Presentation

Family Medicine as Counterculture

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I want to speak about the future of family practice as counterculture.

Some of us recoil at the use of the language of "reform" and "revolution" to describe our discipline. These are the semantics of violence, and they project an image that we do not feel. We are benevolent, well-intentioned, "humble country doctors" who only want to restore some balance to medicine. We do not want to destroy anything, or take anything away from anybody; we just want a place in the sun for ourselves and our residents and students. We are not radicals who wish to turn the world upside down.

Indeed, I have sometimes thought that our cumulative effect on the body politic of medicine has been conservative more than liberal or radical. In many ways, by our success, we have "taken the heat off" the medical profession from the public; therefore, the status quo is being preserved. That is conservative. More radical solutions to perceived problems will not be imposed as long as the public thinks that something is being done.

Short-term effects are not the best criteria, however, for determining the social effects of a movement. Neither are the stated objectives of most of the people who participate in it.

There are a number of perspectives from which one can analyze the renascence of family practice in the sixth and seventh decades of this century. *Quantitatively*, it is an unprecedented phenomenon. The numbers of departments, programs, and residents are well known to you. The magnitude of this achievement required the convergence of social, political, economic, and professional forces, over most of which we had (and have) very little control. Many different institutions, organizations, groups, and individuals with differing agendas and expectations have invested heavily in the family practice movement. No *one* can be given credit for our success. The time was right; the idea was right; and from the perspective of one who has participated almost from the beginning, there has been an aura of serendipity about it all. Most of us have simply responded to opportunities that just seemed to be there. There is a sense of having participated in something that is a great deal bigger than oneself and one's ideas.

Qualitatively there *is* a precedent for family practice in pediatrics. That discipline preceded us by 35 years, and many of the forces that created pediatrics are similar. Rosemary Stevens has chronicled the development of medical and surgical specialties in the U.S., from the late 19th century through the mid-1960s in her book *American Medicine and the Public Interest*.[1] Social reform, rather than science and technology, was instrumental in the development of both disciplines. In the case of pediatrics it was social concern for the welfare of mothers and children. Every society in its development, sooner or later, reaches a stage when the importance of child and maternal health is perceived. In the U.S. this occurred around the time of the first World War, and a group of physicians emerged who became advocates for them. There was no breakthrough in scientific knowledge or technology that required the development of pediatrics, as there was for ophthalmology, surgery, and urology. There was simply a need for some physicians to devote themselves professionally to this social goal. In 1933 the various professional groups that had an interest in diseases of children collaborated to form the American Board of Pediatrics and establish training programs for the education of general pediatricians. This is the second factor that parallels family practice. *It was necessary for the pediatricians to join the medical bureaucracy in order to promote their social reform.* The Advisory Board of Medical Specialties approved their Board in 1934, as it was to do 35 years later for the American Board of Family Practice. The pediatricians sensed a need to distinguish themselves from general practitioners on the one hand and obstetricians on the other, who at the time were manifesting a professional interest in the infant through the first year of life. Parenthetically, it is the pediatricians' skepticism about family physicians' commitments to child advocacy that prevents them from delegating the general care of children to us.

The growth of pediatrics in its first decade was not quite as impressive as family practice, but they established 200 residencies by 1939 and certified 1,500 pediatricians in the same period.

Previously, I have described the social reform ethos of family practice. Each of us might see this in a somewhat different light, but we would agree, I think, that uninhibited access to medical care for everybody, especially the medically underserved, personal and family oriented care on a continuing basis, and comprehensive care at a reason-

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able cost were crucial in the modern rise of family practice. We also saw the need to professionalize and bureaucratize the delivery of these medical services around a group of physicians who declared themselves advocates for such, and we have devoted a decade to defining professional boundaries and creating educational programs for physicians who want to be called family physicians.

There are some deeper reforms, about which we have less agreement, but which have motivated significant subsets of family physicians. I labeled these agrarianism, utopianism, humanism, consumerism, and feminism. These are all themes of reform that can be traced in American history, and their emergence in the 1960s and 1970s created the climate of public opinion that made it possible for family practice to succeed in such an unprecedented way. We benefited from them even though we may not have been conscious that we were drawing on their strength.

Agrarianism dates from the founding fathers and perpetuates the deep and abiding love that Americans have for the land and for the values of rural life. Where would we be as a movement without the dollars appropriated for our residencies by state legislatures who wanted to do something about rural health?

Utopianism reflects the belief that America has been divinely ordained as "the last best hope of mankind," ie, destined to create a society where the well-being of the individual is not to be subverted by class, religion, race, or poverty. Family practice's commitment to serving the underserved with "first-class medicine" and to seek the goals of health and well-being beyond the mere relief of pain and suffering are distinctly utopian. Preventive medicine, rehabilitative medicine, and psychosocial medicine belong to this genre of reform.

Humanism constitutes a broad American resistance to impersonal manipulation of the individual by government, law, industry, or technology. Nothing should violate the rights and autonomy of the individual. When family physicians declare their interest in personal medicine that will not subjugate patients to machines or reduce them to powerless, dependent creatures, we are tapping a wellspring of reform that is much broader than medicine.

Consumerism and *feminism* have been especially active reforms in the past 20 years though each goes back much farther. The commitment to continuing education and recertification by family practice was right on target for the 1960s resurgence of consumerism. Honest labeling of the physician's qualifications, quality control of medical care and medical education, patient education, and patient advocacy are all consumer issues. We are perhaps more ambiguous about feminism than any of the other reforms. Our support of the family unit in the medical care system is clearly on the side of one aspect of feminism, as is our success in enlisting increased numbers of women to join our ranks, but we have not yet shown much willingness to listen to the deeper issues of women's liberation, or to modify our residencies to allow a woman to be a mother and a resident simultaneously.

These sketchy statements are intended to show that family practice, more or less knowingly, has been deeply involved in social reform and that we owe a great deal of our success to that. *Clearly we have been on the side of change in American life.* We have identified ourselves with certain minorities and minority positions. We have been counter to many of the dominant forces in society. *In some respects at least we belong to the counterculture.*

This has been one of the bases for our fascination to medical students. I hope that we never become so indolent, smug, or arrogant that we take the interest of medical students in family practice for granted. That would be a fatal mistake. Recently I, along with many of you, received a question from a member of the student affiliate of AAFP. "Would I support the introduction of a resolution in the AAFP House of Delegates that every medical school should establish family practice as a *required* component of its curriculum for medical students?" This is the sort of question that comes up when a group or organization is shifting from an "out-group" to an "in-group" status. I reacted negatively to the question, because I would now rather be identified with student discontent than with the authority that imposes requirements on them. As things have happened in many medical schools during the past decade, students could express some of their general discontent by "demanding" that the school provide them with a learning experience in family medicine. It would be very easy for the same students to include us in their discontent, if we were administratively imposed on all of them.

While I am digressing a bit, let me say that it is also easy for us to misunderstand medical students' interest in our discipline. It is my observation that they are attracted by the general practice aspects more than the family medicine aspects. There are obvious exceptions to this, but it's a potential trap for us. Our faculty are more likely to be turned on by family care, behavioral medicine, and the like. The students want to see some "blood and guts" general practice. There is a paradox here that should not be lost on us. "Activated" students who are willing to go against the grain of the dominant output of their medical schools are not thereby necessarily buying the most *avant garde* interpretations of family medicine.

Let me return to my theme, that the family practice movement has succeeded in the decade just past because we were identified with reforms that are more pervasive and powerful than ourselves. On the surface it appears that the country is now in reaction against many of the ideas and movements of the 1960s and early 1970s. It is not uncommon now to hear people refer to that time as "the madness of the '60s." Someone has said that the only enduring remains of the "flower children" are the numerous boutiques in our shopping centers. Within medicine, most of the experiments with three-year medical school curricula have been abandoned, and traditional courses are replacing much of the multidisciplinary "organ system" courses. The other specialty boards are withdrawing from a requirement for recertification, and required continuing education is coming under increasing attacks.

It is unlikely, however, that the reforms of the past 20 years can be so easily dismissed. They touched too much that is fundamental in American life: social justice, liberation of minorities, anti-authoritarianism, sexual freedom, ecology, and even nationalism. We may now be catching our breath after a turbulent decade, but most of the issues of the 1960s remain on the nation's agenda.

My prediction for the next decade is that *the family practice movement will have more internal problems with itself* than it will have problems with outside forces and other specialties and institutions. Let me try to be more explicit about this. I turn to the history of the Christian church for an example of second- and third-generation problems that characteristically confront a reform movement.

Before Martin Luther's death, he and other reformers were faced with the issue of how their reform was to be institutionalized. Was he to create a new authoritarian church along the same lines as the Roman Church he had successfully opposed? Could he identify a new form of the church that would preserve the newly rediscovered beliefs in salvation by faith alone and the priesthood of all believers? Who could qualify for membership? Must every member demonstrate a personal experience of grace? What about the families of members? What should be the relationship of the new church to the state? You may recall that the Lutheran reform, which was essentially theological, was followed by a peasant's revolt, which was mainly political, and Luther rejected it! The peasants were slaughtered by the armies of the princes who supported Luther in his fight against Rome. It was not one of Luther's brightest moments.

Church historians have used the terms "sect" and "church" as paradigms of contrasting organizational structures and characteristics that followed the Protestant Reformation. I hope I am not being too presumptuous or grandiose in using this model to talk about family practice. Liston Pope described 21 indices that distinguished sects from churches. Most of these are not either/or criteria but represent spectra along which one could locate a given organization.[2]

Four of these indices concerned membership qualifications:

1. *Adults versus children (of members)*
2. *Voluntary, confessional versus ritual and social requirements*
3. *A moral community excluding the unworthy versus embracing all who are socially compatible*
4. *Propertyless versus property owners*

Five related to the attitude of the group toward others and to the dominant culture:

1. *The cultural periphery versus the cultural center*
2. *Renunciation of the culture versus accommodation to the culture*
3. *Self-centered or personal religion (experience) versus culture-centered or social religion*
4. *Noncooperation or ridicule of established churches versus cooperation*
5. *Suspicion of rival sects versus disdain or pity for all sects*

Eight involved activities of individuals and groups:

1. *Evangelism and conversion versus religious education*
2. *Emphasis on death and the next world versus emphasis on success in this world*
3. *Congregational participation in the services versus delegation of responsibility for public worship to a few*
4. *Fervor and action versus restraint and listening*
5. *Special ad hoc services versus regularly scheduled services*
6. *Spontaneity versus fixed order in worship*
7. *Use of hymns resembling folk music versus hymns from the liturgical tradition*
8. *Religion in the home versus delegation of religion to church officials*

The remaining four are miscellaneous characteristics:

1. *Economic poverty versus economic wealth of the church*
2. *Unspecialized part-time ministers versus professional full-time ministers*
3. *Psychology of persecution versus psychology of success and dominance*
4. *Difficult standards, eg, tithing or nonresistance to force, versus acceptance of general or practical standards*

If one translates these ideas from a religious to a medical model, it is easy to see the parallels. Family practice as a part of the medical professional bureaucracy quite clearly began as a sect (though we might not like this term) and has already moved along several lines to become a "church," ie, to take on the characteristics of the dominant professional organizations. The Society of Teachers of Family Medicine is a particularly suitable organization in which to study this process of transformation. I have read many records of minutes from the Board of Directors meetings with these ideas in mind, and it is uncanny how many of the issues that have consumed hours of debate can be understood by means of this model. The founders of this Society quite clearly intended to create an organization of committed (ie, saved) members from any of the health professions who were actively engaged in teaching and propagating family medicine. We were informal, egalitarian, evangelistic, and certainly propertyless. We did not want to become political, and many of us were suspicious of other organizations that might dominate us or dilute our purposes. We were critical of the dominant medical education culture (AAMC, medical school faculties), and we depended upon volunteer or part-time leaders.

Over the years we have tended to become a much more formal organization, accepting a political responsibility to represent our discipline in the medical bureaucracy and struggling for funds. We have imposed restraint on members' participation in meetings; now there are committees who determine who may speak or make presentations, and our activities are increasingly delegated to a paid professional staff. We have evolved an orthodoxy of beliefs and practices by which we judge each other and outsiders. In short, we are fast becoming a church.

I do not present these ideas in a pejorative or derogatory way. I am attempting to describe rather than judge. My purpose is to call attention to our own evolution and to ask whether or not this is what we really want to do. Is our own best interest to be served by moving as quickly as we can to resemble the rest of the medical bureaucracy, or do we have interests that can best be served by our remaining a sect? We have gotten a lot of mileage out of our minority, sectarian status. Why do we want to abandon it so quickly? I do not expect anyone to answer these questions. They are not the sort that *can* be answered by

appointing another committee, doing another survey, or taking a vote.

The importance of all this is not just the survival and prosperity of another medical organization. The importance lies in whether or not this organization can be used in the service of ideas that, by and large, it did not invent or discover, but which are at work in the larger culture, to make the medical care system the servant rather than the master of our lives. If we cannot be used by these ideas, we can be sure that other organizations will be spawned by them. I am expressing here the belief that ideas will be served one way or another, and that the nurturing of an idea is very hazardous business for any organization. I am convinced that the emergence of family practice was a *response* to ideas whose time had come and that our continued success is dependent on our ability to identify what they are, and to facilitate their expression, not to manage, control, or own them.

What are the ideas in whose service we have been privileged to work? I can do little more than to tell you what I *think* they are. I claim no special revelation, knowledge, or understanding. Like you, I am a participant observer in the drama of medicine. I have not seen the script, nor do I know the playwright. I only have hints and intuitions of what the action is supposed to be, and I grope after my lines and gestures.

Jean-Francois Revel, a contemporary French philosopher, in a remarkably disconcerting book, *Without Marx or Jesus*, wrote about the crucial role of the United States in the future world.[3] He agrees with others that mankind is in the midst of a world revolution that is essential to its survival. On his agenda for the whole world is the elimination of war, some sort of supranational government, elimination of internal dictatorships, worldwide economic and educational equality, birth control on a planetary scale, and complete ideological, cultural, and moral freedom for everybody. His concept of revolution is not the familiar 19th century model of conflict between peasants and landowners, workers and factory owners, or imperialists and their colonies. "Revolution," he wrote, "is not a settling of accounts with the past, but with the future." What he has in mind is nothing less than the creation of a new humanity (homo novum) that is capable of living at peace within the ecological limits of the earth. Such a transformation goes far beyond the arms race, the struggle between communism and capitalism, or the rise of underdeveloped countries. The mere transfer of power from one tyranny to another is no revolution at all.

Moreover, he sees the United States of America as the only country where "the revolution" of the future is going on. This is quite a different view of the U.S. than as the last bastion of imperialism, capitalism, and racism that characterizes so many intellectuals' writings of late. In the U.S.A. is the "only revolution that involves radical moral and practical opposition to the spirit of nationalism. It is the only revolution that, to that opposition, joins culture, economic and technological power, and a total affirmation of liberty for all in place of archaic prohibitions. It, therefore, offers the only possible escape for mankind today: the acceptance of technological civilization as a means and not as an end, and--since we cannot be saved either by the destruction of civilization or by its continuation--the development of the ability to reshape that civilization without annihilating it."

There are actually five interdependent revolutions, according to Revel, that must occur simultaneously or not at all: political, social, technological and scientific, a revolution in culture, values and standards, and a revolution in international and interracial relations. Revel defines the "hot" issues in America today (1971) as:

- a radically new approach to moral values
- the black revolt
- the feminist attack on masculine domination
- the rejection by young people of exclusively economic and technical social goals
- the general adoption of noncoercive methods in education
- the acceptance of the guilt for poverty
- the growing demand for equality
- the rejection of an authoritarian culture
- the rejection of the spread of American power abroad
- a determination that the natural environment is more important than commercial profit

Though Revel's book is now eight years old, and though the public intensity of American dissent is now subdued, no one can doubt that he has correctly identified the main directions of our national shifts. The common theme that unites many of the changes that we have experienced is "the rejection of a society dominated exclusively by economic considerations, ruled by a spirit of competition, and subjected to the mutual aggressiveness of its members." There is a conviction among us "that man has become the tool of his tools and that he must once more become an end and a value in himself."

Remember that this author is not proclaiming that the U.S. has already been transformed into a futuristic, ideal state where the national military interest is submerged, the environment is protected, and free and equal citizens live in harmony with nature and with each other. He has identified a minority position, the counterculture, and described its essential character.

It is my conviction that, on balance, the family practice movement has more in common with this counterculture than it does with the dominant scientific medical establishment. Maybe we never intended that it should be this way, and I doubt that many of us have an image of ourselves as revolutionaries. Most of us deal, on a day-to-day basis, with a much smaller quantum of reality; and, in truth, are much more motivated by purely personal goals than the heady stuff of national purpose. I suspect that that is the way all revolutions look from the inside. But let's look at the bigger picture for a moment. What are the essences of our discipline? What are we trying to do and where do we run into trouble that is not merely idiosyncratic? What are our generic problems?

First, we have a different perspective on science. Even the most politically and philosophically unsophisticated family physician will maintain stoutly that there is more to medicine than science. There is also something called the art. Often this contention comes off sounding pretty weak and lame. It is easy to get ourselves boxed in and open to the criticism that we are merely ignorant, obscurantist, and even anti-intellectual. One comment that I've en-

countered from a "real scientist" is that family practice is "romantic revisionism," a kind of sentimental attachment to the past that has no relevance to the present or future. I was told recently by a former patient of the late Dr. Tinsley Harrison: "He said, 'Never! Never! Never! allow yourself to be treated by a general practitioner.'"

At our best, though, after we have admitted our ignorance, we still have limited confidence in science. We simply do not believe that all health problems have technological solutions. Perhaps that is the essence of our difference. We believe different things about science and its power. Science is not only a method for deriving quantitative data from carefully controlled experiments, it is also a faith--that nature is orderly, consistent, and ultimately rational. There is no place in science for the absurd, the demonic, and the nonrational. Neither is there any place for benevolence, devotion, nor loyalty. Science knows neither good nor evil, and cannot comprehend uncaused effects, genuine novelty, hope, or even real surprise. Science is tautology, predictability, and mathematical equivalence. But all these nonscientific things are a part of human experience, even the experience of scientists. Hilary Putnam, a philosopher of science, has written that there are elements of human experience for which molecular biology is simply irrelevant. Human illness and suffering happen to the entire organism, the self that laughs and cries, and science is applicable to only a part of the self. It is not unscientific to assert this, but it is an affront to the belief in Science.

Family physicians have no unconditional faith in science, and this marks us as belonging to the counterculture.

Second, we have a different perspective on disease and death. Put in its most repugnant form of expression, we do not believe that death is the worst enemy. Kierkegaard probably said it best: "When death is the greatest danger, one hopes for life; but when one becomes acquainted with an even more dreadful danger, one hopes for death. So when the danger is so great that death has become one's hope, despair is the disconsolateness of not being able to die."[4]

For more than a hundred years medical science has been conducting a passionate, spectacular, and costly crusade against death, the most constant reminder of the ultimate impotence of Science. In this crusade, family medicine represents a heretical apostasy, for it does not share with the rest of medicine an unquestioned loyalty to the twin deities, Rationality and Power. The family physician is a proselyte in the temple of Science, a convert from the paganism that has its roots in superstition and magic. He or she knows the terror of human suffering and the limits of Rationality and Power when life comes to its end. He or she also worships at other altars the goddesses of Love, Mercy, Hope, and Reconciliation--deities long cast aside by Science. In our modern temples of healing, controlled so pervasively by the descendants of Aesculapius, those who cast adoring glances at Hygeia are faithless idolaters.

At the deepest level, family medicine is concerned more with life than with death. This is not meant to be a fatuous comment. For prescientific man *life* was the obvious reality, and death was the exception--the intruder. When science began to unravel some of the mysteries of life, it became preoccupied with matter, ie, with protoplasm stripped of all the features of life. Hans Jones commented that then, "Death is the natural thing, life the problem. This means that the lifeless has become the knowable. . .and is for that reason also considered the true and only foundation of reality."[5]

We know that this is not true; the foundation of *human* reality is not mere protoplasm, the stuff that modern medicine knows so well; it is *sentience* and *language* and *meaning* and *other beings* that distinguish human reality. Protoplasm is a *substrate* for them, not their ultimate reality. When these are absent death has occurred--no matter that the protoplasm can be maintained by great and wonderful machines. This is not an apologetic for euthanasia or for life after death; it is an assertion about the nature of the *Self*, that dimension of the human organism that so much of modern medicine, in its tunnel-visioned preoccupation with the tiniest fragments of matter, knows so little about.

The reason for my laboring this point is that the uncritical commitment to more and more technology in medicine, all of which is for the purpose of making a lesion visible, has blinded our perception of any other "disease." This approach has become anti-Hippocratic, ie, nonecological, violent, and even unnatural. Hippocrates understood man as a part of nature, attempted to observe her in the natural setting and was gentle.

In trying to escape the undisciplined empiricism and outright quackery of most of the 19th century, in seeking to purify the profession and to establish an orthodoxy based on the natural sciences, and in committing itself to an unquestioning faith in a reductionistic hypothesis about the human organism, modern medicine has traveled the well-known primrose path to seduction by a charming and fascinating but dishonorable lover, namely a mechanistic and flawed concept of disease. Since the days of Virchow, medicine has committed its whole heart to the belief that diseases are fundamentally protoplasmic in nature, and that if we could only understand the molecule, we could not only conquer disease, but even death itself. Like a garishly glittering and fascinating but increasingly obscene sideshow, medicine has become obsessed with its technological legerdemain in the past century. We do our tricks automatically and passionlessly without noticing that the faces in the crowd show less astonishment than fear, less amazement than disgust, less pleasure than anger.

Along the way there have been some brilliant and gratifying successes using the man-as-a-machine model of research. But now we are finding that our single-minded commitment to this ideology has produced a monster--a monster that has at least as much power to harm as to help and that threatens to bankrupt us if we continue to worship it.

Medicine has not noticed that the tides of its intellectual fortune have gone out in the past 75 years. Now we are grounded on a shoal and we are alone, because in the euphoria of our halcyon days we are guilty of overweening pride--what the theologians call *hubris*. Modern medicine has no philosophy of science or mind; no anthropology, no concept of history, no ethics--*only power*.

In comparison with physics we are in a pre-Einsteinian phase of existence. We still worship Newton. Physics was forced to deal with the dilemmas of determinism 60 years ago. In medicine it is not discussable even today. Physics also had to deal with the demonic aspects of its technology and power at the time of Hiroshima. Medicine still worships the power itself.

Whatever the merits of my understanding of the dilemma of faith, it seems clear that the family practice movement is onto something bigger than itself. Our quantitative successes over the past decade are evidence of that--but it would be the most shameless arrogance for us to suppose that our success is somehow due to our own cleverness--either political or intellectual. Rather, it seems to me to have had a certain serendipitous quality. We have found ourselves responding to challenges and opportunities which we did not create, but which just seemed to be there.

We have said more than we knew. Amidst the endless fights, games, and debates of the past decade we have heard ourselves speak a new language. We have become so accustomed to the new words that sometimes we think we know what they mean--words like care, wholeness, person, sensitivity, responsibility, continuity, and comprehensiveness. We have glimpsed a new vision of what medical care can and ought to be--and we have turned toward it, but as every mountain climber knows, the big ones have false summits which must be passed in order to scale the real top. We've all had our clear days when we could see forever, but then the clouds swirled in and obscured the higher elevations.

We've had to settle for less than we had hoped for. We hoped for everyone to have access to a personal physician --we've discovered that not everyone wants or can utilize a personal physician properly. We hoped to produce compassionate physicians--we've had to settle for producing less cynical ones. We hoped to teach continuity care but found that there was little time in which to do it. We wanted to educate the patients but found that we ourselves lacked the education to do it. We wanted to integrate the art and the science but seemed always to have to choose one or the other. Perhaps our unfulfilled hopes are less remarkable than that we hoped at all.

I have no unconditional optimism about the capacity of our medical schools to produce enough family physicians for the nation within the next 20 years. We have a good beginning, but our future success depends on a number of factors over which we have no control. My hope is that we can find leaders who are willing to rethink the priorities of medical education on the basis of the medical needs of the public rather than on the basis of preserving the professional self-interest of organized medicine. We have told ourselves and the public that we are committed to excellence in medicine. I hope we can take an honest look at what that really means. Surely it means more than technical competence, and at the very least it means providing enough physicians who are willing to serve all the people for the majority of their medical needs in settings that are as close to the people as possible. Family practice is dedicated to this goal. What could be better than that?

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Family medicine needed a broader and deeper basis of social support and legitimacy for its development than mere professionalism. The resurrection and rehabilitation of general practice were never sufficient reasons for its special claims for public money, for legislative and administrative support, to aid its transformation into the twentieth medical specialty, family practice. The Millis Commission, in particular, did not identify traditional general practice as the nation's best hope for curing the ills of its medical care system. Millis wrote that general practice failed in the U.S. because it never succeeded in becoming institutionalized within the medical care system, and he called for a new kind of physician, the primary physician, whose roles he likened to quarterbacks, captains, and senior partners.

How did it happen, then, that general practice, a.k.a. family practice and family medicine, became a conspicuous voice for reform in medical education and practice, and either assumed or was given the responsibility for alleviating the doctor shortage, correcting the maldistribution of physicians geographically and by specialty, taking on the lion's share of primary care, repersonalizing medical care, enhancing distributive justice in medical services, and, in some way, controlling costs through patient advocacy, patient education, and preventive medicine at the level of the individual and the family?

Among all medical specialties, before and after 1969, only pediatrics, psychiatry, and family medicine have made similar *social* claims on the nation's resources for a place in the sun, and neither of the others was invested with the same pervasive hopes for change in the medical care system as was family medicine. It might be argued that these hopes and responsibilities were not assigned to family medicine, certainly not by organized medicine or the medical education establishment, but even so, their assumption is all the more remarkable.

It came about perhaps more by default than virtue, because family physicians, accustomed to being "outsiders," were willing to take on, in a self-conscious way, the reform spirit of the 1960s and to identify themselves with issues that have deep roots in American history: the preservation of rural life, humane values, consumerism, and the rights of women. The preceding article represents one person's attempt to make such connections. It did not assume that family physicians were unanimous about their role as reformers, or that other physicians were not also committed to change; but it recognized that those who take change seriously will find themselves often in an adversarial relationship with the powers that be. The term "counterculture" might have been too strong, too provocative, or even too trendy, but it expressed a felt reality among many who chose to join family medicine.

Nothing has happened in the decade just past to obviate the continuing need for reform, or to make our original commitment to it regrettable. The doctor shortage was

short-lived, but the maldistributions remain. Rural communities are medically underserved, and the numbers of people who lack access to ordinary medical care have increased. The industrialization of medicine has further attenuated the personal relationships between physicians and patients. Women have entered medicine in increasing numbers, but their roles, status, and pay have not kept pace with men's. Consumerism has gained strength, largely through the adversarial system of litigation, which is a far cry from informed patients making intelligent, collaborative decisions with their physicians about their medical care. There is still no reliable, stable "front door" to the medical care system staffed by quarterbacks, captains, or senior partners.

Our chief regret can only be that we were not able for our tasks. We have expended our energy on professional legitimation and enfranchisement rather than reform. In Paul Starr's words, we have sought freedom from our work rather than freedom in the work. We need to perpetuate the reform ethos, to expand our numbers, to join with other primary care physicians and other specialists in working for some sort of national health program that will give equal access to everybody, regardless of ability to pay.

There is no intrinsic virtue in standing in a countercultural relationship to mainstream medicine, but it is only as the inequities are healed that we can rejoin the mainstream as full-fledged members.

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