampal, or Alicia de la Rocha is best appreciated in the balance of the symphonic piece where every instrument contributes to the full richness of the music. In this analogy, Family Physicians should be the conductors; it is our job to make sure that the music is at its best.

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