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THE EMERGENCE OF FAMILY PRACTICE
A SOCIOLOGICAL PERSPECTIVE

by

Irene L. Arroyo

DISSERTATION

Submitted in partial satisfaction of the requirements for the degree of

DOCTOR OF PHILOSOPHY

in

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of the

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To Frank

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I am indebted to my husband who uncomplainingly became engulfed by mounds of papers and by dissertation mania. Having no level surface to call his own, he truly gave new meaning to the word "adaptation."

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ABSTRACT

This study examines the general process of specialization and the specific case of family practice as a specialty. Medical specialization is described as an interactive process between general social movements in society and specific social movements within the medical profession. This study views the emergence of family practice as a complex social, political, and segmentation process which culminated as part of an interlocking social movement labeled by a time frame called the sixties. Family practice is identified as an emergent segment arising from within general practice. This segment is considered essential to the emergence of family practice.

Within the study, various theories of specialization are critiqued. In addition, a great deal of historical data is presented, revealing how certain characteristic features of the medical profession have evolved from certain historical conditions. One such historical condition, the 1960s, is examined in detail.

A wide range of research methods was used to accomplish this study, including historical and contemporaneous readings, field observations, and in-depth interviews.

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INTRODUCTION

This thesis seeks to explain the emergence of family practice as a medical specialty in 1969. Sociological literature contains various explanations of the emergence of specialties in medicine. For example, the functionalist approach emphasizes differentiation and specialization based on functional specificity.[1] Specialization based on function has been elaborated in the sociology of organizations[2] as well as in human ecology.[3] When applied to the emergence of medical specialization, functionalism stresses different functions performed by different role occupants.[4]

The political economy perspective combines aspects of conflict theory with theories that focus on the marketplace.[5] Its chief contribution is to focus attention on economic determinants of social behavior. The political economist looks at specialization as emerging from conflicts between various interest groups and attempts to monopolize the market.[6] Vested interests give rise to an unequal distribution of services based on patients' race, class, geographic location, and income.[7] Dubos and Illich raise questions about the actual benefits of medical care.[8]

Freidson and Berlant represent yet another approach which emphasizes professional dominance and autonomy of the medical profession.[9] They have examined how the medical profession established its power and continues to wield power for its own ends. The continual quest for power and

autonomy propels specialties to carve out their own domains so that no other specialty can evaluate or regulate it.

Finally, Bucher and Strauss represent the symbolic interactionist perspective. In their model, Bucher and Strauss draw attention to the constant movement and change occurring within professions. Medical specialization is defined and analyzed as a social process and is viewed as a social movement within the profession.[10]

It is this process model which stimulated my study of the emergence of family practice as a specialty. What appears missing from the Bucher and Strauss model is the value shifts in the larger society as a contributing factor to the emergence of segments or specialties. The process model tends to see the emergence of a medical specialty as internal to the institution of medicine. This thesis will expand Bucher and Strauss's model of the emergence of a medical specialty as a social movement by looking at the cultural milieu in which the movement takes place.

In this thesis, I argue that it is not coincidence that family practice was designated as a specialty in the year 1969. The problems in health care that received attention, if not notoriety, in the 1960s were not new problems; on the contrary, the need for primary care and the concern over costs of care had been raised by the Committee on the Costs of Medical Care over forty years earlier. What was different was the intersection of

various conditions in the 1960s that were not present in the 1930s.

There was a shift in thinking in the 1960s which emphasized "power to the people." Other movements included the self-care health movement, the women's movement, the antiwar movement, and the civil rights movement. In many ways, expertise and authority were challenged in this antiestablishment geist.

Another shift in thinking contributed to the emergence of family practice. Systems theory became popular in many disciplines in the 1960s and the 1970s.[11] Systems theory was applied in a variety of fields, including nursing, social work, psychiatry, public health, education, and economics.[12] Scholars began looking at the family as a system of interacting parts. Family medicine was seen as the specialty which would bring this view to medical practice.[13]

Family practice became the locus within medicine that espoused the ideals of health care delivery for all people, independent of race, income, and prestige. Family practice became known as the specialty that would rectify socio-medical injustices and would rehumanize medical care. It was also used by the medical establishment as a public relations foil to counter the prevailing attack on medicine. Medicine was accused by its critics as having become overmedicalized, overspecialized, and fragmented.[14] Doctors were accused of treating illness and disease rather

than the person,[15] thus dehumanizing the patient.[16] Family practice emphasized the whole person.[17] Family practice became the hope of many young medical students as the specialty that would bring human compassion to medicine. Young doctors who went into family practice did so to "save the people." This sentiment was repeatedly expressed in personal interviews with family practice residents.

In addition to its humanistic ideology, family practice was viewed by the government as the specialty that would help resolve the "crisis" in medical care delivery. President Nixon made the official pronouncement of the health care crisis in a press conference in July, 1969.[18] As a consequence, the government poured millions of dollars into medical education in the form of scholarships, residency programs, and other stipends earmarked for family practice.[19] Because of the combined effects of ideology and new federal support, family practice attracted minorities, women, and poorer students. Even admission standards were altered to accommodate these new students.

Family practice was also seen as the solution to yet another problem. The cost of medical services had skyrocketed. Government officials were alarmed by high expenditures in health care. Increased cost for services, coupled with inflation and increased government responsibility for payment with the advent of Medicaid and Medicare, were causes for concern at all levels of government: county, state, and federal. Too much duplication of

services, over-utilization of specialists, and other inefficiencies required cost containment measures. If the medical profession did not provide a solution to these increasing costs, there was a threat government might intervene. To avoid this situation, the medical profession offered family medicine as a solution.

In sum, this thesis will focus on the relevance of social-historical context in examining specialization processes within a profession. By looking at the specific case of family practice, one can study the complex interactions between "biography, history and society."[20] By examining the social movements within the 1960s, one can better understand the simultaneous parallel movements within the medical profession.

It is the central thesis of this paper that the creation of family practice as a medical specialty was a segmentation process embedded in an interlocking social movement, a time called the sixties. It is argued that the ideology of the 1960s, which emphasized equality, open access to institutions, and larger social concerns, presented fertile conditions for the emergence of family practice.

CHAPTER ONE

THEORIES OF SPECIALIZATION: A REVIEW OF THE LITERATURE

Sociology has much to contribute to our understanding of the emergence of medical specialization, especially in terms of illuminating milieux, social worlds, and the historical context for the emergence of that specialization. The exploration of the emergence of family practice as a medical specialty is a case study in the process of specialization. In order to understand the particular case of family practice, it is necessary to have an understanding of the process of specialization in general.

Specialization has been a subject of interest to a great many scholars. Specialization is a common feature in our everyday lives and involves complex social, economic, and political processes. Within the field of sociology, there are basically four prevailing explanations of specialization: the developmental, evolutionary model; the structural functionalist approach; the political economy approach; and the process model. Each of these explanations is guided by a different theoretical perspective.

This chapter will examine each of these approaches, revealing the theoretical assumptions underlying each perspective. This process of analysis has informed this research, providing the conceptual tools to construct a theoretical perspective. This thesis will seek to

synthesize these various approaches into an integrated explanation which will better illuminate the empirical case of the emergence of family practice in the 1960s.

The Phenomenon of Specialization

Specialization in modern life is a phenomenon taken for granted. It is difficult to imagine any line of activity in which specialization does not occur to some degree.

The notion is reinforced in the biological sciences (even man's thumb has specialized status representing a major evolutionary development), in the physical sciences (the solar system), and in the anthropological and sociological sciences (the division of labor). Specialization permeates everyday life.

Medical specialization has been a taken-for-granted feature in the field of sociology as well. It has been more a theme than a subject--assumed to be real, alluded to or referred to, but rarely the specific subject of inquiry. This study proposes to make problematic the seemingly unproblematic: the phenomenon of medical specialization itself.

Specialization is commonly associated with complexity, existing in a cause-effect relationship. From this viewpoint, increased complexity demands increased specialization. Yet, anthropological evidence could suggest otherwise. There are numerous examples of specialization in primitive tribes which differentiate between medical

practitioners. Just how the medical specialist is differentiated depends on the concept of etiology and pathology of disease.[1] In northeastern New Guinea, there are different specialists who treat abdominal pain, chest pain, or rheumatism. Or, as on Dobu Island off eastern New Guinea, different persons or families may own different powers effective on different ailments.[2] There are specialized shamans in western North America, each distinguished by treating either rattlesnake bites, horse injuries, or arrow wounds.[3] In Africa, there are types of medicine men who treat only one type of complaint.[4]

Nor is medical specialization a practice characteristic only of modern times. Recorded evidence of specialization dates back to antiquity. Herodotus describes the organization of medicine in ancient Egypt as a

> plan of separation; each physician treats a single disorder and no more; thus the country swarms with medical practitioners, some undertaking to cure diseases of the eye, others of the teeth, others of the head, others of the intestines, and some of those which are invisible [internal].[5]

Specialization in Modern Life: The Sociology of Occupations and Professions

Sociologists have long examined the profession as a key feature of specialization in society. Herbert Spencer poetically wrote of professions as "augmenting" life.[6] Emile Durkheim referred to all occupations as professions. He analyzed professions in terms of groups who establish

their own sets of rules and sanctions. He viewed professional groups as the "organs of society."[7] Toennies, Park, Weber, and Simmel all wrote on occupations which were based on the application of science and reason. In Great Britain, Carr-Saunders and Wilson described characteristics of professions.[8] T. H. Marshall highlighted the trends of professionalism within industrialized societies.[9] Marshall observed that more professions were developing and that society was becoming increasingly dependent on professions. In turn, more professions were working within complex organizations.

Interest in professionalism increased in the early 1940s. Sociologists Everett Hughes generated much of the study and theory of occupations and professions.[10] Hughes states that he "dwelt on the professional conception because it is so highly valued in the western world."[11] The surge of sociological interest was also due to the American idea of the right to the services professions were supposed to provide, namely, health, education, and legal representation. Also, and consequently, the distribution of those services became more and more complex.[12]

Many sociologists analyzed medicine as the prototype of professions. Initially, much of the work on professions in the United States was devoted to prestige scales derived from opinion surveys. In addition, a great deal of research was directed toward identifying characteristics or

attributes which distinguished professions from occupations.

There were predominant themes generated by researchers which were identified as characterizing professions.[13] Professions were identified as possessing specialized skills based upon a body of abstract knowledge and systematic theory; therefore, professions justified prolonged specialized training as necessary. Professions provided a service to others and were sanctioned by the community.[14] Professions were motivated by a deep sense of commitment and a service orientation; indeed, professions were sometimes idealized as "callings."

Most writers identified formal occupational organization as characteristic of professions. Furthermore, professions were distinguished by autonomy.[15] A profession determined the definition and organization of its work, setting its own policies and standards of practice. A profession had the power and authority to license, recruit, train, regulate, and enforce norms. Professions had a distinct code of ethics covering a wide range of relationships.

Moreover, professions also claimed a moral, legal, and intellectual mandate. "Every profession considers itself the proper body to set the terms in which some aspect of society, life or nature is to be thought of and to define the general lines or details of public policy concerning it."[16]

Not only was a profession autonomous as a collectivity, but members within the profession were granted a high degree of autonomy. The individual practitioner was seen as competent to determine what was best for the client. Only those properly schooled in the knowledge and skill of the profession were considered to be competent to judge, and those criticisms were most often made privately rather than publicly.

A final theme prevalent in the literature was that members within a profession shared a general sense of community. There was a sense of common identity among the members. This sense of community extended to aspects of a member's non-work life as well. Hughes emphasized that a profession represented both a culture and a technique.[17]

The trend toward medical specialization over the past fifty years has been given considerable attention. The occurrence of specialization has primarily been explained in terms of the complexity of knowledge. The logic of the explanation was constructed as follows: The vastness of medical knowledge has made it quite impossible for one person to know everything in the field.[18] Although students are trained to tolerate some degree of uncertainty,[19] training for control is more the focus of professional education.[20] One way of minimizing uncertainty is to specialize. Thus, the growth of knowledge is seen as the key factor leading medical students to specialization.[21] Following this line of

reasoning, a great deal of research on medical specialization focused on the participants themselves, examining such aspects as when the decision to specialize was made and on what basis.[22]

Another primary area of research has involved the informal organization of medicine, generating such concepts as sponsorship, referral, exclusion, and group acceptance.[23] The formal organization of medicine also has been the focus of a great many scholars. The official organization, the American Medical Association, has been the political arm of medicine. Its formal structure reinforces the informal mechanisms of the profession.[24]

Numerous studies have focused on the process of becoming a physician. Studies in this area involved a wide range of interests. Socialization in professional schools has been the subject of inquiry in several studies. These studies showed how one's conception of self-as-professional developed and how and to what extent one learned and incorporated the knowledge, skill, and perspectives of a profession.[25]

The Student Physician[26] and Boys in White[27] are two classics in the literature of socialization in professional schools. Although both studies focused on medical students, the two studies represent critical differences in interpretations of the socialization process. The Student Physician was developed from a functionalist point of view; Boys in White explored socialization from a symbolic

interactionist perspective. The Student Physician rendered a picture of the student moving incrementally from a junior colleague to a full professional. During the course of his training, the student acquired the necessary knowledge, skills, values, and attitudes. On the other hand, Boys in White concluded that the system of education did not permit students to take on the full professional role.

Samuel Bloom identified several areas of conflicting interpretations between the studies.[28] He contended that the status attributed to the medical student differed in the two studies. The Student Physician described the student as a junior colleague, more or less an equal to the faculty; Boys in White depicted the student as subordinate to the faculty, continually in need of proving himself.

A second area of controversy identified by Bloom involved the effects of medical school on the student's attitudes and values. The Student Physician argued that the effects of medical school led to a gradual and cumulative professional maturation. Boys in White reported important shifts in student values during medical school: a gradual change going from idealism to cynicism to a more informed and realistic idealism.

A third issue of controversy which Bloom identified involved the relationship between the medical school and the medical profession. The Student Physician viewed medical school as providing the student with a nearly complete set of competencies. The student, having

completed training, was seen as wholly prepared for full participation in the profession. In contrast, Boys in White identified medical school as only part of the professional process. Medical school was seen as providing only a minimum level of competence for entry into the profession once training was completed. Such differences in the findings of the two studies demonstrate the importance of theoretical perspective in research.

Although the studies referred to thus far are informed by diverse theoretical perspectives, revealing differing dimensions and arriving at varying conclusions, they do share a common premise. It is striking that these studies treated specialization itself as a given--a product of a complex, ever-increasing body of knowledge and advancing technology. Specialization has been assumed as necessary in order to master vast amounts of information or in order to improve organization of services. The need for and the occurrence of specialization was not critically analyzed. In fact, relatively few studies have dealt specifically with how medical specialties have come to be.

Specialization in the Sociology of Science

Within the sociology of science, sociologists studied the development and growth of scientific knowledge, traditionally focusing on social organization or on the knowledge itself. Merton formulated models for studying science as a social institution. Merton and Sorokin looked

at cognitive structures and their corresponding social structures.[29]

Studies also examined "indicators" of system stratification, formal and informal communication patterns, and lines of conflict. Cole and Zuckerman identified indicators of the emergence of a scientific specialty. They examined the importance of communication networks in developing a specialty.[30] In fact, Mullins asserted that communication, not content, was the chief factor in specialty development.[31] Derek Price linked communication patterns with manpower growth and scientific investigators, pointing to the informal network of investigators as the core of any specialty.[32]

Studies also have focused on the social and existential basis of knowledge itself, how it grows, becomes codified and institutionalized. Merton studied science and invention.[33] Ogburn and Thomas looked at the role of culture in the creation of technological innovations and inventions.[34] Invention and discovery caused a network of effects. Ogburn's "cultural lag" theory described how aspects of culture trailed behind the technological, material cultural changes.[35]

Thomas Kuhn explored the notion of consensus in science, examining the relationship between science, facts, and research. He contended that scientific paradigms were not the product of evolution, but a process of revolution within a field: a process of recruitment, conflict, and

social dominance challenges prevailing or dominant scientific theories.[36]

Kuhn revealed the significance of theoretical perspective in his work on "scientific revolutions." Kuhn demonstrated how major scientific "discoveries" led to the recasting of previous work. This recasting rendered a linear historical picture of scientific development which did not reflect the sociopolitical dimensions of scientific development.[37] Kuhn asserted that the process through which ideas change and develop could only be understood through sociological analysis.[38]

Theoretical Perspectives

Any sociological study of specialization is informed and guided by the researcher's theoretical perspective. Based on differing perspectives, four predominant explanations of specialization occur in sociological literature. The first is a developmental, evolutionary model, what Robert Nisbet calls "the natural growth metaphor"[39] and Freidson calls "technological determinism."[40] The second explanation is a structural functionalist approach. The third explanation is based on a political economy perspective. The fourth explanation, the process model, is based on the symbolic interactionist perspective.[41]

The Evolutionary Model

The evolutionary model points to the increase in medical knowledge as stimulating specialization.[42] As

scientific knowledge and technology expands and becomes increasingly complex, specialization necessarily occurs. From this viewpoint, specialization is seen as a natural and inevitable result of scientific progress.

Often studies dealing with specialization begin with the evolutionary premise: that the growth of scientific knowledge resulted in a corresponding growth in specialization.[43] This premise is simply asserted with no attempt--or perceived need that such an attempt is necessary--to justify or prove the validity of such a supposition.

The acceptance of this view permeates much of our current thinking. This taken-for-granted link between increased knowledge and specialization can lead us to believe that specialization occurs as if by itself, as part of a natural process. This outlook legitimates, reinforces, and stimulates further specialization. This idea of evolutionary progress is embedded in Western thought in general.[44]

This evolutionary vision, the idea of a movement from the simple to the complex, was a nineteenth century notion advocated by Darwin. Herbert Spencer, in Principles of Sociology,[45] applied Darwinian theory to society. Spencer contended that society changes from an undifferentiated, homogeneous condition to a differentiated, heterogeneous condition. For example, Spencer pointed out that medieval feudal society had been continuously bombarded by forces

(such as population growth and the introduction of European trade products and trade routes) which had a multiplication of effects. This multiplication of effects, which Spencer described as forces bombarding matter with pieces flying off in all directions, led to further differentiation. This differentiation led to a selecting-out of common aggregates (based on their similarity of response to the persistence of forces). These aggregates formed a differentiation of categories, held together by a division of labor. These aggregates, in turn, formed a new equilibrium.

Spencer is also the early forerunner of the second predominant perspective in explaining the occurrence of specialization: the functionalist, organicist viewpoint.

The Functionalist Model

Functionalism analyzes social phenomena in terms of the function they perform. Functionalism is based on an organic model. In this model, principles of natural systems are applied to society.[46] Society is conceived of as a system of interrelated parts working together in a normal, healthy state of equilibrium. The central proposition is that the system will always strive to maintain (or restore) its equilibrium. Social action and social systems adapt to and fulfill functions for social requirements or requisites.[47]

This perspective begins with how things are and how elements function to maintain that social order. Equilibrium and social harmony are the underlying values.

Conceptual-theoretical roots of structural functionalism are found in Comte, Spencer,[48] Pareto, Durkheim,[49] Radcliffe-Brown, and Malinowski.[50] Auguste Comte's work was replete with comparisons between social and biological organisms and systems. Spencer developed the notion of differentiation (which is an important aspect of modern functionalism). Vilfredo Pareto based his system of sociology on a physiochemical system rather than on a biological system, identifying the "molecules" of a social system as individuals. Pareto developed the idea of a dynamic or moving equilibrium, an idea which Parsons borrows.[51]

Durkheim focused on the concept of integration of specialized parts. Although Durkheim's functionalism was not reductionistic, as was Spencer's, he did seek to examine the "function" of the division of labor in The Division of Labor in Society. In The Elementary Forms of Religious Life,[52] he sought to demonstrate how religion was an integrative force (its function) through its instilling of common values.

In The Division of Labor in Society, Durkheim stated that order in society is maintained by consensus. But the source of consensus changed as society became more complex. Hence, mechanical solidarity was distinguished from organic

solidarity. Mechanical solidarity referred to the primitive, preindustrial type of societies. Mechanical solidarity was characterized by an unquestioned belief in the nature of things. There was a consensus of opinion. This common world view was what Durkheim referred to as the "collective conscience," a consensus based on similarities between people. The division of labor was a natural division, based on the collective conscience. The division of labor was simple, lacking complex industrial organization.

Organic solidarity was contrasted with mechanical solidarity. Whereas mechanical solidarity was analogous to a machine, organic solidarity was analogous to an organism consisting of a whole set of theoretically unrelated parts which work together to define the organism.

According to Durkheim, the division of labor developed historically. Organic solidarity was characterized by a highly specialized differentiated division of labor. But these groups were forced to work together cooperatively by virtue of their interdependence, benefiting society as a whole. Organic solidarity was a result of consensus based upon differences rather than similarities. For Durkheim, the development of the division of labor caused mechanical to become organic historically.

Bronislaw Malinowski and Arthur Radcliffe-Brown were two anthropologists who applied Durkheim's functional analysis. In fact, Malinowski was the first person to use

the term "functional" to describe this analytical perspective.[53] Yet, Malinowski and Radcliffe-Brown differed in what they viewed as the basis of social integration. Malinowski believed societies fulfilled psychological needs and functions; Radcliffe-Brown believed social institutions fulfilled functions essential to maintaining a social system.[54]

These explanations illustrate how various functionalists have differed in what they regard as the primary source of integration within society. But the shared commonality among functionalists is the focus on the integration of various parts of a social system. In analyzing social phenomena, a structural functionalist seeks to account for the cohesiveness of the whole; his task is to identify the various parts or "determinants" of a social structure; his primary objective is to demonstrate how these "mechanisms" preserve and maintain the social structure. Hence, functionalism has been called a "sociology of social order."[55]

Thus, when analyzing professions, the functionalist will tend to focus on the cohesive aspects of a profession. Members within a professional organization are seen as sharing common identity, values, definitions, interests, and beliefs. Members are bonded by their common community and guided by mutually agreed upon norms and codes. This is not to say that variation and conflict are totally rejected conceptually or that a functionalist is

simpleminded. The point being made is that, given a functionalist perspective, conflict and change is not a primary focus. As Pierre L. van den Berghe writes:

> Although integration is never perfect, social systems are fundamentally in a state of dynamic equilibrium, i.e. adjustive responses to outside changes tend to minimize the final amount of changes within the system. The dominant tendency is thus towards stability and inertia. . . . Dysfunctions, tensions and 'deviance' do exist and can persist for a long time, but they tend to restore themselves or to be 'institutionalized' in the long run.[56]

Within a functionalist framework, people are analyzed in terms of roles and status. The division of labor is governed by norms and entails differentiation of positions and duties. Each position, and its correlative role, is ranked into a hierarchy of roles. This complex array of roles and status defines behavior and relationships constituting social organization.[57] Values legitimate the social structure.[58] Differentiation is seen as the result of organizational requirements and necessary in dealing with large groups of people, things, functions, and relationships.[59] Stratification is seen as inevitable and necessary to the preservation of society. Stratification is thought of as "structures consisting of roles."[60]

Talcott Parsons is the theorist who is most frequently associated with the structural functionalist approach. It is Parsons who formalized the structural functionalist perspective, especially in The Social System.[61] For Parsons, function was held paramount, over and above

structure or process. Function is concerned with consequences of structures and processes within social systems.[62]

Structural functionalism, as defined by Parsons, is a methodological and theoretical framework for the analysis of social phenomena in terms of both the structure of the society and the functional relation of its parts.[63] Such a conception is actually based on the "organic" system model of the biological sciences; however, the "organicism" is replaced by the "system."[64] Society is conçeived of as a system of interrelated parts. Each part is mutually interdependent; a perturbation to one part of the system affects all parts of the system. And, as in the organic system, society is thought to be in a healthy state of equilibrium or homeostasis. When an imbalance occurs (i.e., a perturbation, a change) at one level of the system, all the parts of the system reorganize in order to restore the equilibrium of the whole.

Parsons's functionalist perspective is called "structural functionalism" because of its focus on the structural aspects of society. Structural functionalism focuses on the functional "needs" that must be met if a system is to survive. Based on this view, that social systems perform tasks necessary for their survival, sociological analysis therefore involves identifying and examining those social structures that perform those tasks.[65]

In Parsons's model, social needs are met by specialized institutions. Parsons contends that institutions maintain their equilibrium by fulfilling "needs" (AGIL: adaption, goal attainment, integration, latent pattern maintenance) and solving problems which recur. The process of socialization, internalization of values, and social control maintains this equilibrium.[66]

Increasing differentiation is critical to the evolution of social systems. Differentiation of roles is essential to technological development. Social stratification evolves from an increase in differentiation.[67] Parsons argues that in a complex industrial society, stratification is inevitable, necessary, and desirable to keep the system functioning smoothly. Stratification is a functioning mechanism which occurs because there is a necessary division of labor which must be rewarded differentially in order to induce members to perform the duties of their position.[68] Specialization is viewed as a more efficient, rational utilization of society's talents, which contributes to the ultimate success of the society as a whole.

Much of the early sociology of work in the 1950s and 1960s followed in the evolutionary, functionalist tradition. Specialization was not made problematic; it was assumed. Sociologists focused their attention on identifying characteristics that distinguished professions from other occupations.[69] William Goode's work epitomizes

such an approach. He identifies two primary attributes--special knowledge and a service orientation--as the determining variables in a profession.[70] According to Goode, differentiation and stratification in work roles are products of special knowledge. The service orientation of professionals sustains a relationship of interdependence between these work roles. Members share common identity, values, and role definition.[71] Behavior is guided by common norms, creating a professional culture.[72]

George Rosen's analysis of specialization represents the evolution of knowledge perspective embedded in a functional theoretical framework.[73] Rosen attributes the development of specialties in general (and ophthalmology in particular) to the increasing expansion and complexity within a field of medicine. As foci of interests develop within a medical field, these develop into new or distinct fields of medicine. He calls this theory the "field concept."[74]

Rosen examines the factors giving rise to these interest areas and explores the conditions enabling interest groups to organize. But, utilizing a typical functionalist approach, he examines specialization in terms of its function within the medical profession, the values which sustain it, and the problems of professional control for the benefit of society. In the final analysis, Rosen views specialization as "a process operating to provide an

organizational structure for the satisfaction of certain human needs."[75] Rosen identifies segmentation and accretion as the two complementary processes within medicine which lead to the formation of new specialties.[76] Specialization by segmentation occurs when a developing area of interest divides into separate, independent fields. Specialization by accretion is a process by which a new specialty arises which bridges two fields of interest.

Rosen states that specialization was the result of scientific and technological development.[77] Rosen expands the concept by arguing that specialization arose not so much from an accumulation of knowledge, but, rather, from a changing conception of disease.[78] Disease began to be conceptualized as a distinct entity rather than as some vague, generalized condition. The concept of localized pathology, making possible the correlation of clinical observations and pathology, provided a scientific basis for the foci of interest in medicine.[79] The new conception of the nature of disease--that there were distinct diseases of organs or regions of the body--led to new foci of interest within the field. This, in turn, led to the expansion of knowledge and technological innovations which, in turn, resulted in the development of new foci.[80]

In analyzing the development of ophthalmology, Rosen examines the functional effects resulting from the interplay of knowledge, technology, and methodology.[81] "A technique becomes attached to a specialty . . . in

consequence of the functional importance . . . for the development of the specialty."[82]

Rosen also points to various social factors as contributing to both the hindrance and the rise of specialization. He discusses the significance of urbanization and institutions primarily in terms of their role in the development of specialism.[83] But the "operation of these factors must occupy some positive level in the hierarchy of values which makes up the general value-complex of the society."[84] Hence, Rosen proceeds to examine attitudes, but these attitudes are selected and evaluated in terms of their function as controlling forces in specialty development.[85]

Rosen demonstrates that the same forces causing opposition to specialization brought about acceptance of specialization: attitudes toward economic prosperity, social prestige, and innovation as well as public demands, moral sanctions, and public opinion varied at different points in history causing either opposition to or acceptance of specialization. For Rosen, these attitudes are evaluated as "favorable" or "antagonistic" to the development of medical specialism, again characteristic of a functionalist approach. Rosen often describes both attitudes and social factors as "forces," again a reflection of his functionalist orientation (as contrasted with conflict theorists who argue that conflict arises from within the social structure).

As Rosen sketches the development of ophthalmology, he identifies the various factors contributing to the ultimate success of ophthalmology achieving specialty distinction. Rosen's critique clearly illustrates the functionalist approach to process and conflict. Rosen seeks to uncover the underlying reason for opposition, but he examines such opposition largely in terms of its relationship to the development of specialism. The identification of the function or influence of the social factor becomes the equivalent of explaining the fact.[86]

For Rosen, the process of specialization is essentially "historical in character."[87] For the political economist, specialization is a political process.

The Political Economy Perspective

The political economy approach considers medical care as a commodity. Utilizing this approach, researchers focus on the ways in which workers organize into an occupation to establish control of the supply of and demand for their services. This perspective views specialization not as an outgrowth of knowledge, but as an outgrowth of the conflicts between groups to gain exclusive rights over selling certain commodities (i.e., performing certain skills).[88] Knowledge and technology are not seen as causal factors of specialization, but rather as valuable, self-serving resources utilized by interest groups to justify specialty status and a dominant position in the division of labor scheme.[89]

According to this perspective, specialization is a development of occupational consciousness.[90] The group advances its own interest on the basis of occupational ideologies.[91] Specialization, justified by the ideology of scientific advancement, provides an opportunity for competitive market advantage.[92]

Within this framework, conflict is viewed as a central process and power is viewed as a crucial determinant of social structure; therefore, the distribution of power and authority is a central issue. Specialized groups are analyzed in terms of power, of domination and subordination; knowledge and skill are examined in terms of distribution and monopoly.[93]

Robert Alford has described problems in the health care system as the result of power conflicts between

> professional monopolists--seeking to erect barriers to protect their control over research, teaching and care--and the corporate rationalizers--seeking to extend their control over the organization of services.[94]

It is interesting to note how Goode's earlier noted features are transformed by this perspective. Magali Sarfatti Larson, for example, contends that workers join in a group in order to organize markets for their services. "Commodity definition" is the process by which a group makes their product identifiable to the consumer. This is the fundamental step necessary for occupational organization. Once a group acquires a separate, relatively uniform

body of knowledge, then it organizes a system of training forming a cognitive base necessary for occupational organization.[95]

For the political economist, the medical profession may be viewed as an

> organized occupational group which has been granted a monopoly over the performance of certain functions (such as prescribing drugs, surgical practice, and classifying people as fit or unfit for a variety of functions) and a certain degree of autonomy in carrying them out (such as judging competency of members, setting standards[96] and controlling admission of new members).

The medical profession is a legal entity, a social and political entity, whose position of authority was not derived from technical superiority, but from political and economic influence of the elite, ruling class.[97]

The political economist typically views the hospital hierarchy as a division of classes maintained by passive alienation and the ideology of professionalism. The unskilled workers accept the class division; the skilled workers translate the service ethic into a professional ethic of institutional loyalty.[98]

Whereas the functionalist sees the advent of localized pathology as responsible for the development of specialization and progress in medical science, the political economist sees this as an ideological doctrine which camouflages the social conditions responsible for disease. The political economist identifies this conception of

disease as an ideology reflecting material interests of the groups and classes promoting the ideology. The political economists charge that the germ theory of disease removed responsibility from the economic and political environment.[99] Flexnerian medicine was "ideologically compatible with industrial capitalism's desire to depoliticize medicine."[100] Treatment focused on the biological system of the individual rather than on public health, hazardous working conditions, and other social considerations.[101] The focus on pathology structured research to reinforce the exclusion of social causality of disease.[102]

Gritzer and Arluke's analysis of the development of rehabilitation medicine exemplifies the political economy explanation of medical specialization.[103] Gritzer and Arluke challenge the evolution of knowledge and functional explanations.

Gritzer and Arluke view the division of labor as dependent on the interplay of the marketplace and history.[104] They argue that technological innovation (in this case, electrotherapeutic devices) defines a marketable commodity. Occupational specialization is a subsequent development, representing the victory of competitive struggles for control over the division of labor. A group called specialists triumphs, having won domination and monopoly of the marketplace, and having successfully seized golden opportunities provided by unique historical events.

Within the political economy perspective, knowledge and technique are resources which groups of workers use to justify a structure of occupational domination and subordination.[105] The unequal distribution of knowledge, then, presupposes an unequal ordering and ranking in the division of labor. Science is used as a rationale for economic competition.

History, too, is viewed as a resource. Groups of people take advantage of opportunities provided by historical occurrences. The authors demonstrate how events such as war provide special opportunities which an occupational group recognizes and utilizes to advance, secure, and maintain its position.[106] For instance, prior to World War I, disability was not considered a medical or social problem.[107] World War I changed that. World War II created demands for medical rehabilitative services. World War II stimulated physician training and provided occupational identities. Connections and associations continued after the war.[108] The demands for services spurred legislative action, leading to the reorganization of the Veterans Administration and extensive medical programs. The Veterans Administration provided a rich arena for empire building.[109]

In contrast to the evolution of knowledge position, Gritzer and Arluke assert that commodity definition precedes a cognitive base: "For medical specialties, the cognitive dimension develops later in the game and is the

outcome of occupational organization rather than its cause . . . "[110] The authors point to electrical devices as the organizational and ideological foundation for physical medicine and rehabilitation specialties. Electrotherapeutists were not distinguished by their knowledge, but by their technology. This technology became the identifiable commodity for the market. Gritzer and Arluke further challenge the evolutionary model by emphasizing that such technologies need not be esoteric or complex. They declare that the most important feature of technology is that it be recognizable. Thus, Gritzer and Arluke contend that technical skills, not theoretical knowledge, are the basis for medical specialization. Specialty groups develop around service commodities defined by readily recognizable technical devices. It is later, argue the authors, that claimed theoretical knowledge becomes important for securing the market for services. In order to establish specialty status, define boundaries, and attract recruits, a group will seek to obtain closure around a scientific body of knowledge and the accumulated assortment of techniques.[111] These boundaries are not a natural occurrence; they are organizationally carved out. Knowledge is used as a justification for monopoly.

The Symbolic Interactionist Perspective

Bucher and Strauss represent the symbolic interactionist perspective and focus on the process of

specialization. In this model, the emergence of medical specialties is seen as a social movement within the profession.[112] Rather than assume commonalities, Bucher and Strauss ask: "To what extent, and under what conditions, can we speak of professionals as having interests in common?"[113] In order to illustrate the process model for studying professions, Bucher and Strauss select medicine as an exemplary profession.

The process model for studying professions posits the existence of groupings or "segments."[114] These segments are grouped around certain values, interests, and identities. Segments exist even in the most established of professions.[115]

The values of one grouping may conflict with the values of another. Bucher and Strauss suggest that there may be great differences between segments regarding a sense of mission, definitions of appropriate work activities and how these activities should be carried out, methodology and techniques, relationships with clients and who these clients should be, circles of colleagueship and alliances, interests, and associations.

As coalitions develop and organize, they tend to take on the characteristics of social movements. As such, segments take on a sense of past, present, and future. They share a sense of the past. Their distinctive sense of mission orients them to the future. They develop activities and tactics which will secure an institutional

position.[116] These segments, when viewed as social movements, are the focal points of social change. Within a given profession, there may be a number of interacting social movements.

In discussing the variance between values, Bucher and Strauss demonstrate that the notion of segments is one of both organized identity and dynamic movement. Segments are not fixed and static. They continually change. Thus, Bucher and Strauss direct our attention to the constant change and movement within any given profession.

Discussion

It can be seen that each perspective has much to contribute to our understanding of the process of specialization. Each perspective renders a different angle on the study of specialization, revealing different dimensions and highlighting important distinctions.

Yet, it may also be said that each perspective provides only a partial explanation of specialization. The interactive effects of historical and social milieux on the emergence of specialization has been under-analyzed in sociology. As Everett Hughes points out, "Social unrest often shows itself precisely in questioning the prerogatives of the leading professions."[117]

Accordingly, this thesis examines the empirical case of the emergence of family practice as a specialty. The forthcoming chapters will demonstrate how the social unrest of the 1960s was a partial and necessary condition for the

emergence of family practice. This study proposes that the times in which people live and the ideas and values that are prevalent during those times constitute a condition that must be fully examined. This thesis will also demonstrate how specialization cannot be fully explained without detailing the ongoing segmentation process which occurs within any given profession.

CHAPTER TWO

THE EMERGENT FEATURES OF AMERICAN MEDICINE: AN HISTORICAL EXCURSION

It is important to historically ground the study of medical specialization in order to gain an understanding of how and why certain characteristic features in the medical profession evolved. In America, the profession of medicine did not develop with steadfast certainty. Although American medicine was unavoidably linked to European heritage, it was socially, scientifically, and organizationally distinctly American. The sprawling colonies did not have major cultural or political centers. The colonies were without universities and research centers, medical schools, professional organizations, or regulating bodies. Until 1765 and the establishment of the first American medical school at the College of Philadelphia, university medical education meant study in Europe.[1] But such study was rare; the passage to England was dangerous and expensive.

Without a centralized medical leadership or cultural center, medicine in America developed parochially. Training was obtained through apprenticeship. The apprentice paid a fee, lived with the preceptor, and provided around-the-clock services. In this way, the trainee gained patient contact and experience.[2] This domestic style of practice promoted the all-around bedside practitioner.

The general practitioner traveled in his proverbial horse and buggy, carrying his black bag filled with tablets, extracts, tinctures, and instruments.[3] Specific pathologies were unknown to the practitioner. The cause of all disease was ascribed to a few generalized conditions such as "impurities of the blood" or "tension in the nervous system."[4] Thus, prior to the mid-1800s, specialty distinctions were not conceptually recognized. All forms of illness were perceived as manifestations of one or two underlying conditions. It was not until specific diseases were correlated with specific lesions and symptoms that the possibility for specialization arose.[5]

Any proposal to distinguish practitioners in America was viewed as an aristocratic design. In Britain, medical practitioners were divided into three distinct branches: physicians, surgeons, and apothecaries. This authoritarian hierarchy of guilds was based on social significance rather than functional necessity.[6] As an elite group of gentlemen and scholars, physicians did not lower themselves by working with their hands as did surgeons, nor did they engage in a trade as did apothecaries who prescribed and sold drugs. Physicians were learned men, trained in universities, and conferred the title "doctor." On the other hand, surgeons and apothecaries were unlearned men, rarely college educated, who were trained by apprenticeship. They were addressed as "mister"[7] and were considered inferior to physicians.[8]

Anti-British sentiment made adoption of a similar system undesirable. American practitioners upheld an indignant sense of egalitarianism. Indeed, in contrast to the English custom, the term "doctor" was applied to all American practitioners despite the fact they lacked university degrees.[9] In fact, many practitioners had not even graduated from high school.

Eventually, distinctions between members of the profession began to emerge on the basis of educational rather than functional differences. Those educated in European universities believed themselves intellectually superior; yet, attempts to distinguish themselves by what they deemed to be superior training was blocked by the majority of practitioners.

Health, illness, and their treatments are both historically and culturally bound.[10] Medical practice was not always well received by the public. Public horror over dissection practices led to riots and attempted lynchings.[11] Preferred methods of treatment by "regular" physicians--that of sweating, blistering, purging, and bleeding--did not appeal to all patients. These methods were often lethal.[12] Thomsonianism and homeopathy, whose methods were less invasive and extreme, gained popularity.

After the American Revolution, British influence became notable, and passage to England became common. The original medical faculty at the College of Philadelphia was composed entirely of Edinburgh graduates. Based on the

European model of education, this faculty introduced lectures into the educational system.

With immigration and westward expansion, population centers began to develop in America. These cultural centers were essential to modern medicine.[13] With this expansion came increasing wealth. Universities were established, often endowed by wealthy humanitarians. The universities developed medical education training programs. Unlike European training centers that developed in hospital wards, American medical training was developed in educational institutions. Notably, there were few hospitals in the colonies at this time. This precedent was to have far-reaching effects on medical education.

Proprietary schools, based on the local apprenticeship system, also flourished. These schools, established by local practitioners, existed on student fees and operated for profit. There were no set standards for these schools to meet. Virtually anyone could claim to be a doctor and establish a medical school;[14] in fact, proprietary schools became a lucrative business. Student fees were the chief source of income for the professors.[15] The more students a school could attract, the more profits to be reaped. Professors were reluctant to flunk students or deny admission. Admission requirements were lax, and educational standards were virtually nonexistent. Harvard President Charles Eliot commented that more than half the students in proprietary schools could "barely write."[16]

The number of proprietary schools proliferated, and schools competed for students by reducing requirements, decreasing the length of study, and cutting fees.[17] As the number of proprietary schools began to outnumber the universities, questions of quality were raised. But the political climate in the 1800s thwarted efforts for quality control. Efforts toward state licensing were doomed in the Jacksonian era (1830-1840). Jacksonian democracy stood for independence and open competition. Shryock wryly notes, "Thus did Jacksonian Democrats proclaim their inalienable rights to life, liberty, and quackery."[18] Licensing regulations were viewed as elitist and restrictive to a free market economy. And, indeed, the existing licensure laws were often used by medical societies to restrict competition. Licensing laws were repealed and by 1850 were nearly nonexistent.[19]

Even though medical societies had lost their licensing authority in the 1830s and 1840s, new societies formed. One such society was the American Medical Association (AMA), established in 1847. For many, membership in a society was the only point of contact with other practitioners. The advent of journals in the 1840s provided a further link between the mass of isolated, rural practitioners and leaders of the profession who were located in the cities.[20]

It is significant that "the proliferation of proprietary schools came at precisely the time when medical and

scientific knowledge was advancing at a rapid rate."[21] The late 1800s was a period of dramatic scientific change. Major advances were made in bacteriology and immunology. The work of Pasteur and Koch led to improvements in public hygiene and to antiseptic surgery. Later, discoveries of diphtheria antitoxin (1890s) and salvarsan for use against syphilis (1910) were made.

By the 1890s, advances were made in diagnostic techniques as well. Laboratory tests could detect tuberculosis, cholera, typhoid and diphtheria. The stethoscope, ophthalmoscope, and laryngoscope improved diagnosis. Further diagnostic tools--the microscope and the x-ray--enhanced the practitioner's ability to connect symptoms with causes.[22]

With such impressive aids at his disposal, the practitioner not only increased his skills, but also increased his authority and sense of expertise. Patients and doctors no longer solely relied on empiricism. Technology had begun to replace subjective judgment, implicitly subjugating one's empirical senses to the unobservable "deeper" senses of technology.[23]

Germany became acclaimed the center of scientific development, noted for its large clinics, laboratory research, and high training requirements. Between 1870 and 1914, fifteen thousand Americans studied in German universities. Upon returning, those practitioners sought to reform American medical education according to German

standards. Comprising virtually entire faculties at Harvard, Johns Hopkins, Yale, and Michigan, these practitioners rooted the German university structure of medical training in America.

In the 1870s, Harvard began reorganizing its system of medical education. Harvard stiffened entrance exams, instituted specific curriculum with written exams, lengthened instruction to three years, and paid professors part-time salaries.

As advances were made in clinical medicine, the whole course of medical training began changing. Rather than two years of general apprenticeship, the student took two years of scientific subjects. And as content changed, so did the faculty. As the apprenticeship became replaced by specialized subjects, the general practitioner was no longer the most appropriate instructor. By the 1870s, hospitals began developing specialty departments. Hospitals, in institutionalizing specialty departments, encouraged and reinforced specialization.[24]

Clinical advances stimulated new needs. Clinical medicine required patients; scientific pathology required laboratories. Universities turned to hospitals as the new foci for medical training.

In 1873, merchant Johns Hopkins bequeathed seven million dollars to build a medical school and a hospital.[25] Both the school and the hospital, established in 1893, were based on the German clinical specialty departments.

Admission to Johns Hopkins required students to have a college degree. This was the first such admission requirement of its time. Faculty members were noted men of research rather than local practitioners. Johns Hopkins established the first residency training in specialized fields.[26]

It was at Johns Hopkins, then, that medicine as graduate study was developed. There medical training became rooted in the university and formally linked to hospital medicine. Graduates of Johns Hopkins became professors and scientists throughout the country and were a major influence in shaping the character of medical education and research in the twentieth century.[27] As more hospitals hired full-time clinical and basic science faculty, displaced general practitioners grew increasingly resentful.

Even though hospitals began to formally recognize differing departments, it must be recalled that hospitals were established at a time when there was no formal distinction between one type of practitioner and another. Turner reminds us that the institution of full-time clinical departments aroused intense controversy and "led to deep division within faculty and staff."[28] Proposals to distinguish practitioners by training or by specialty were attacked as elitist, undemocratic, and monopolistic. So, as specialist associations began to form, they maintained that they were scientific interest groups recognizing

special interest areas. These groups formed under the auspices of promoting medical knowledge and research, emphasizing that they did not represent social or educational stratification.

Hospital specialty services flourished. The hospital was transformed from a charitable refuge for the poor into a medical institution financed by all classes of patients. From 1870 to 1910, "hospitals moved from the periphery to the center of medical education and medical practice."[29]

The development of hospitals in the U.S. in the late 1800s had a profound impact on the direction of medical practice. Until 1860, Paris was the center for clinical study. The French schools correlated clinical symptoms with pathological anatomy. Keen observations, examination, and diagnosis were made possible by the invention of the stethoscope (1819), ophthalmoscope (1851), and laryngoscope (1855). In contrast, American physicians had not had access to patient wards or even cadavers.

The rise of hospitals in America was related to the evolution of American society from an agricultural economy to an industrial economy. Rapid urbanization and immigration, coupled with humanitarianism, led to the development of hospitals. "Hospitals provided new foci for the institutionalization of medicine."[30] The concentration of patients and doctors made systematic clinical observation, study, and treatment possible.

Viewed in social context, the establishment of hospital specialty departments was not an isolated development. Starr suggests that specialization reflected a trend in society in general. Industrialization in society promoted the rise of specialization in all fields. A division of labor was viewed as a more rational, efficient system. The concurrent rise of surgery and nursing with the rise of specialist services and general clinics were manifestations of an efficient, rational organization applied to the care of the sick.[31]

Industrialization also attracted people into urban centers. Such migration shattered the traditions of community and self-sufficiency. Dependence on self was passed on to dependence on those who were deemed experts. In this way, industrialization legitimated professional authority.

The Reform Movement

The concurrent rise of cities and hospitals provided doctors opportunity for contact with one another. City doctors began taking a leading role in advancing medical studies and practice. These doctors were the information source to the mass of rural practitioners. The professional journals of these city practitioners provided a further point of contact and were instrumental in creating a professional identity.

As professional identification developed, so did issues of quality and of reform. Medical societies and

universities wanted to upgrade standards to eliminate the existing disparity between graduates of different training.

The "reform movement" did not represent a united professional front. Notably, most medical students in the 1870s had but a grade school education, an apprenticeship, and possibly a brief course in a proprietary school. The gap between this training and university training was staggering. The rural practitioner could not possibly keep up with the scientific advances and improved techniques. The difference in training, coupled with the emergence of specialists, was a threat to the ordinary general practitioner. Suggestions for reform were met with hostility, skepticism, distrust, fear, and adamant opposition.

The reform movement was aimed at leveling physicians (in the twentieth century, this became known as "standardization") rather than at accentuating differences. It is highly probable that industrialization, and its focus on mass production, influenced this idea of organization.

The idea of leveling was also rooted in the egalitarian spirit of the times. Standardization represented an equality among doctors. Even as special interest groups were emerging, these groups "had to be assimilated into the prevailing egalitarianism of professional reform."[32]

Even though Johns Hopkins and Harvard initiated steps for upgrading standards, and even though in 1876

twenty-seven colleges set up what was to become the Association of American Medical Colleges (AAMC) to upgrade educational standards, universities did not take the central role in professional reform. It was the American Medical Association which became the powerful force in medical education reform.

State medical societies looked to state licensing as a means of leveling the profession. It was reasoned that graduates of poor schools would not be able to pass the eligibility exams. Denial of a license would be denial of practice. The AMA would accredit schools; only those graduates of accredited schools would receive licenses. Through state legislature, medical societies were able to get licensing requirements passed and to establish licensing boards.

As interest groups emerged, forging their roles into the forms we know today, alliances and opposition developed as well. The interests of state and local medical schools, universities, hospitals, and the AMA might enhance, coincide, or conflict with one another. As interests and time changed, so did professional relationships.

The organization of physicians and the licensing movement of the profession were part of a general movement in America in the late nineteenth century. As large corporations began to dominate the economy, various groups of workers were organizing throughout the country creating labor unions, trade associations, corporations, and trusts.

Independent workers banned together to fight large monopolies. Workers formed professional organizations and trade associations to push for antitrust legislation. In an effort to limit competition, plumbers, barbers, horseshoers, pharmacists, and embalmers, as well as physicians, secured licensing protection.[33] The AMA followed suit, copying the organizational structure of these other associations. In 1901, the AMA created the House of Delegates comprised of representatives from state societies; in turn, these representatives were selected from county medical organizations in each state. This organizational strategy, which many writers argue was essentially a political process,[34] increased AMA membership from eight thousand in 1900 to seventy thousand in 1910. By 1910, half of all physicians were AMA members.[35]

Starr points out that organization on a national scale in all fields, including medicine, was made possible by advanced communication channels: the development of railroads, hard roads, public transportation, autos, telegraph, telephones, and the establishment of medical journals.[36]

The Flexner Report: The Symbol of Reform

One of the expressed organizational goals of the AMA was educational reform. The failure of licensing agencies to provide integrated leadership strengthened the national role of the AMA.[37] Educational reform unified the profession, establishing a common goal that would benefit members

professionally, socially, and economically. By upgrading standards, weaker proprietary schools would collapse; their demise meant reduced competition for practitioners. But reformers had to proceed with caution, careful not to antagonize the main constituency. In 1900, the vast majority of physicians had been trained in apprenticeship or proprietary schools. Less than ten percent of practicing physicians were graduates of authentic medical schools; twenty percent had never even attended school lectures.[38]

The AMA established the Council on Medical Education in 1904; its purpose was to formulate an ideal standard for medical schools. The Council recommended that admission standards be raised to equal university entrance standards. It also recommended that training be lengthened to six years of study: five years of medical courses (one year of physics, chemistry, biology; two years of laboratory sciences, two years clinical) and a final year as an intern. Headed by Dr. Colwell, the Council then conducted a survey inspection to evaluate and rank schools based on the Council's definition of ideal. Since it was against professional ethics for doctors to "take up cudgels against each other in public,"[39] the AMA did not publish its evaluation.

Such decrees, and the understandable resentment it created, may have been less noteworthy had it not been for the financial backing of the Carnegie Foundation for the Advancement of Teaching. The Carnegie Foundation's mission

was to investigate problems of higher education in medicine, law, and theology. The Carnegie Foundation joined the crusade for medical educational reform. Stevens points out that during the early 1900s, professional schools of all types were coming under public scrutiny. Concern arose regarding the proliferation of professional schools. The U.S. Bureau of Education joined foundations in order to upgrade and limit all types of professional schools.[40]

The Carnegie Foundation appointed the young educator Abraham Flexner to inspect the medical schools throughout the country.[41] Since the Carnegie Foundation represented the possibility of endowment, the majority of medical schools agreed to the inspection. Dr. Colwell accompanied Flexner on many of the inspections.

Flexner examined faculty credentials and size, admission standards and records, curriculum, laboratories and equipment, hospital facilities, budgets, resources, and staff. His report, Bulletin Number Four, published in 1910, was a detailed assessment of 155 individual schools.[42]

His report was known for its candidness. For example, an inspection of Mayfield Medical College described the laboratory facilities as "one neglected and filthy room . . . [where] a few dirty test tubes stand around in pans and old cigar boxes."[43] A "hospital" might, in reality, consist of two beds in an attic; an "extensive

teaching course" might consist of two lectures.[44] Many schools barely had a lecture hall, let alone a laboratory.[45]

Based on such inspections, Flexner arrived at five general conclusions:[46]

First, there had been an overproduction of uneducated and ill-trained physicians.[47] Flexner asserted that what the country actually needed was fewer and better doctors.[48] Second, "this disgraceful situation" was the result of unregulated commercial schools that had mushroomed everywhere. Third, these proprietary schools had been profitable because training had been based purely on didactic instruction. Flexner declared that this situation must change. Advances in science demanded that physicians receive laboratory training. Such laboratories would represent a considerable expense to schools. Fourth, Flexner insisted that the upgrading of schools was essential. He disagreed with opponents who contended that by upgrading schools, the less fortunate would no longer have the opportunity to pursue a medical career. He maintained that this "poor boy" argument was "in reality an argument on behalf of the poor medical school."[49] Fifth, a hospital and laboratory were critical to proper medical training and must be a part of every medical school.[50]

The thrust of the Flexner report was to produce a scientifically well-rounded generalist with training in

physics, chemistry, and biology. This generalist would no longer solely rely

> on the senses with which nature endowed him, but . . . [would have] those senses made infinitely more acute, more accurate, and more helpful by the processes and instruments which the last half-century's progress placed at his disposal.[51]

Flexner envisioned the modern physician as applying scientific research method in practice. "The scientific physician still keeps his advantage over the empiric. He studies the actual situation with keener attention; he is freer of prejudiced prepossession; he is more conscious of liability to error."[52]

In an effort to upgrade and standardize the quality of physician training, Flexner recommended that admission requirements be based on two years' college preparation in chemistry, biology, and physics.[53] He then devised a four-year graded medical school curriculum. In the first year the student would study anatomy, physiology and chemistry. The second year's studies would consist of pharmacology, pathology, bacteriology, and physical diagnosis.[54] The course of study in the third and fourth years would focus on clinical work.

The medical school would be a university department, most favorably located in a large city whose large population would serve as a source of clinical material.[55] In order to teach clinical medicine, the medical school would have to be affiliated with a hospital. The teaching

hospital would consist of separate (specialty) departments systematically organized.[56] Johns Hopkins was held as the ideal model. Flexner envisioned a full-time faculty engaged in both research and teaching.[57]

Finances played a key role in the ultimate success of the reform movement symbolized by the Flexner report. Generous monetary endowments, rather than the report itself, was a major reason for the report's ultimate success. The early 1900s was an age of philanthropy. Great fortunes had been made during and after the Civil War. Wealthy donors such as Rockefeller and Carnegie financed medical institutions and research. Between 1903 and 1934, nine private foundations alone granted $150 million to medical institutions.[58] Foundation money enabled certain schools (those recommended by Flexner) to implement Flexner's suggestions. Foundation money financed medical school improvements and massive hospital construction as well.

As large universities such as Johns Hopkins and Harvard were endowed with money to lead the way in educational reform, the small proprietary schools did not have the financial means to lengthen curriculum, pay salaries to faculty, develop libraries, or purchase laboratory equipment. Half of the schools Flexner inspected were in dire economic condition even at the time of the inspection.[59]

Most historians agree that the Flexner report was not solely responsible for the demise of the proprietary

schools; the report, rather, accelerated the process. Licensing requirements were effectively closing down many schools as well. As state licensing boards raised requirements, many proprietary schools did not have the money to implement such requirements.

The advent of the Flexner report further legitimated and fortified the authority of the AAMC and the AMA Council on Medical Education. Using the Flexner report as an evaluative standard, these groups continued to conduct periodic inspections of colleges. They began to publish a scaled rating of these schools. Licensing agencies began to recognize the accrediting ratings. By the 1920s, most states deemed that graduation from an approved school was necessary in order to obtain a state license to practice medicine.

Small proprietary schools could not possibly pay for required improvements. Some schools pretended to meet standards, others merged, and still others collapsed under financial duress.

Even if proprietary schools were prepared to make such improvements, such requirements would increase tuition and extend the length of training from two years (and, in many cases, no high school education entrance requirement) to eventually three years beyond high school. Most students could not afford such an investment, let alone be without earnings for such an extended period.[60]

Thus, the combination of licensing controls, financial pressure, and the Flexner report contributed to the decline in proprietary schools. Of the 155 schools operating in 1910, only 85 survivors remained by 1920.[61]

The Flexner report was to have a tremendous impact on the future of medical training. Flexner's academic standards were accepted as legitimate. Consequently, foundations were guided by Flexner's perspective. The fortunes donated to medical institutions determined which institutions would dominate. This was a crucial point historically. Prevailing institutions would also determine what kinds of values, ideals, and patterns of organization and training would prevail.[62] The orientation and focus of an academic specialist dramatically differed from the local general practitioner's.

The Rise of Hospitals and the Rise of Specialization: Interacting Processes

By World War I, the AMA had gained momentum. The standardization movement had succeeded in unifying (and homogenizing) the profession. The Council on Medical Education met with state licensing boards to influence standards and requirements, and in 1915 a voluntary National Board for Medical Examiners was created to standardize licensing examinations nationwide.[63]

But these changes brought other problems as well. Medical education was so research oriented that training markedly differed from conditions of practice. As medicine

moved from the patient's bedside to the hospital, practitioners moved from generalism to specialism. Institutionalization unwittingly gave rise to specialization, and the uncoordinated rise of specialism gave rise to fragmented health care. Meanwhile, the role of the general practitioner became dubious.

Just as medical education reform was a concurrent and interdependent movement with the rise of universities, the rise of hospitals was both the result of and impetus for the rise of specialization. With incredible advances made in surgery, the explosion of surgery stimulated the rapid development of hospitals in which surgery could be performed. Science had redefined the hospitals, bestowing a "new moral identity" on them.[64]

Before the end of the nineteenth century, hospitals and medical practice were not related. The hospital was a charitable refuge, a shelter for the insane, the debilitated, the poor, and the homeless. They were overcrowded, filthy places of shame. One illuminating example which exposed the appalling conditions of Bellevue Hospital was reported in the New York Tribune on April 25, 1860:

> A young Irish woman gave birth on a Sunday night. The following morning the infant was found dead next to the mother, who had been too weak to prevent rats from devouring the baby's nose, upper lip, toes, and half of the left foot.[65]

Instead of being financed by taxes, these hospitals were financed by voluntary donations (hence, the name voluntary or charitable hospitals). Since these hospitals were financially dependent upon donors and sponsors, these hospitals were governed by boards of trustees rather than by physicians or commissioners.

The hospital was transformed from a pitiful house of horror into a technological complex honoring the triumphs of science. The successes of surgery brought the middle class into the hospital for the first time. And, consequently, the middle class brought in money. For the first time, hospitals were offered the prospects of paying patients.

The relationship between the hospital and its physicians appeared to be mutually beneficial. Tradition had established that hospitals did not pay doctors for their work. Hospitals provided the surgical facilities, opportunities to specialize, status, and influential contact with colleagues. In return, doctors provided revenue to the hospital, either by wealthy sponsors or--beginning in the early 1900s--by paying patients.

The hospital system reflected a stratified system of relations in terms of physicians as well as patients. The hospital staff was composed of four tiers: consulting, visiting, house, and dispensary. The consulting medical staff was composed of distinguished physicians. These doctors had no regular duties but were consulted for their

expertise. The visiting staff brought in private patients and supervised treatment. It was the house staff who attended to the details of treatment. House physicians gave their services for a year to eighteen months in exchange for room, board, and experience. Thus, the hospital and the visiting staff benefited from the twenty-four-hour patient care the house staff provided free of charge. The dispensary hospital staff, who saw outpatients, provided free service in efforts to gain visiting physician appointments. Hospital appointments remained small and constituted a select elite.

In terms of patients, hospitals had transcended their earlier role as charitable refuges for the poor. Hospitals began servicing certain categories. Hospitals in the latter half of the nineteenth century were distinguished by religious affiliation (such as Catholic), ethnicity (such as Irish), categories of disease, categories of patients (such as women or children), or medical sects (such as homeopaths). Then, in the early 1900s emerged profit-making hospitals (proprietary hospitals) headed by physicians.

Starr points out that this pattern is related to society. As structural opportunities changed, so did the institutions.[66] Denominational hospitals emerged largely as a result of a great influx of Catholic immigrants. Proprietary hospitals emerged as progress in surgery proved

to be profitable. The development of the nursing profession hastened the transition.

The basis of medical care was also changing. Increasingly, patients entered hospitals for treatment of acute rather than chronic illness.

As hospitals became a vital part of medical practice, access to the hospital became vital (and lucrative) to the physician. Access to hospitals became restricted as elite power groups of private physicians developed. Because hospitals depended on these visiting physicians to bring in revenue, they acceded authority to the physicians. As monetary relationships changed, so did the system of authority. Authority passed from trustees to physicians.[67]

Throughout society in general, emerging professionals were granted increasing authority and responsibility. The late nineteenth century saw salaried management in corporations, administrators and professors in universities, salaried editors and reporters on newspapers, and civil servants in government. Starr suggests that society was moving from "communal" to "associative" relations.[68]

The emergence of hospitals with specialized departments, combined with advances in surgery and its potential for profit-making, made surgery very attractive to many physicians. More and more physicians began building their practices in surgery rather than establishing general practices.

Improved surgical procedures demonstrated astonishing success to the public. For example, with the introduction of anesthesia, asepsis, and antisepsis, the mortality rate from abdominal and pelvic surgery dropped from forty percent in 1880-1890 to below five percent in 1900.[69] More and more patients desired surgery. Surgery became a profitable business. Increasingly, surgery was being performed by practitioners untrained in the new surgical procedures. Since most hospitals had an open-staff policy, hospitals themselves were not organized to control access. General practitioners were at liberty to perform surgery regardless of competency or training.

Concern arose over the standards and practice of surgery. The underlying issues central to these concerns were specialism, standardization of hospitals, and professional control. These were the issues that concerned the accomplished surgeon, Franklin Martin, when he took leadership in establishing the American College of Surgeons in 1921. The question of standardization versus a highly trained elite of surgeons arose: Should all physicians be upgraded to an acceptable level or should a distinct group of expert surgeons be created?

There were also questions over hospital standards. Since successful surgery partially depended upon the adequacy of facilities, the upgrading of hospitals was an important aspect of surgical practice.

Rivalry between surgeons and general practitioners mounted. General practitioners charged that surgical specialists represented a caste system. These specialists threatened the status and income of general practitioners.

The American College of Surgeons decided to create a separate and distinct group of physicians specifically trained to practice surgery. The College established a precedent for later specialty boards: Control over standards and qualifications became a professional responsibility organized by a voluntary group within the profession.[70]

The American College of Surgeons established both a specialty and a new professional role. Prerequisites for admittance to the College included three years' extended education beyond the basic education for general practitioners. This education was derived from hospital experience and supervision.

Internal medicine was the next group to identify themselves as distinct from general practice. To become an internist, another layer of training was added to the basic education of the general practitioner. Following the German model, internists emphasized the physiological and chemical bases of disease rather than the more generalist approach of the general practitioner.

Such a perception of general practice had important implications. The general practitioner was no longer distinguished as a man of science. In fact, internists

implied that general practice was a more "folksy" approach to medical care.

In 1916, the American Board for Ophthalmic Examinations was established (later renamed the American Board of Ophthalmology) and constituted the first specialty board. Following the English model of Royal Colleges, the Board established prerequisites for training (two years of graduate study and one year of supervised clinical training) to be concluded by an examination. Completion of these requirements earned a diploma rather than a degree or a license; hence, the creation of board certification in the specialty.

The development of a specialty board was an alternative to licensing.[71] The board became both an examining body and a prescriber of training standards,[72] acting "independent of the AMA, and taking to itself responsibility for graduate education and qualifications in a self-delineated specialty."[73] Graduate training was developing in the hospitals and outside the jurisdiction of the AMA.

Thus, only two years after the publication of the Flexner report, various segments within the medical profession were beginning to formally specialize. While the AMA was concentrating on standardizing undergraduate medical education into a scientifically well-rounded general education, groups were emerging demanding specialty recognition. While undergraduate training was being developed in the university, specialty training was

developing in the hospital. Already, the premise of the Flexner report had become obsolete. By 1951, only 23 percent of medical school graduates would become general practitioners.[74]

The rise of hospitals and of specialization are two processes within a larger social context. Starr emphasizes that the rise of the hospital took place within the rise of an industrializing society. The hallmark of industrialization was efficient and rational organization through a division of labor. The rise of specialties was sanctioned as the most efficient method of delivering hospital care.

Specialties and hospitals rose to eminence together. Specialty training developed in the hospital rather than in the university. The rise of specialties and the rise of hospitals were simultaneous, interacting developments. Just as medical schools proliferated when medicine was becoming an attractive occupation, hospitals flourished amidst the proliferation of the developing specialist groups. Surgery, in particular, stimulated hospital expansion. Moreover, hospital care was sustained as nursing emerged as a profession.

The Internship

Surgery also transformed the role of the internship. With the rise of surgery, the internship took on new meaning and significance in the early 1900s.[75] Young graduates wanted hospital experience to acquire surgical skills. In turn, these interns provided a variety of

services that ranged from menial tasks to assisting in surgery. The intern met the staffing needs of the hospital. Eventually, he became the mainstay of hospital staffing.

Although the AMA recommended that the internship be developed within the university, the College of Surgeons supported the idea of professional group control via a certification process. The College of Surgeons focused on hospital standardization and specialty training. The College took the initiative in the hospital standardization movement and emerged as a competitive threat to the AMA.

The ambiguous role of the internship aroused great controversy. It was debated whether the internship was part of basic training or part of entry into a specialty. There arose heated discussions as to whether the internship even belonged in the hospital at all. Many argued that the internship should be incorporated in university medical school training. Others contended that the hospital internship was not the appropriate preparation for practicing physicians, since most physicians primarily treated patients outside of the hospital context.

The rise of specialism and the flurry of concern threatened the general practitioner who was the main constituency of the AMA. The AMA was strategically in a precarious situation. The AMA had gained its strength on the merit of its undergraduate educational reform movement. The AMA could not afford to lose ground as a leader in

training reform. On the other hand, the AMA could not afford to alienate its membership by involving itself in the specialist movement.

One way to get around this awkward position was to designate the internship as part of completion of basic medical education. By designating the internship as part of basic training in 1905, the internship then "legitimately" fell within the AMA's domain, minimizing protest by its members. In 1919, the AMA established a list of standards for internships, "The Essentials of an Approved Internship." The Council recommended establishing a systematic program under the university.[76]

Eventually, many state boards required an internship for state licensing. Yet, although the internship remained part of undergraduate education, it did not develop under the surveillance of medical schools. Internships were left to develop as hospitals deemed; consequently, the interns were, for the most part, unsupervised. Although the internship was technically considered part of basic training, the process of acquiring the medical degree and the medical license became increasingly distinct and separate. The degree represented training; the license represented experience.

It is important to note that medical schools and medical societies developed independent of one another. Each wanted authority over professional regulation. The

division remains today, whereby medical schools confer degrees and medical societies grant licenses.

The Residency

The residency was distinguished as experiential training in a specialty area. The term "resident" was first used at Johns Hopkins to designate the extended period of specialty training within the hospital.[77] It was a competitive system, modeled after the German university hospital "assistantship" system. The original purpose of the German system was to produce researchers and teachers. The American adaptation of this system was essentially a combination of the German pyramid structure of specialized training and the product of an older apprenticeship mentality. The apprenticeship was transformed into a hospital training system. Eventually, the residency system was adopted by other prestigious universities.

Great discrepancy existed between speciality training programs and, hence, the quality of different specialists. University trained specialists were appalled by practitioners who claimed specialist expertise following a six-week course. The residencies that developed at large universities were geared towards developing a select group of researchers, scholars, teachers, and practitioners.

It is fascinating that the rapid advances in science far out-distanced the organization of the profession. Only four years after the Flexner report, a four-year medical course was no longer considered adequate training.

The residency developed as a counterpart to the earlier Flexner reform. But the development of the residency was not a coordinated, planned approach by centralized leadership; rather, it was established by autonomous boards independent of one another. Individual programs were established almost haphazardly. Programs were not integrated with one another or with undergraduate education. The standards and quality of individual programs for a given specialty widely differed. Furthermore, the requirements of a residency of one specialty could dramatically differ from those of another specialty.

The residency not only developed in a fragmented fashion but was also fragmented geographically. Residencies were developed in community hospitals scattered all across the country. In reality, accreditation of programs was an uncoordinated, scattered responsibility.

In order to be accredited by the Joint Commission on Accreditation of Hospitals, the hospital was supposed to follow the American Medical Association Council on Medical Education guidelines set forth in the "Essentials of Approved Residencies."[78] The essentials prescribed three or more years of training for specialty preparation, with definite clinical assignments and increasing responsibility for the management of patients and teaching of other graduate students. Hospitals were to provide daily contact with patients and instruction by attending staff. The essentials emphasized the importance of a well-qualified

teaching staff. The students' training should consist of a coordinated educational program including laboratory study, teaching rounds, conferences, lectures, seminars, and demonstrations. In addition to these general guidelines, each specialty board specified its own requirements.

However, in practice, many residencies were not providing this type of training to students. Initiated by a residency review committee created by the American Board of Surgery in 1950, residency review committees were formed by specialty boards in cooperation with the Council on Medical Education. But the Council faced difficulties. The AMA resented the Council and wanted to maintain control, while the specialty boards were unwilling to relinquish their absolute authority. Thus, the review committees remained separate entities of each specialty with limited function. Instead of unifying graduate medical education through a coordinated system of organization, the committees strengthened specialty independence and further fragmented training.

The disorganized, unsupervised and decentralized system of residency training was welcomed by both local hospitals and community doctors. Hospitals had no interest in promoting educational reform or in inviting university scrutiny. Hospitals depended on "graduate students" to staff their hospital wards and provide twenty-four-hour service to patients. Stipends for students were extremely low. Students were virtually denied any labor rights and

worked grueling hours. The hospitals were presented with an ideal system of cheap labor.

The community doctors had no interest in changing the situation. Their own hospitalized patients were cared for around the clock by the house staff, and these services were provided free of charge to the private physician.

Hospitals relied on house staff to manage and attend their wards. The "education" offered by different hospitals widely varied. Internships and residencies were becoming a service to the hospital rather than an educational experience for the physician. Hospitals competed for graduate students. "Acceptance" to a program was often a mere formality. By the mid-1940s, there were more residency and internship positions than there were physicians to fill them.

After World War II, community hospital expansion became a congressional priority. The federal government, under the Hill-Burton program of 1946, expended $3.7 billion between 1947 and 1971. An additional amount, estimated at $9.1 billion, was spent in state and local matching funds.[79]

While the numbers of hospitals were increasing, medical school enrollment was not. It appears that what the government deemed as a doctor shortage in the 1950s was, in actuality, a house staff shortage as perceived by hospitals. Yet, there were not incentives for hospitals to decrease available positions or terminate their programs.

So hospitals began to recruit foreign medical school graduates.

Foreign Medical Graduates

By 1950, the number of residencies, increased to accommodate World War II veterans, had depleted the veteran manpower supply.[80] The Korean War had an additional negative impact on physician supply. In addition, the political interests of the government further intensified the situation. Freedom and democracy were being advertised and promoted in the cold war era. As a demonstration in democracy, the Smith-Mundt Act of 1948 instituted educational exchange programs. The exchange program encouraged visitors to study in the United States. This program provided a convenient opportunity for hospitals to meet their staffing needs. Hospitals concentrated on recruiting and sponsoring visitors, taking advantage of these students as an inexpensive source of labor. At the onset, most doctors came from Europe. In the 1960s, most came from Korea, India, and the Philippines.[81] Some American students also took advantage of the chaotic system. Some students purchased fraudulent medical degrees from schools in the Caribbean.[82] By 1969, thirty-one percent of all internships and thirty-two percent of all residencies were filled by foreign medical graduates.[83]

The intent of training had been overtaken by the hospitals' intent of staffing. More than two-thirds of the foreign educated interns in 1968 were in hospitals which

were not even affiliated with medical schools or universities.[84]

The availability of residency positions was not based on social need; on the contrary, available positions were based on the hospitals' perception of staffing needs. (For example, in 1970, there were more residency openings for urologists than for general practitioners, for radiologists than for pediatricians, for pathologists than for obstetricians and gynecologists.) The selection of study by a visitor was dictated by job availability rather than by educational preference and future practice needs in his homeland. For example, in 1968, fifty percent of the positions in anesthesiology were filled by foreign medical graduates.[85]

The wide discrepancies in the basic educational skills and technological competence of visitors brought the problems of residency and regulation to a climax. The varying quality between both graduates and residencies undermined the standardization attempt of the Flexner reforms. The AMA tried to legislate reforms, but the government blocked reform and even promoted further deregulation due to its own political interests. For example, in 1952, the Brydges Act (passed in New York state) granted hospitals permission to appoint unlicensed foreign house staff regardless of their lack of qualifications. Government did not protect public interest or guarantee public safety, nor did it develop a master plan.

Hospitals did not develop different staffing patterns or examine the system. There was no overall body with enough influence, foresight, and authority to control what was happening.

The medical profession sought to assert some control over the chaos in graduate education. In 1957, after much deliberation, the Council on Medical Education, the Association of American Colleges, the Federation of State Medical Boards, the American Hospital Association, and government agencies created the Educational Council for Foreign Medical Graduates (ECFMG). The Council developed the ECFMG multiple choice exam designed to test for equivalent competency of foreign graduates.[86] But, because residencies were not standardized, hospitals were left to their own judgments regarding the enforcement of the ECFMG. Moreover, critics of the ECFMG exam argued that a four-hundred-item multiple choice exam was an inadequate measurement of medical competency.

The foreign medical graduate was taken advantage of from a staffing standpoint. He faced numerous difficulties in completion of his training. His future was affected by complicated, often contradictory and irrational legislative rulings and requirements (such as those pertaining to immigration). There was no general plan, orientation, or policy to coordinate his training experience. The quality of residencies was often questionable. Frequently, the most vacancies existed in the least desirable substandard

programs. Many residencies were unsupervised and were essentially a self-learning experience. Often an entire house staff would consist of foreign medical graduates who were not receiving the training they had anticipated. The majority of visiting physicians chose to remain in the United States after their residency,[87] which conflicted with the government's scheme and immigration requirements. Foreign visitors did not merely vanish as the government had, at best, expected (or at worst, had not even considered). Furthermore, specialty boards often denied certification to foreign graduates.

The issue of training was but part of the problem. Quality of care was ultimately the critical issue. Patients were subjected to substandard care, both while the resident was in training and then subsequent to his training. Substandard training produced substandard doctors.

The Rise of Specialty Boards

Specialty boards emerged from independent specialty associations. As more and more specialty boards emerged, there was a need for some sort of coordinating body. In 1933, the Advisory Board for Medical Specialties was created by a joint action of the National Board of Medical Examiners, the four existing specialty boards (Ophthalmology, Otolaryngology, Obstetrics and Gynecology, and Dermatology and Syphilogy), specialty sections of the American Medical Association, the American College of

Surgeons, the Council on Medical Education and Hospitals, the Commission on Graduate Medical Education, and the Association of American Medical Colleges. The Advisory Board for Medical Specialities established standards for specialty boards, "Essentials for an Approved Special Examining Board," in 1934. It was decided that the Council on Medical Education and the Advisory Board would approve specialty boards. "Essentials" identified twelve specialty boards as appropriate for certification. By 1937, all twelve boards had been approved: Ophthalmology (1917), Otolaryngology (1924), Obstetrics and Gynecology (1930), Dermatology and Syphilogy (1932), Pediatrics (1933), Neurology and Psychology (1934), Orthopaedic Surgery (1934), Radiology (1934), Urology (1935), Internal Medicine (1936), Pathology (1936), and Surgery (1937).[88]

Yet, the role between the Council on Medical Education and the Advisory Board was unclear and remains so today. The Advisory Board had no real authority. Specialty boards were powerful autocracies and considered themselves best equipped to define and enforce what they deemed best. Once a specialty board was designated, responsibility for training and examinations was assumed by the individual board itself.

Specialty associations struggled to gain specialty recognition and endorsement. These struggles were basically a political and social process. Defining boundaries was a complicated process and involved many

issues. Radiology and pathology hinged on status and financial concerns; pediatrics was distinguished by the age of patients rather than by a specialized technique or category of illness; anesthesiology dealt with issues of competition and contractual arrangements with hospitals; surgery could be viewed as one branch or divided into many. In an attempt to contain the proliferation of specialties, the Advisory Board in 1942 refused to approve any additional certifying boards. The Advisory Board decided that additional subdivision of specialties would occur within existing specialties. Hence, the birth of subspecialties. When associations could not receive endorsement from the Advisory Board and the Council on Medical Education, subspecialization developed within the specialties.

Conflicts arose regarding the Advisory Board's decision and its authority. Subspecialties demanded independent board certification. Specialization represented professional equality and professional independence. Groups challenged the legitimation of the Board's authority: On what grounds, they asked, are orthopaedic surgeons qualified and entitled to decide whether emergency medicine should be a specialty? Furthermore, how can those who sit in judgment justify their positions when obvious conflicts of interest exist? For instance, if surgeons viewed trauma as part of surgery, it would not be in their best interests to approve specialty certification in

emergency medicine when such a decision would exclude themselves. New subspecialities could threaten groups of practitioners within the dominating specialty.

Moreover, in light of traditional training requirements, subspecialization added an additional layer of training requirements. There was no direct route to specialization. A board certified dermatologist, for example, must first pass examinations in internal medicine. Only then is he eligible to take examinations in dermatology. Furthermore, demarcations of specialities is a complex issue. Distinct boundaries often are not clear-cut. For example, is pediatric surgery a subspecialty of surgery or of pediatrics?

Board certification did more than define who was and was not a specialist. Board certification became increasingly significant to the career of the individual practitioner. Increasingly, the granting of hospital privileges or of medical faculty appointments hinged upon board certification. And hospital privileges were essential to the survival and practice of the individual practitioner.

The determination of who would be eligible for certification was tightly controlled. Charges of discriminatory board policies abounded. Boards often instituted eligibility qualifications that were discriminatory and exclusionary, restricting access to certain races, religions, and women, for example. Subjective evaluations

were conducted regarding an individual, his background, and his behavior. Many specialists who met training and experience requirements did not meet particular, exclusionary eligibility requirements such as U.S. citizenship or the requirement to spend one hundred percent of the time practicing the specialty. There was no opportunity to appeal such discriminatory practices. Essentially, the individual practitioner had no recourse. Individual specialty boards were left to their own, often unethical, devices. Political moves thwarted reform efforts of various individuals or groups.

Residencies proliferated, and it was nearly impossible to keep a watchful eye on the individual programs, their policies, or their facilities. Residency programs were often initiated at the whim of hospitals and run by a small clique of doctors. They remained unchecked by any outside agency. These new residencies often lacked any semblance of a coordinated training program or appropriate hospital facility. The concept of "graduate education" was laughable to many interns and residents; trainees were essentially cheap, unsupervised hospital servants. Yet, there was little option available to the individual practitioner whose future depended upon board certification.

The rapid expansion of residencies, coupled with the lack of coordination, produced utter chaos in residency training appointments. By 1945, a committee comprised of

representatives of the AAMC, AMA Council on Medical Education, and the American Hospital Association (AHA) devised a plan for matching interns with hospital appointments on a set date. This plan, the National Intern Matching Program, was implemented in 1949. Although this system greatly improved the coordination of appointments, it can be seen chiefly as an instrument to aid hospital staffing arrangements. It did not evaluate, improve, or call into question the system itself.

Specialty boards and requirements for residency training dramatically stimulated hospital expansion. By 1945, there were more residencies than internships, while at the same time, the length of residencies had increased. By 1939, there were 1,791 three-year residency programs compared to 331 in 1934.[89] As much time was being spent in preparation for board certification as for the medical license.

While specialty boards were dramatically affecting the development of hospital residencies, there was no overall coordination or policy to address such consequential developments as health services, manpower distribution, hospital expansion, hospital staffing patterns, or the misuse of residents and the extraordinary demands placed upon them.

Other established groups did not initiate steps to intervene. The monitoring of residencies and board practices represented an enormous responsibility and

expense. Medical schools in the 1930s were facing drastic financial problems and did not want to take on additional burdens. Politically, the AMA was not in a position to launch into specialty problems. Universities did not want to fragment their resources into community hospitals. It was not in the best interests of hospitals themselves to curtail such staffing opportunities or to invite evaluation of such operations. There was no government agency readily prepared to deal with these rapid changes or the political ramifications thereof. Thus, criticism was ineffective. Boards seemed to assure some sort of quality control; boards appeared preferable to no regulation at all.

The Advisory Board was determined to strengthen its own authority and enlarge its scope. In 1970, the Advisory Board changed its name to the American Board of Medical Specialties in order to reflect a more authoritative image. The Board envisioned its role as more than granting approval of specialty boards. It was to sponsor manpower and educational studies and develop more coordinated specialty policies. The Board's main focus was on evaluation and certification of physicians, accreditation of graduate medical education programs, and recertification of physicians.[90]

By 1970, the twenty existing specialty boards were responsible for 42,000 hospital residencies.[91] Sheer numbers forced specialty boards to reexamine their purpose, form, capabilities, and policies. The original intent of

boards--to produce a select group of exceptionally skilled consultants--was being transformed by a situation in which virtually all physicians were to become specialists.

World War II: Trend Toward Specialization Accelerated

It is evident that specialization is a complex web of social, economic, political, and professional processes. Specialization was a professional approach to managing the vast changes and advances within medicine as well as establishing boundaries and claims to these advances. However, the independence of individual specialty boards not only resulted in fragmented training, but in fragmented delivery of health care. Aims of specialty boards to produce technological experts had diverged from the public aims in the 1960s to provide basic care for all.

As medicine became increasingly valued by the public at large, the public became increasingly interested in how this care was to be financed and delivered.

Government involvement in medical care did much to stimulate and reinforce specialization in unforeseen ways. Government programs unwittingly discriminated against nonspecialists. Various civilian medical programs rewarded specialists with higher pay and responsibility than non-specialists. Moreover, nonspecialists were specifically excluded from providing care in such government programs as the Emergency Maternity and Infant Care Program. Specialists in Veterans Administration (VA) hospitals

received differential pay and special cases. Thus, specialization was both stimulated and reinforced by government policies.

World War II had a huge impact upon specialization. The military rewarded board certified specialists with a higher military classification (and thereby, higher status, privileges, and pay). Servicemen saw that specialization was desirable, carrying with it definite concrete advantages.

The war also exposed physicians to various specialties. This exposure contributed to the rise of various specialty groups. For instance, the number of full-time orthopaedic surgeons doubled between 1940 and 1949 and tripled by 1955.[92]

Not only did military service encourage specialization, but it also encouraged the use of specialists. Servicemen became accustomed to being treated by specialists. Consequently, veterans sought specialists for themselves and their families.

The GI Bill had an enormous impact on the growth of specialization. This bill, the Servicemen's Readjustment Act of 1944, provided tuition for education and living allowances for returning veterans. Since residency training was considered graduate education, a returning physician could receive four years' financial assistance while enrolling in a residency. The stipend was much more than those offered by the hospitals prior to the war.

Hospitals had much to gain in the arrangement. The hospitals also were entitled to subsidies when engaging a GI as a resident. This was a fortuitous state of affairs, since hospitals were experiencing a shortage of house staff. Money was given to all residency programs, whether or not they were affiliated with a medical school. The government was so overwhelmed with applicants that it could not possibly inspect programs. It began issuing temporary approvals, often approving substandard teaching programs. The government went about blindly generating more and more specialists.

The impact of government financing cannot be overstated. In 1940, there were 5,233 resident positions; by 1946, there were over 12,000; by 1957, over 30,000; and by 1970, over 45,000.[93]

The government programs not only generated massive increases in the number of residencies, but affected the proportional increases in various specialties as well. Since funding did nothing to assess health care and manpower needs, residencies were developed at the whim of the hospital. The type of residency a hospital instituted was based upon what the hospital perceived its immediate staffing needs to be. The number of residencies in general surgery, for example, increased from 808 in 1940 to more than four thousand in 1950. Subsidies affected both the number of types of specialities, contributing not only to a disproportionate number of specialists, but also to a

disproportionate number of types of specialists. Moreover, once the residencies were created, there was the continual need for filling the positions of graduating residents. So disproportionate supply continued.

The advent of World War II also led to medical research as a national priority. War did not only produce specific medical problems to be attended, but it produced specific circumstances as well. Quinine sources had been seized by the Japanese. American researchers worked to develop a substitute. Methods were developed to produce penicillin in great quantities.[94] Vaccines were perfected to control yellow fever, dysentery, typhus, tetanus, pneumonia, and meningitis. Methods were developed to treat venereal disease and to control malaria.[95]

In contrast to the European economy, which had been devastated by the war, the American economy was stimulated by the war. In postwar years, medical care became a leading industry. Starr contends that the health concerns of the prosperous post-war economy reflected an affluent society. Only Americans could afford the luxury of worrying about such conditions as heart disease, cancer, neurosis, and obesity.[96]

Federal Funding, Research, and Specialization

The Flexner reform had conceived of medicine as one discipline. Yet, by the 1940s, the scientific bases of medicine were evolving and subdividing. Physiology, biochemistry, and microbiology had become complex research

specialties. Medicine could no longer be regarded as a single, uniform discipline. Increasingly, the physician was becoming super-scientist.

The single most significant development in the 1950s was the government's role in medical school financing. Until the 1940s, medical schools had been primarily supported by endowments and grants from private foundations.[97] In contrast, by 1970, up to seventy-five percent of medical school expenditures were paid by federal subsidies.[98] The federal government replaced private foundations as the source of medical school financing.

Government money was granted primarily for research programs.[99] Stimulated by government financing of biomedical research, medical schools were transformed into great scientific research centers. It has been argued that the government overstimulated research while understimulating actual medical training.

The relationship between government funding and medical education is complicated with far-reaching consequences not fully appreciated today. The continuation and direction of programs were outside the control of the medical school. Areas of study were essentially determined by available government grants. The nature of grants was often based on the personal or political interests of officials, or on the political contests between various government agencies, or on the research interests of individual faculty members, rather than on public needs or

applicability to the future practice of physicians. The very arrangement of financing caused serious problems. Medical programs became fragmented from the university. Department chairmen, key to research money, became powerful autocrats. Standards and requirements of funding were often arbitrary and irrelevant, governed by politics rather than appropriateness.

The National Institutes of Health (NIH) did much to stimulate and sustain these scientific enclaves. The Institutes date back to 1887, when the U.S. Public Health Service created a laboratory for bacteriological studies. From this humble beginning spawned a vast empire, with a budget of $11.6 billion by 1968.[100] The Institutes were oriented toward specific diseases and disease conditions.[101]

NIH research grants became critical to the survival of medical schools. The more accomplished the researcher or the more attractive his area of research, the greater potential for government funding. Accordingly, accomplished men of research were selected as faculty.[102]

Not only were the interests of medical school faculty research oriented, but their time and energies were necessarily absorbed by their research projects. Grants paid faculty to conduct research, not to teach. The faculty's principal obligation was to their research, not to medical students or teaching. A school's survival depended upon the success of specific research projects,

sponsored by specific faculties. Such faculty members wielded great influence and power within the medical school.

It was the lobbying efforts of the "Lasker lobby" that promoted and perpetuated the NIH research funding in the 1950s and 1960s. The Lasker lobby was composed of NIH director James Shannon, Rhode Island Representative John Fogarty, Alabama Senator Lister Hill, New Yorker Mary Lasker, and Florence Mahoney of Georgetown. This group was instrumental in funneling money into large-scale expansion of specific areas of research.[103] The Lasker lobby represents a marvelous example of Mills's intersection of biography and history. Essentially, through its pet project, an influential group dramatically altered medical education. Their actions had far-reaching implications.

The interests and faculties of medical schools were directed by the seemingly never-ending supply of federal monies. Because of the funding situation, even the advent of full-time administrators in the 1950s could not address the issues and problems being created by research funding. Deans were left with little choice: either accept the situation (and money) or attempt to change the situation (and lose the money upon which the survival of the institution depended).

Moreover, to challenge the situation may have been politically unwise. Biomedical research was perceived as a national purpose. Government support was being channeled

in other scientific fields as well, such as mathematics, physics, biology, and engineering.[104]

The launching of the first Russian sputnik prompted Congress to pass the National Defense Education Act of 1958 (P.L. 85-864). Government officials were alarmed that the Soviets were capable of directing a missile to land in the United States. The U.S. did not possess this capability. The government feared that America was lagging behind scientifically. The National Defense Education Act granted monies to universities to expand their science departments, faculties, research, and scholarships. Thus, the support for scientific research was considered both a national priority and a national responsibility.[105]

The government's concern for scientific research turned to medical manpower as well. As a solution to understaffed areas and the hospitals' unmet needs for house staff, Congress concluded that more doctors were needed. Government reports recommended that the number of medical school graduates be increased from 7,400 in 1959 to 11,000 in 1975.[106] Medical school deans were in favor of government interest, seeing money for education as a way of claiming their authority.

In the early 1950s the AMA denied that there was a doctor shortage; by the late 1950s the AMA changed its stance. The AMA supported medical school construction but opposed student scholarships and loans, arguing that government intervention would serve as a monetary incentive

to students and thereby would decrease high standards. The AMA also recognized that government spending might eventually invite government control. Ultimately, the government would want to claim control over what it was paying for. The AMA wanted to retain control over what and how the government would pay.

But as the length of education increased, the student's educational costs increased. By 1950, trying to attain such an education became a financial impossibility for most individuals. While the AMA protested student assistance programs, Congress had a different point of view. In its determination to increase the number of physicians, Congress enacted legislation to assist students in financing their education.

The Health Professions Educational Assistance Act of 1963 (P.L. 88-129) granted money for a three-year medical school construction program and a six-year student loan program. Loans were available to students in medicine, osteopathy, and dentistry. This act was further expanded by the Health Manpower Act of 1968 (P.L. 90-490).

As Congress began authorizing money towards medical education in the 1960s, it began to decrease research money. Criticism of research spending was spearheaded by the Fountain committee, which questioned whether the high costs of research were worth the benefits to society.[107] As domestic social problems increased and the Vietnam War escalated, Congress needed to realign its spending.

Health Care and Costs

Congressional concern over health care and costs was not a new concern. In fact, the situation labeled "crisis" in the 1960s was not a new situation. Concerns regarding health care, the social implications of medicine, specialization, and costs of care had been developing for over forty years.

In the mid-1920s, concern mounted regarding costs of medical care and the lack of care in many parts of the country. Leaders in social welfare, public health, medicine, and economics formed the Committee on Costs of Medical Care (CCMC). The Committee met in Washington to discuss a crisis in medical care.[108]

The Committee produced twenty-seven research reports regarding the delivery and financing of medical care. In 1932, the CCMC published its final report, Medical Care for the American People. In this report, medicine was defined as a

> social as well as biological science, and it has economic, psychological and sociological relationships. The effects on physical and mental health of mass unemployment, undernutrition, and poor housing should form a part of medical instruction. The social background and interrelationships of medicine should be as much as part of medical education as the physical, chemical, and bacteriological background."[109]

One is struck by the ring of familiarity. The report recognized the oversupply of specialists (remember, this is 1932) and emphatically stated, "The real needs of the

people call for three to five times as many well-trained general practitioners as specialists."[110]

The report conceptualized the general practitioner as a specialist and urged that qualification training be instituted. The committee envisioned the general practitioner's possessing "special aptitudes and training, with wide general knowledge in medicine and some insight into psychological and social conditions."[111]

The report proposed the creation of municipal health centers staffed by salaried specialists, general practitioners, dentists, social workers, nurses, and educators. In rural areas, the committee proposed a network of clinics and health service stations.[112]

The report raised questions regarding preventive care, the role of the general practitioner, and health care financing. Should the general practitioner be an authority on social aspects of medicine, or should the general practitioner maintain a traditional role as the family doctor managing uncomplicated cases? Should medical care be financed through private funds, voluntary insurance, or taxation and a national insurance? Should medical care be directed by an electorate or by medical societies and the AMA?

The report concluded that group practice and group payment for medical care would be an initial step in removing economic barriers to care.[113] The committee anticipated that once group practice organizations were

well established, compulsory insurance could then be more readily enacted.[114] The report favored professional control of health care structured within a rational, bureaucratic model of organization.

The AMA opposed any form of national insurance, charging such arrangements were socialistic and communistic.[115] The AMA argued that proposals in the report were serving the interests of business.[116]

In 1935, Dr. Hugh Cabot proposed that a national health program founded on group practice could be an appropriate answer to the social and economic problems of the time. He had persistently pressed for group medicine, noting that: "The medical profession, though showing great ability to adjust itself to scientific change, has not shown ability to adjust itself to economic change."[117]

Since the early 1900s the prospect of instituting a compulsory health insurance was a recurring debate. But proponents and opponents shifted as interests, politics, ideologies, and social contexts shifted.

In the late 1800s, American society was primarily agrarian and populist. Social insurance was not a pressing concern to farmers. At this point in history, the government had not established a role in social welfare or economic regulation.

As socialism and the progressive movement gained momentum in the early 1900s, the issue of a national health insurance was raised. Although the AMA supported the idea,

the American Federation of Labor and the insurance industry opposed it. Union leader Samuel Gompers saw that union insurance attracted union membership.[118]

A few decades later unions completely reversed their stance. In the wake of the Depression, millions of people were out of work. Unions no longer had contributing union members. But in the early 1920s, physicians were changing their stance as well and began to oppose the concept. Opposition from the AMA grew into an adamant denouncement. The AMA opted for voluntary health insurance instead.

Historically, government support for a national health insurance program was divided, inconsistent, and varied as well. Government agencies argued over priorities and programs. As social contexts, interests, and demands changed, so did support. The 1920s witnessed a growing concern over costs and distribution of care. The Depression turned the focus on public health programs, unemployment insurance, and old age benefits. Other programs took precedence in the Social Security Act and Roosevelt's New Deal. In the forties, Truman proposed a compulsory insurance. But Congress as well as the public had mixed opinions. The AMA launched a massive lobbying campaign opposing compulsory insurance. Other interest groups, such as the American Hospital Association, the American Bar Association, the Chamber of Commerce, National Grange, pharmaceutical companies, corporate employers, National Civic Federation, and the insurance industry

opposed national insurance. Government agencies had their own internal interests and fought for survival of their own individual programs. Anticommunist sentiment further hindered the passing of "socialized medicine." In 1950, Korea demanded Truman's full attention and the issue faded.[119]

The general public, too, had mixed sentiments. Working-class males (and eventually their families) bought private insurance, unions bargained for insurance as a fringe benefit for union membership, and nine million returning American veterans received care by the Veterans Administration. Compulsory insurance meant an increase in social security taxes. This was not always favored by working people.[120]

In 1968, national health insurance again became a political issue, spearheaded by labor (president of the United Auto Workers, Walter Reuther) and furthered by Senator Edward Kennedy in 1969.

In sum, the health care issues raised in the 1960s were virtually the culmination of issues of the past forty years.[121]

The developments in the 1960s somewhat paralleled the Flexner era. Historically, the fragmented profession had been united by the AMA, Flexnerian reform, leading medical schools, and private foundations. After World War II and the proliferation of specialties, the profession once again was fragmented and divided. But issues were now far more

complex. The profession was now composed of various specialties loosely federated but virtually autonomous. Questions involved numbers, standards, types of specialists, availability of service, types of service, access to service, costs and responsibility for payment, responsibility and control, distribution, and standards. The health legislation passed in the 1960s further aggravated the problems, producing more physicians while the core problems in health care remained.

General Practice and Specialization

The problematic nature of general practice in America is primarily a result of how general practice was conceptualized. The Flexner report solidly established generalism as the cornerstone of medical education. This became translated, in practice, as the minimum standard. Specialization was grafted onto a system specifically designed to produce one basic, general practitioner. Conceptually, a physician was first a generalist, second a specialist.[122]

This perspective had far-reaching implications for the entire structure of the medical profession. If all practitioners were generalists, then by implication a specialist was a generalist plus something more. The specialist was required to take the same educational courses and undertake the same general internship as the generalist. Then the specialist went on for further training in a specialist area. The specialist's training equipped him with the same

skills as the general practitioner plus the additional skills of the specialist. The specialist claimed to offer an educational background and specific services unavailable from the generalist.[123] The specialist was seen as something more, the generalist as something less. The generalist was seen not by what he had, but by what he did not have. He was seen as medically inferior, if not antiquated.[124] He had become displaced by specialists.

Moreover, the general practitioner did not have a formal organizational role or clearly defined professional identity within the health care system. He did not fit into the specialized departments within the hospitals or medical schools. Nor was he a member on hospital attending staffs. Although specialist sections in the American Medical Association had given interest groups a definition and identify, general practitioners were not even recognized by an American Medical Association section, a certifying process, or a defined position within health care delivery. General practitioners lacked an organizational or political identity.

From the beginning, the relationship between generalists and specialists had generated controversy and division within the profession. "The chief objection brought against specialists is that they operate unfairly toward the general practitioner, in implying he is incompetent to properly treat certain classes of diseases, and narrowing his field of practice."[125] Although the

American Medical Association officially recognized specialties in 1869, it forbade practitioners to advertise their specialty.[126] In fact, it was not until 1977 that specialists were even permitted to designate their specialty affiliation by initials following the M.D. after their names.

A recurring issue in the specialty controversy was the economic issue. It is noteworthy how many of the same considerations causing opposition to specialization eventually brought about is acceptance.[127] Initially, specialty interests were considered risky. Not only did one risk moral indignation, public humiliation, professional ostracism, and scientific rebuttal, but one jeopardized one's income as well.[128] The specialist in practice would be turning away unrelated cases.

However, by the late 1800s, practitioners began realizing that "by devoting themselves to one branch instead of working up a general practice, they could often do more good, earn more money, and have less arduous work to perform."[129] In short, specialism had proven to be profitable.

Furthermore, specialists had gained increasing prestige and influence. They became powerful men in the American Medical Association. Rothstein notes that between 1850 and 1859, six out of ten AMA presidents were general practitioners; during 1890-1899, only two out of ten AMA presidents had been general practitioners.[130]

Also central to the issue were the various groups or classes specialists would serve. As specialists rose to prominence, people who could afford to chose to consult specialists.

The relationship between the generalist and the specialist developed in a uniquely American fashion. Medical care had evolved from the bedside to the hospital. To the American physician, the hospital is part of private practice. Every stage of patient care may be carried out by the same general practitioner. The hospital became essential to the practice of medicine. Accordingly, physician access to the hospital became essential to the doctor's livelihood.

As specialty board certification increasingly became a prerequisite to hospital privileges, general practitioners were being squeezed out, particularly in areas of obstetrics and surgery.[131]

In contrast, the European medical system assumes hospitalization as a special case of medical care rather than a normal part of private practice. When a patient needs hospitalization, he is treated by a cadre of hospital physicians who are specialists. When the patient is referred, the referring physician relinquishes his care-taking responsibility for that patient. In the European system, the different practitioners do not compete for the same patients. An interdependent role, at least in theory, is thus established.

Interest in general practice steadily declined. Medical students began to look at general practice as "what specialists discarded."[132] General practitioners were not represented on medical faculties. They were not highly regarded for their expertise and held little professional status. Hospitals were organized into specialty departments in which the general practitioner had no designated role or clinical responsibility.

As the majority of practitioners chose to specialize, the composition of the American Medical Association began to shift. Historically, the main constituency in the American Medical Association was made up of general practitioners. In 1931, 83 percent of practicing physicians in the United States were general practitioners.[133] In the 1940s, there were many practitioners in their late fifties who had entered medical school before the Flexner report. These doctors apparently thought it safer to hang onto the status quo rather than risk reform or change. However, by 1940 the specialists, not the generalists, dominated the AMA. By 1969, only 18 percent of practicing physicians were general practitioners.[134]

The problems facing the general practitioner were not so much the way he had been trained as the way medical practice was organized. Unfortunately, instead of examining alternative systems of practice, the focus in the 1950s and 1960s was on education. Higher educational standards were cherished within the medical arena as well

as in other fields. The research orientation of the 1950s and 1960s not only encouraged specialization, but also academic excellence. This excellence was to be achieved through the teaching of an elite group of specialists and researchers.[135] Since the orientation and financing in training was geared toward academic achievement, the criteria in selecting medical students corresponded. Students were selected on the basis of intellectual abilities and scientific orientation and achievement (following the tradition of the Flexner reform movement). General practice was not viewed as an intellectually stimulating area of study or practice. Medicine had become an intellectual field; family medicine had not.

Nor was there a financial incentive to become a general practitioner. Specialists earned significantly more than general practitioners. Insurance and Medicare coverage reimbursed the specialist more generously. They also provided complete coverage for hospital treatment but only partial coverage for ambulatory care.[136]

The future and success of family practice would depend on organization, policies, financing, and incentives--both for physicians to become family practitioners and for patients to utilize them.

CHAPTER THREE

THE SIXTIES

Social Movements: Theoretical Background

The decade of the 1960s is frequently referred to as "the sixties movement." To illuminate this notion, it will be useful to define and review "social movement" as a sociological concept.

Social movements, as viewed by Herbert Blumer, are "collective enterprises to establish a new order of life"[1] whose final stage "takes on a culture, a social organization, and a new scheme of life."[2] Wilson considers social movements to be an indication that the existing social order has lost its sacredness.[3]

Rudolf Heberle characterizes a social movement as "a collective attempt to reach a visualized goal, especially a change in certain social institutions." Its goal is to "bring about fundamental changes in the social order."[4] New social worlds are envisioned.

Lang and Lang emphasize again that social movements occur in order to create change, a "collective action in pursuit of an objective that affects and shapes the social order in some fundamental way."[5]

Thus emerge two features common to these definitions. First, a social movement is a collective activity. Second, the primary goal of a social movement is to initiate social change. Turner and Killian further observe that the

collectivity promotes change "in the society or group of which it is a part."[6] Social movements reflect the belief that by united efforts people can improve their conditions.[7]

In every social movement, adherents are bonded by a common set of values, the raison d'etre of the movement.[8] These values often take on visions of mythical proportions. They become highly idealized illusions, out of touch with political and social realities. Thus, the values become what Georges Sorel calls "myths."[9] But these mythical values serve as the guiding force of the movement. "It is the adherents' belief in them, not their 'reality,' which makes them important."[10] These values serve to gather support and promote the cause as well as unite the followers, generating a "we-consciousness."[11] "The movement starts out as an idealistic, optimistic crusade to which large numbers are expected to rally. It creates an issue in support of which followers may align themselves and around which a public also arises."[12]

The challenge of the 1960s was "the reorganization of American values."[13] Thus, it is significant that the sixties are frequently called "the sixties movement." It is important to identify the major movements within the 1960s and to make explicit the underlying values reflective of the era. By understanding not only the events but the spirit of the sixties, we will better understand the emergence of the family practice movement.

Social Movements of the 1960s

The sixties movement was a social phenomenon, a generalized umbrella encompassing a proliferation of movements.[14] Yet, the various movements of the 1960s did share many common values.

The civil rights movement pressed for full legal and participatory equality for blacks. The movement began as early as 1955 with the first Montgomery bus boycott protesting segregated public transportation.[15] The civil rights movement, led by Martin Luther King, Jr., gained visibility and support as racism, inequality, and police brutality were exposed to the nation by the media. National attention forced the federal government to intervene, forced the legislature to enact laws, and forced the courts to uphold and enforce these laws.

The student movement erupted as a spin-off from the civil rights movement. Students represented a large proportion of the population. In the 1960s, college enrollments more than doubled from 3.5 million to nearly 7.5 million.[16]

Students for a Democratic Society (SDS) formed in 1960 and held its first convention in 1962. The Student Nonviolent Coordinating Committee (SNCC) formed in 1961 and mobilized voter registration drives in the South. Both organizations sought to defeat racism and poverty and restructure the social order in America.

When, in 1964, the University of California interfered with on-campus recruitment for local civil rights protests, Berkeley students rebelled. Why, they asked, was recruitment for military service allowed on campus but recruitment for civil rights forbidden? This touched off the free speech movement, protesting the suppression of free speech on college campuses. Students protested the war in Vietnam and the depersonalized and unresponsive bureaucracy in general.[17] As youths were being drafted and sent to Vietnam, young people were incensed by their powerlessness. Students demanded a right to vote and a right to governmental decision-making. Campus sit-ins, demonstrations, and the seizure of university buildings erupted across the country. Students became involved in electoral politics, rallying support for antiwar presidential candidates Eugene McCarthy and (later) George McGovern. Student support mounted for Bobby Kennedy, who supported ethnic equality.

Students demanded the right to decision-making in the universities. Students protested the irrelevance of education. They demanded a share in university decision-making regarding curricula, teachers, teaching methods, and admission standards and procedures.

As the Vietnam War escalated, so did the antiwar movement and the peace movement. U.S. involvement in Indochina was protested. Key issues in the antiwar movement were American imperialism, purposelessness of the war, draft resistance, peace, nuclear testing, and the

production and use of napalm. The more the war escalated, the larger and more intense the protest became.

Activists of the counterculture, or hippie movement, decried the empty, materialistic, "plastic" lives of their parents, lives which they felt lacked feeling, love, sexual pleasure, or meaning. In reaction to the perceived forced conformity of their parents, middle class youth articulated the desire to live "authentic" lives, with the freedom of natural expression. Freedom of the individual to "do your own thing" was a common theme.

The cultural and spiritual movement which transpired envisioned a community of brotherhood, of love--a family of man. The lyrics of a popular song reflected this vision:

> C'mon people now
> Smile on your brother.
> Everybody get together
> Try to love one another right now.[18]

The flower children wore love beads to symbolize the power and essentiality of love for mankind. "Make love, not war," was a common but significant phrase.

In pursuit of happiness and community, one sought to explore his inner world and to gain a sense of the beauty of one's internal spirit. Mind expanding drugs and hallucinogenic drugs were a means of "connecting."

Haight Ashbury became a hippie haven where a utopian vision of community was experimented. The "summer of love" in 1967 was the crystallization of these beliefs and behaviors.

The women's movement was essentially a women's civil rights movement. This movement denounced the exploitation and subordination of women in American society and sought to raise a new consciousness about women. Reformists charged that women had been exploited as consumers, as employees, and as patients, as well as sexually and domestically. Women's groups sought legislation to guarantee and enforce change and equality.

The women's movement spawned many other organizations and movements. The women's movement was closely linked with the women's health care movement and the self care movement. The women's movement stressed the need for control over one's own body in all facets of life, including health care. The Boston's Women's Health Collective published Our Bodies, Our Selves, which became a model guide for self care.[19] The self care movement emphasized the importance of personal behavior in contributing to health and well-being.

The community movement, or grass roots movement, pressed for democratic participation and control. The movement denounced boards of experts and demanded that power be shifted to boards comprised of community members. The community movement criticized the police, the educational system, the housing system, and the welfare and health care system, and promoted antipoverty and community action programs. The community movement pointed to the failures of large institutions and emphasized the need for

the common person to reestablish control over his own life; hence, "power to the people."

The self help movement established the effectiveness of self help mutual aid groups, emphasizing the importance of individuals' assuming responsibility for their behavior, peer support, and self determination. These groups were based on a voluntary small group structure, formed by peers coming together for mutual assistance toward a common goal. The self help movement could be seen as a response to a perceived overly technological complexity of institutions and depersonal, dehumanizing professionals.

Proponents of the environmentalist movement awakened public awareness regarding man's abuses and destruction of his natural resources. Cars, electric power, detergents, disposable containers, and factory wastes polluted our air, land, and water. DDT and other chemicals were lethal to animal life. Cities were becoming centers of poverty and congestion. The environmentalists advocated legal safeguards to protect the environment and its inhabitants. The environmentalists also brought to public attention hazardous working conditions and environments.

The gay liberation movement promoted the right to freedom of sexual choice and sought legal recourse and protection against discriminatory and restrictive practices.

The minority movement united groups of people who demanded recognition of their rights. Chicanos, American

Indians, and Asians demanded equal rights. Cesar Chavez headed the National Farm Workers Association fighting for the rights of agricultural laborers. The Gray Panthers fought for rights of older citizens.

Ralph Nader became an articulate proponent of the consumer movement. His group, often referred to as Nader's "raiders," lobbied for legal restrictions, protection, accountability, and disclosure regarding consumer products and the production of these products for the sake of public interest. Young idealistic lawyers and other individuals joined the crusade as consumer advocates for community interests. Government institutions and regulations were no longer trusted as public protectors. The consumer movement emphasized that people needed to protect themselves. People could no longer relinquish that responsibility to social institutions which had proven ineffective.

The sixties movement is an apt description of the decade itself. "Movement" was a key feature of the decade. Involvement, participation, and action were paramount. It was believed that if all people recognized and assumed social responsibility, social inequities could be rectified. Thus, not only did the 1960s witness a proliferation of movements, but the decade itself was an era of dynamic movement.

The Spirit of the Times

The sixties movement signifies "the complex of positions, actions, and attitudes . . . including not only

political and social aspects, but psychological and cultural ones as well."[20] As Morris Dickstein summarizes, "The sixties gave impetus to both revolution and reform, and tried to combine the quest for social justice with the search for personal authenticity."[21] The sixties became a "cultural revolution."[22]

In a broad thematic sense, the sixties movement was a cultural vision, a "vision of liberated selves in a loose community of equals."[23] This vision was informed by American values: freedom, equality, justice, a belief in full democratic participation, guided by a sense of personal authenticity, meaningful action, and a spirit of community.

Within each movement of the 1960s, these themes resound over and over again. The underlying principles of the 1960s--equality, personal freedom (and the unequivocal right to such freedom), and a full participatory democracy had been written into the Constitution. These rights had already been established two hundred years prior. Essentially, the 1960s represented a revival of the Bill of Rights, and an insistence that the execution of these rights be a reality for all Americans.

The youth of the era were described as the most idealistic in history.[24] The "youth culture" envisioned a global fraternity of man, "a mythical community where people are free, equal . . . able to act out their own

desires within a fluid context of a benevolent general will."[25]

The Port Huron Statement, written in 1962 by leaders of the SDS, is a marvelous recording of these high ideals. "Man is infinitely precious and possessed of unfulfilled capacities for reason, freedom and love." What is required in order for man to achieve his capacity is a new social situation,

> a democracy of individual participation, governed by two central aims: that the individual share in those decisions determining the quality and direction of his life; that society be organized to encourage independence in men and provide the media for their common participation.[26]

The 1960s began on the threshold of unprecedented prosperity in America. Per capita income was the highest in history. The gross national product reached a record high $503 billion. Sixty-two percent of all families owned their own homes. Americans had become accustomed to the "good life" and were comfortable and complacent.[27]

The nation was filled with confidence with the election of a new president, the youngest in history. John F. Kennedy was handsome, charismatic, intelligent, and energetic. The nation was injected with idealism and optimism. The 1960 Kennedy campaign theme song reflected the mood of the nation: "We've got high hopes. We've got high hopes, high apple pie-in-the-sky hopes."[28]

Ivan Illich points to such groups as the Peace Corps, the Alliance for Progress, Israeli Aid to Central America,

and the medical missionary zealots as the "export of optimism [of the 1960s] to the third world."[29] Furthermore, Elliott Krause notes how wider society capitalized on idealism by creating programs such as the Peace Corps, positions of high prestige, but no power or material reward.[30]

The decade of the sixties was "an era of unprecedented convergence of popular initiative and public power [that] saw a surge in the spirit of national service, with people really interested in what they could do for their country."[31] Upon Kennedy's mention of a notion of a Peace Corps (made in a campaign speech at the University of Michigan), he was besieged with student letters, petitions, and enthusiastic support.

There seemed to be an expansive faith in America's potential.

> The cultural and political explosions of the '60's will make sense to us if we remember that they came at the crest of an economic boom, the climax of a generation of spectacular growth . . . the dynamism and energy of our economy seemed boundless."[32]

The concern of the 1960s, then, was a distribution of this abundance in order to redress inequalities. "The rediscovery of poverty in the 1960s marked an important milestone in the evolution of social consciousness in America."[33] Kennedy, in his campaign speech, stated that seventeen million Americans went to bed hungry. He declared that America must turn its attention to "pockets

of poverty" throughout the nation. Michael Harrington's The Other America estimated "the invisible poor" in the country to be at least forty million.[34] Harrington's book made the middle class face the fact that poverty existed in this country.[35] This book was a moving force in the War on Poverty.[36]

But, again, note the resolved spirit of the times in addressing the issue of poverty: "Any attempt to abolish poverty in the U.S. must seek to destroy pessimism and fatalism that flourish in the other America . . . there should be a spirit, an elan, that communicates itself to the entire society."[37] Thus, Yale law professor Charles Reich declared, "At the heart of everything is what we shall call a change of consciousness . . . a new knowledge of what it means to be human."[38]

The sixties were passionate times. Caring, involvement, and participation were paramount. "Give a damn" buttons jolted people from the complacency of the 1950s. In the 1960s, the commitment of involvement and direct action advanced the idea of personal, as well as social, responsibility.

The Erosion of Institutions and Authority

This idea that "man must shoulder full responsibility for history was unique for the 1960s not because it was new but because that awareness impressed itself upon unprecedented numbers of people and because it represented the

ultimate form of revolt in a cultural situation where authorities everywhere were undergoing reappraisal."[39]

Events of the 1960s demanded that people participate in decision-making processes. Authorities were undergoing considerable questioning and evaluation. It had been assumed that authorities acted in the interest of the public. Yet, Southern policemen were seen across national television bullwhipping and clubbing peaceful civil rights marchers. Domestic problems mounted. The war in Vietnam continued in spite of considerable protest and public opinion. Environmental and consumer issues were raised questioning the lack of controls and protection for the public. The scandals of Watergate cast doubt on the integrity of our leaders. There evolved a "deepening mistrust of the ability of established institutions to make good decisions."[40] Bumper stickers became a sort of medium for social commentary. "Question authority" became a popular expression.

The sixties witnessed a startling and "massive erosion of the legitimacy of American institutions. . . . The fundamental legitimacy of the established order had never before been questioned on such a scale."[41] Increasingly, anything or anyone associated with established institutions were suspect. "Antiestablishment" became an oft-quoted phrase.

Americans became disillusioned with the very institutions that had figured so prominently heretofore.

Beginning with the Depression in the 1930s, governmental institutions began providing basic needs for Americans.[42] Large institutions had represented strength and security. In the 1960s, these same institutions were called into question. The public began to challenge the authority and legitimacy of economic, political, educational, military, and religious institutions.

The confidence and trust in authority had been undermined. The public began to demand active participation. Bureaucratic institutions were deemed as impersonal and unresponsive and incapable of making good decisions. Moreover,

> the economic injustices that grew out of a vastly maldistributed wealth of a rich society revealed a moral and intellectual failure on the part of the responsible leaders both private and public. Since a nation willing to finance expensive wars and the development of technology necessary to place men on the moon could not convincingly plead scarcity of resources, it appeared to critics that the very will to right the wrongs was lacking.[43]

Traditional newspapers were being challenged by an underground press. Papers such as The Los Angeles Free Press, The Berkeley Barb, Rolling Stone, Old Mole, and Oracle, were subject to constant harrassment by government agencies; their people were arrested, their offices broken into.[44]

An anti-intellectual public climate developed. The application of science and technology for military bombing and maming of peasants was condemned. Humanists cried out

that ungoverned science was dangerous to mankind. Science was no longer seen as an ally, but as a threat. C. Wright Mills declared that rationality and science do not necessarily lead to informed and independent intelligence; rationality and science can also lead to idiocy.[45]

It was in this social climate that the institution of science and medicine came under vehement attack. There evolved a "crisis of confidence in modern medicine."[46]

Economic Realities and Medical Deficiencies

Just as inequities in society at large were the focal point of the early 1960s, inequities in medical care became an issue of concern. Critics contended that medical care was unequally distributed. The poor, elderly, minorities, and rural community dwellers often lacked access to good care. Not only was the access to care an issue, but variations in the delivery of care became obvious. The poor received a different kind of care, a lower quality of care. Other critics accused medical practitioners of unethical practices on the poor and on women--such as performing unnecessary procedures, surgeries, and sterilizations.

Some social critics contended that the inequalities and problems of the health care system mirrored the injustices in society as a whole.[47] Critics such as Waitzkin and Waterman and Navarro called into question the capitalist economic system, claiming that social inequity,

discrimination, and self interest will always persist in capitalist societies.[48]

As American values and institutions were being redefined in the 1960s, rights were being asserted, codified, and legally tested--what a U.S. News & World Report article referred to as a "rights explosion."[49] Reformists advocated that medical care is a right, not a privilege. Patients' rights declared the right to treatment, the right to equal care, the right to information and informed consent, the right to privacy and confidentiality, even the right to die.[50]

Equal access to medical care became the number one priority when Johnson took office in 1965. Three days after his State of the Union address, President Johnson initiated his Great Society program, urging the passing of the Medicare bill that would provide health care assistance to the aged. Upon the passage of Medicare, the President joyously proclaimed,

> No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings that they have so carefully put away over a lifetime so that they might enjoy dignity in their later years.[51]

In the beginning of the 1960s, the nation experienced years of unprecedented economic growth. In this kind of economic environment, it seemed idealistically possible to envision a nation without poverty (hence, the War on Poverty and the Great Society programs), a nation where

each individual would be guaranteed health care (hence, Medicare and Medicaid and neighborhood health centers), a nation where opportunity is possible for all (hence, federal funding of universities, student loans, changes in admission procedures). Generosity is perhaps easier in times of plenty.

But generosity is a social, political, and economic construction, a relative value having to be juggled and balanced with other values and realities. Early in the decade, reformists sought to resolve inequities; in the latter part of the decade, efforts were directed at containing costs. In the late 1960s, changes in the economic realities and in social pressure imposed changes in national priorities.

The escalation of the Vietnam War and its duration was draining the nation's resources and energy from domestic needs.[52] The government chose to spend twenty to thirty billion dollars per year on the Vietnam War, yet spent less than two billion dollars per year on poverty. It became evident that there was a huge discrepancy between the promise and performance of the Great Society and War on Poverty programs.[53]

By the end of the decade, unemployment and runaway inflation rapidly rose. The recession of the early 1970s signaled that affluence could no longer be assumed.[54]

Medicine did not escape the runaway inflation highlighted in newspaper headlines. Per capita health

expenditures rose from $79 to $324 between 1950 and 1970, representing a 310 percent increase at a time during which the consumer price index rose by only sixty percent.[55]

Pressed by economic pressures and mounting inflation, the government evaluated health expenditures in terms of "diminishing returns." Costs were high, access to care was poor, and the U.S. health levels were not as high as in some other developed nations.[56] Despite a massive increase in expenditures, the nation's health did not improve--or, at least, not in ways that had been expected.[57] In other words, legislators did not feel that they were getting their money's worth; cost was not worth the benefit.

It was a shocking--not to mention costly--realization: Medical care did not equal health.[58] More medical care, more treatments, and more medicine did not necessarily render "more" health.

President Nixon announced that the U.S. faced a major "crisis" in health care in a press conference in 1969.[59] First, this was an economic crisis. The effects of inflation, the introduction of Medicare and Medicaid, and the existing reimbursement structure contributed to soaring costs. Not only had unit costs for services increased, but Medicare and Medicaid had raised the demand for medical services.

Not only had costs increased in general, but there was a dramatic increase in the government's share of these costs. The government's share of the nation's health

expenditures increased from twenty-six percent in 1965 to thirty-seven percent in 1970.[60] By 1970, Medicaid, which had received little attention when enacted into law as part of the Medicare package, cost the federal government almost as much as Medicare.[61]

Advances in medical technology also contributed to costs. Every new procedure and new technology that improves the quality of care is accompanied by additional costs.[62]

Social values played a key role in increased costs as well. The public had higher expectations of what medicine should accomplish. The heightened commitment to health care as a right prompted the passage of legislation to ensure and finance that right. Furthermore, the "medicalization of deviance" increased health care expenditures.[63] Behaviors such as alcoholism, child abuse, and drug addiction which were previously defined as sinful or criminal acts, were newly defined as medical problems. Thus, the burden of cost was transferred from religious and penal institutions to medical institutions. These actions also contributed to the increase in medical care costs.

The definition of a situation as a crisis by the executive branch of the government signaled to the legislative bodies to act. More than thirteen hundred health care bills were introduced in Congress in 1974.[64] A crisis becomes official priority, a situation demanding

immediate attention. A crisis also presents a whole realm of opportunities.

The crisis of costs and issues surrounding health care financing turned attention to the inadequacies of the American health care system. The crisis in medical care afforded reformists the opportunity to express opinions toward changing the system. Critics used the opportunity to enumerate, analyze, and in some instances berate, the deficiencies of the health care delivery system. Others offered feasible alternatives and provided options for changing or improving the system.

Public health issues gained increasing attention. Repeatedly, epidemiological studies demonstrated the multiplicity of factors which contributed to health and disease. Although advances in medical science (especially in the development of vaccines and anti-infectious drugs) did much to reduce mortality and morbidity, the major threats to health in the 1960s were genetic and environmental factors and personal behavior.[65] Health was "only marginally affected by medical care."[66]

Age and disease-specific mortality rates revealed that in adolescents, three out of four male deaths were due to accidents, suicide, or homicide; in midlife, heart disease, neoplasms (especially lung cancer), accidents, suicides, homicides, and cirrhosis of the liver were leading causes of male deaths. The same pattern held true in late middle age.[67] It became evident that factors such as heredity,

housing, income, sanitation, air and water quality, smoking, alcohol consumption, exercise, diet, and stress were major contributors to health.[68] It was noted that these major health problems were "frequently the result of disease-inducing human behavior, culturally influenced social patterns and environmental factors."[69]

Moreover, it was said that medicine tended to emphasize illness and cure rather than health and preventive care. Public health interest had become isolated from medical care.

Some critics even asserted that the medical establishment had become "a major threat to health."[70] Illich claimed that the medical establishment created an illusionary and detrimental public dependence upon medical care evolving into a "medicalization of life."[71] The patient had relinquished his responsibility to his own health. "To ward off disease or recover health, men as a rule find it easier to depend on the healers than attempt the more difficult task of living wisely."[72]

The structure and delivery of health care was called into question. Alford attributed the problems in health care delivery to the conflict between the structural interests between two interest groups: the market reformers and the bureaucratic reformers. These groups, he contended, compete for dominance within the context of a market society.[73]

Physicians came under vehement attack. The prevailing anti-medicine mood of the country transformed doctor into villain.[74] Physicians were accused of being the cause of the current predicament, motivated by self interest and secured by monopolistic practices.[75] Health providers were portrayed as being uncaring, unsympathetic, condescending, and controlling.

Doctors were blamed for the lack of communication and distrust in patient-doctor relations. It was believed that doctors did not understand the kinds of people they served.[76] Doctor-patient communication became a focal point of sociological interest.[77]

President Nixon's 1969 task force investigating the problems of Medicaid and related programs concluded,

> Not only do millions of consumers get care on a hit or miss basis or lack access to care except in medical crisis, but virtually all consumers lack access to decision making machinery that can bring about that change.[78]

Thus, it was felt that the community must be involved in the planning process. Consumer participation became law in 1975. Public Law 93-641 established health planning agencies on a national, state, and regional level, and mandated consumer participation.

In 1971, John G. Veneman, an undersecretary of the Department of Health, Education and Welfare (HEW), announced a turning point: Decisions on health care

delivery had passed from professional to political.[79] This was hailed as a victorious solution.

Thus, political, legal, and reformist efforts focused on resolving deficiencies and containing costs. In doing so, the organization, financing, and delivery of care was called into question. New measures were introduced to impose external regulation of the medical profession. Governing bodies such as health maintenance organizations (HMOs), Professional Standard Review Organizations (PSROs), and Health Systems Agencies (HSAs) were created. It was contended that the medical profession must be accountable to the public financially, socially, and medically.

CHAPTER FOUR

THE EMERGENCE OF FAMILY PRACTICE AS A MEDICAL SPECIALTY

The Crisis

In the late 1960s, concern for equity was accompanied by concern for cost. Cost containment and the maldistribution of physicians became congressional concerns. In his message to Congress on February 28, 1967, President Johnson expressed the need for government intervention in reducing medical costs: "Federal programs must also play a role in promoting cost consciousness in medical care."[1]

In April, 1968, Kerr L. White, speaking to the Congressional Committee on Medical Costs and Health Care Organization, cited the failures of the American medical care system. He recognized the eminent need for the medical profession to reorganize: "Medicine must organize itself and its resources or it will surely be organized by others."[2]

In July 1969, President Nixon announced that U.S. medical care faced a "massive crisis . . . unless something is done about it immediately." This pronouncement primarily referred to costs. A report by the Department of Health, Education and Welfare (HEW) alerted the President and Congress that inflation had produced small return for government dollars. The nation was being taxed far beyond its capacity.[3]

It is interesting to note that although it was the report from HEW which prompted Nixon's declaration of the crisis in the nation's health care system, HEW Secretary John W. Gardner resigned from his post effective March 1. He resigned

> reportedly because there was dissatisfaction with the Administration's policy of placing higher budget priority on the war in Vietnam than on domestic needs. However, Gardner denied the report.[4]

Congress itself criticized the administration for its inaction after pronouncing the "massive crisis." The administration reduced (Johnson administration) requests for funds for various health programs, manpower, research, and Hill-Burton. Furthermore,

> Dr. Roger O. Egeberg was not confirmed as Assistant Secretary for Health and Scientific Affairs until July because of political dispute and then did not take office until September. By December, only three of his eight assistants had been selected.[5]

The process of defining and labeling social situations as "crisis" is both problematic and fascinating.[6] In viewing the administration's unsatisfactory response subsequent to the declaration of an urgent health care crisis, one is reminded that a crisis is a social construction, one which exists only if socially defined and perceived. "Social, economic, and political stakes are involved when social problems are represented as having reached a crisis stage."[7] Whoever declares there is a

health crisis has the opportunity to define it; whoever defines the problem has the opportunity to ensure that these definitions are institutionalized through policies backed by resources allocated to them in the midst of the perceived crisis situation. Moreover, a crisis implies a condition that is different from all others.[8] A crisis situation often permits a broader range of action presumed necessary to alleviate the urgent situation. Actions by government that would ordinarily be resisted are often readily accepted in response to a defined crisis.[9] Finally, the defining of a crisis can be the result of the symbolic and political shaping of popular demands.[10] For example, a fascinating observation regards President Nixon's address to the AMA House of Delegates on June 27, 1971. The main thrust of his speech was the issue of drug abuse as "America's public enemy number one."[11] He but merely made a passing reference to the need for health care system reform.

In 1965, equity of health care was the primary concern guiding health legislation. President Johnson, in his State of the Union report on January 7, 1965, asserted:

> Our first concern must be to assure that the advance of medical knowledge leaves none behind. We can--and we must--strive now to assure the availability of and accessibility to the best health care for all Americans, regardless of age or geography or economic status.[12]

Yet, less than ten years later, economics became the primary concern guiding health policy actions. The Vietnam

War had dragged on for twelve years and had drained the American economy. Faced with a severe economic recession, soaring inflation, an energy "crisis," and an economic slowdown, federal efforts and legislation such as medical peer review and health maintenance organizations focused on containing health care costs.[13] The early 1970s faced the bitter reality of limited resources.[14]

John Ehrenreich notes the transition of those affected by deficiencies of the health care system: "The Johnson era health care crisis was the political property of the poor. Health programs came wrapped in antipoverty packages, along with housing, education, and welfare." Under Nixon, with soaring increases in insurance rates, the crisis moved to the suburbs.[15]

The Profession Under Pressure

The medical profession was besieged with problems. High costs of care continued, and the medical profession was blamed. The threat of government control loomed. Public sentiment and criticism of physicians was frequent and fierce.[16]

But critics did not only reside outside of the medical profession. Within medicine, physicians themselves became critical of AMA practices and the organization of health care delivery. The AMA was losing ground. Younger doctors, in particular "no longer accepted the AMA's view of society."[17] For the first time in fifty years, AMA membership fell to fifty percent of the profession.[18] In

1971, younger doctors organized their own group called the Medical Committee for Human Rights.[19]

A protest demonstration disrupted the first general session of the AMA in 1969. A group of demonstrators marched down the aisles chanting "Hip, Hip, Hippocrates . . . Up with service, down with fees," bearing signs saying, "Caution, the AMA may be hazardous to your health."[20] One protestor, a third-year resident, declared that the AMA stood for "American Murder Association." "You're the criminals," he charged, "who, rather than developing a preventative health program, have prevented progress. You're the criminals, who through your monopolistic, exclusionary, and racist practices have created a vast shortage of health manpower, resulting in a needless death of countless millions."[21]

The AMA dismissed the demonstration and proceeded with its meeting, conducting ordinary business in an ordinary fashion. Later, JAMA merely made a brief reference to the incident.[22] But such a display could not help but arouse concern. At the annual convention in New York in November, 1969, security measures were enforced to prevent the possibility of future demonstrations.[23]

AMA leaders recognized that the AMA must reorient itself in order to survive. In August, 1969, AMA president Dwight L. Wilbur called for the association to take a lead in developing new and more economic methods in health care delivery. "Our problem as physicians and members of the

AMA is to develop a social sense that matches our clinical sense."[24] In his presidential address in November, 1969, Gerald Dorman said,

> In the decade ahead the AMA must become--and prove to the public through visible action that it has become--more patient-oriented. . . . During the 1960's, we did find it difficult to enhance our reputation as protectors of the public or of our patient.[25]

The importance of the profession's public image was indeed recognized:

> We must realize that our reputation as physicians, and the reputation of our profession, does not consist of what we think we are . . . or even of what we really are. Our reputation is what people believe us to be--right or wrong.[26]

Not only did Dorman express concern for public approval, but for approval from the younger generation of physicians. Recruitment was essential to the survival of the organization. Dorman believed that younger physicians were more patient-oriented. Not only must the AMA establish an equitable and quality system of patient care, but it must enhance its attractiveness to physicians. "If those young physicians shun our Association, what happens to the AMA when we have all passed on?"[27]

Bruce Fagel, president of the student section of the AMA, reflected on the loss of faith in American institutions. He observed: "The Vietnam War . . . destroyed the students', the youth's, basic trust and basic faith in many of our institutions. . . . The real question for the

future is not whether our established institutions can withstand challenges and attacks that are present today, but whether they can respond to the basic problems underlying these challenges. Many of the problems today are not new . . ."[28]

Thus, the AMA felt pressures from within as well as from outside the profession. Such pressures forced the AMA to adopt a more liberal, patient-oriented stance. Family practice became the profession's answer to high cost, inaccessible, fragmented, and depersonalized medical care.[29] As stated in a basic family practice text,

> Personalized, holistic care is an essential component of family practice. The need for personalized health care is consistently recognized by patients and philosophers alike. Our increasingly fragmented health care system has propelled this issue to major prominence.[30]

Family practice developed as a specialty primarily as a response to major deficiencies and needs in the health care system.[31]

The Family Practice Movement

Two professional bases for general practitioners were evolving. One was the AMA Section on General Practice established in 1946. The second base was the American Academy of General Practice (AAGP), established in 1947 by a group of physicians who favored specialty designation.[32] By 1950, the Academy had more than ten thousand members; by 1970, thirty-one thousand members. The rapid growth of the

Academy posed a possible divisive threat to the AMA.[33] Ironically, the AMA's wariness toward the Academy was a reversal in history. In the late nineteenth century, the AMA's main constituency was made up of general practitioners who feared organized specialty competition. By 1970, the AMA's main constituency was composed of specialists who viewed organized general practitioners as potential competition.

The Academy sought specialty status. Other specialties had defended their interests proclaiming unique missions, identity, and technical expertise. Key to success was the establishment of a certifying board. But, again, the historic problem was raised: Should the goal be to standardize the whole of general practice or to formulate a level of excellence? The problem was again a touchy issue and could threaten to divide the Academy just as it was trying to unite as an organized whole. Community practitioners feared outside regulation, potential compromises to other specialties, and loss of hospital privileges.[34] Rather than generate divisive controversy, the Academy dropped its push for certification and instead adopted a continuing education requirement for membership.

The Academy opted for a united front, emphasizing the role of the generalist in medicine. In 1950, five basic tenets were formulated:

1. Voluntary or nongovernmental forms in medical practice.

2. General practice as the foundation of medical practice.

3. Medical practice is a public trust.

4. Every competent physician should have access to hospital staff membership.

5. Postgraduate studies on a continuing basis.[35]

These tenets did not merely represent the Academy's goal; it is evident that the tenets reflected the Academy's fears as well.

The number of generalists continued to decline. In 1957, the AAGP, the AAMC, and the Council on Medical Education organized a committee to restudy general practice. The committee worked to define general practice as a distinct specialty and recommended a two-year graduate training program for the acquisition of special proficiency (to shed the label of "well-rounded"). He would provide continuity of care. A debate ensued whether family practice should include surgery and obstetrics as well as medicine and pediatrics; it was finally resolved that training would encompass all of them.

The AMA developed pilot training programs. But of the 824 residency positions offered, only 132 of these were filled by American or Canadian graduates.[36]

A group within the AMA Section of General Practice was pressing for the establishment of a specialty board. The Academy needed to act in order to maintain its leadership.

By 1965, the Academy mobilized and pressed for board certification.

The AMA faced a demanding public and internal pressures as well. General practice now had some organizational representation. The shift to family practice, as representative of primary care, was further reinforced by the findings of several reports commissioned in the early 1960s. These reports focused on defining health care needs, graduate medical education, and the academic base, role, status, and working conditions of the general practitioner. The reports unanimously concluded that there was a drastic deficit in the number of primary care practitioners.

The family practice movement was not solely an American phenomenon.[37] The World Health Organization (WHO) Expert Committee on General Practice met in 1962 to discuss the worldwide shortage of general practitioners.[38] Its report recommended postgraduate training programs.[39]

The National Health Council and the American Public Health Association analyzed the impact of changing patterns of health and disease.[40] Their 1962 document, Health Is a Community Affair (commonly referred to as the "Folsom report"), stressed the need for a "personal physician," suggesting a personal doctor-patient relationship. This personal physician would provide comprehensive, continuing and preventive care. The report emphasized that the "personal physician" should have training, status,

remuneration, and professional privileges comparable to other medical specialists.[41]

Meanwhile, concerns mounted regarding the lack of policies or standardization of internship and residency training, as well as specialist manpower issues. Every phase of medical education was answerable to and dependent on different elements. Undergraduate education was developed by medical schools and the federal government. Medical schools affiliated with internships and residencies but exercised little control or involvement. Hospitals established internships and residencies to be accredited by the review committees. Review committees were accountable to specialty associations and to the Council on Medical Education, while the content of training and certification was controlled by specialty boards. Board certification, although not an official requirement, was essential to the acquisition of hospital privileges.[42]

In 1963, the AMA Council on Education recommended that an outside study of graduate education be conducted. (It may be recalled that in the early 1900s, such a tactic produced the Flexner report.) The Citizens' Commission on Graduate Medical Education was formed. John Millis, president of Western Reserve University and chairman of the board of the Carnegie Foundation for the Advancement of Teaching, headed the committee.

Funds and staff lacking, the Commission determined its first priority was to analyze graduate medical education as

a whole; manpower issues were relegated to second priority. The Millis report of 1966 defined graduate medical training as part of university training. The report recommended terminating the internship and implementing a three-year residency system instead.

The Millis report also identified the need for a "new" specialist, a "primary physician." The term primary physician emphasized the concept of primary responsibility for the patient's welfare. This new specialist would be responsible for comprehensive and continuing care of the patient, focusing on supportive preventive care, rather than episodic, acute care. This specialist would be physician, counselor, and manager of the patient's well-being and therapy.[43]

The Coggeshall report, a report by the Association of American Medical Colleges in 1965, also called for the expansion of the role and responsibility of the universities in graduate medical education.[44]

In 1966, the AMA Council on Medical Education created the Willard committee to examine general practice specifically. The Willard report identified the need for a "family physician," emphasizing the importance of the family in health care. The family physician would serve as the patient's first contact, evaluate the patient's total health needs, and refer the patient when indicated while providing continued, personalized care throughout. The Willard report concluded that family practice possessed

both a distinct body of knowledge and function different from other specialists.[45] The niche for family practice was created.

Undoubtedly recalling past failures of general practice residency attempts, the Willard report recommended not only specialty status (with training equivalent to other specialties, development of a specialty board, and a certification process), but also recognized the critical importance of funding from federal, state, and local sources if family practice were to succeed.

In 1966, the Academy established a committee composed of representatives from AAGP and the AMA Section on General Practice in order to define actual content of family medicine and to delineate specific criteria for certification.[46] The specialty of family practice was defined as comprehensive medical care in which the physician accepts continuing responsibility for the patient. Not only would the family practitioner develop clinical skills, but he would be trained to incorporate sociological, behavioral, and environmental approaches in patient care.[47] A three-year residency would be required, and recertification would be required every six years. The committee worked with the National Board of Medical Examiners to develop its first exam, given in 1970. (Note the switch in alliances here: For thirty years, the National Board had denied proposals for general practice certification. Now the Board became an agent of family practice.)

Thus the reports supported each other. The reports unanimously identified the need for family practitioners and endorsed the concept of board certification. As these processes gained momentum, approval for a certifying board was finally granted in 1969.

Primary Care and the Family Physician

The development and acceptance of family practice was related to perceptions of both the government and the general public who defined an urgent need for primary care.

The influential reports of Millis, Willard, WHO, and Folsom seemed already predicated on the need for primary care and family practice in the United States.[48] The reports pointed to the fragmentation of health care, the preponderance of specialists, and reiterated the need for continuity in care. The reports called for a broader perspective on health and disease, calling for comprehensive care which would incorporate social as well as scientific approaches.

> Specialization to date has been mainly disease oriented. . . . There is a growing recognition of these deficiencies among the medical profession and the public at large. There is increasing pressure upon the profession to provide a way by which the patient and his health problems can be viewed as a whole . . .[49]

The Folsom report stated that comprehensive care required an awareness of all factors affecting the individual, including religion, social, economic, cultural, personal, and heredity.[50]

The reports represented a shift in philosophy

> from episodic to continuous and comprehensive patient care; from disease oriented emphasis to the whole patient and his family; from rigidity to flexibility; from an individual physician to the physician as a member of a group and health team.[51]

Primary care was viewed as a form of medical care delivery that would right the wrongs of the American health care system. A new type of medical doctor was deemed necessary to deliver such care. Thus, the production of this "new" type of practitioner, whether he be called general practitioner, personal physician, or family physician, was seen as essential in meeting the need for primary care. Family practice became defined as the equivalent of primary care.

Primary care is first contact care. It assumes ongoing continuity of patient care, both in health maintenance and therapy of illness. It is a personalized care, yet comprehensive. It serves a coordinative function for all the health care needs of the patient and the appropriate use of consultants and community resources.[52]

These expectations were masterfully synthesized into a medical specialty called family practice. Rakel and Conn's basic text of family practice explicitly states: "The specialty of family practice is specifically designed to deliver primary care."[53]

The Willard report defined the family physician as one who:

> (1) serves as the physician of first contact with the patient and provides a means of entry into the health care system; (2) evaluates the patient's total health needs, provides personal medical care within one or more fields of medicine, and refers the patient when indicated to appropriate sources of care while preserving continuity of his care; (3) assumes responsibility for the patient's comprehensive and continuous health care and acts as leader or coordinator of the team that provides health services; and (4) accepts responsibility for the patient's total health care within the context of his environment, including the community and the family or comparable social unit.[54]

Family practice was conceptualized as a "specialty in breadth," combining behavioral sciences with biological and clinical sciences.[55] The range of family practice is reflected in the table of contents in any basic family practice text. A table of contents will typically contain chapters regarding: the family (i.e., family dynamics, sociocultural influences); medical records (problem oriented record taking); community medicine (i.e., preventive medicine, health screening, epidemiology, utilization of community resources, allied health professionals, use of consultants, rehabilitation, care of the geriatric patient); behavioral problems (i.e., alcoholism, drug abuse, medical ethics, personality disorders, anxiety, depression, schizophrenia, sexual assault); counseling (i.e., interviewing techniques, psychotherapies, marriage and family counseling), contraceptive counseling, sexual counseling, genetic counseling; clinical specialities (i.e., surgery, orthopaedics, otorhinolaryngology,

ophthalmology, gynecology and obstetrics, urology, proctology, pediatrics, pulmonary medicine, gastroenterology, cardiology, neurology, nutrition, dermatology and syphilology, allergy and immunology).

While many championed family practice as a new and unique specialty,[56] others claimed that family practice was virtually indistinguishable from traditional general practice.[57] Some claimed it was merely a renaissance; others claimed family practice had evolved as a concept as well as a specialty.[58]

While this debate continues to the present day, an important point clearly remained: The mere designation of family practice as a specialty did not guarantee its ultimate success. Success of family practice required a massive investment of resources to support its development.[59]

The allocation of funds for family practice was supported by a social, economic, and political environment willing and able to commit to such an investment.

Federal Funding for Primary Care[60]

The government, the medical profession, and the public looked to primary care as the solution to the problems facing health care delivery. The need for primary care was translated into a need for more primary care physicians.[61] Consequently, massive health manpower legislation began.[62] Between 1963 and 1977, funding by congressional legislation succeeded in increasing medical school enrollment (and

aggregate physician supply), directly stimulated minority and disadvantaged student enrollment (and recruitment), stimulated and supported curriculum development and reform, and established and increased primary care training.

Although federal support of medical education had been subsidized indirectly through post-World War II research grants, 1963 marked the first time that federal funding was directed explicitly at medical education and enrollment.[63] The Health Professions Educational Assistance Act of 1963 (P.L. 88-129) was formulated with one clear objective: to increase the aggregate supply of physicians. The rationale behind this was that increased supply would presumably remedy problems of access and usage of medical care and, ultimately, improve the health of Americans. P.L. 88-129 allotted federal matching grants for the construction and expansion of teaching facilities. A major development was the establishment of the Health Professions Student Loan program (HPSL).

The Health Professions Educational Assistance Act Amendment of 1965 (P.L. 89-290) extended P.L. 88-129 for an additional four years. P.L. 89-290 also expanded the student loan program, increasing the amounts available to students. This was the establishment of the Guaranteed Student Loan Program (GSLP) and the Federally Insured Student Loan Program (FISL).[64] These programs became a major source of financing for students' education.[65] This act also instituted a foregiveness program, canceling fifty

percent of the loan amount in exchange for services in a physician shortage area upon graduation. Scholarships were established for students who could demonstrate extreme financial need.

This legislation also initiated capitation support to medical schools. Payment to schools was based upon the number of enrolled medical students. This legislation was to serve as both a monetary resource and a monetary incentive to expand medical school enrollment. Yet, many of the schools developed under these programs continued to emphasize research.[66]

The Allied Health Professions Personnel Training Act of 1966 (P.L. 89-751) concerned itself with student loan policies. It established a student loan revolving fund for health professions and opportunities to students to complete loan forgiveness in exchange for practice in low income areas.

The Health Manpower Act of 1968 (P.L. 90-490) established and supplemented grants based on enrollment. This legislation also allocated money for curriculum development as well as for student scholarships.

The National Health Service Corps was established by the Emergency Health Personnel Act of 1970 (P.L. 91-623) to deliver health care to underserved areas.[67]

The Comprehensive Health Manpower Training Act of 1971 (P.L. 92-157) was the first act to directly emphasize primary care training. This act was specifically directed

at augmenting the development of family practice and increasing the number of physicians training in family medicine. In 1969-1970, less than ten schools listed family medicine departments.[68] Grants were made available for the establishment and expansion of family practice programs. Special project grants were offered for the development of family practice in medical school curriculum.[69]

Medical schools facing financial problems were given monetary assistance. The government subsidized the further construction of research and teaching facilities. Student enrollment was encouraged through capitation grants. To hasten physician supply, medical schools were paid a bonus for each graduate of a shortened three-year curriculum.

The student assistant program emphasized recruitment of financially disadvantaged students. Loan repayment policies were revised, with forgiveness provisions and scholarships available to primary care practitioners in physician shortage areas or in areas populated by a large concentration of migratory workers.

The Emergency Health Personnel Act Amendments of 1972 (P.L. 92-585) established the Public Health Service and the National Health Service Corps. These programs awarded scholarships in exchange for service in physician shortage areas.

To encourage physicians into the military, the Armed Forces Health Professions Scholarship program of 1972

offered government subsidy of medical school education in exchange for military practice upon graduation.[70]

Federal expenditures for manpower training had almost doubled between 1969 and 1976 to $1.5 billion.[71] The series of legislative measures succeeded in reaching their objective of increased medical student enrollment. The number of first-year medical students increased from 89,000 in 1966 to 153,000 in 1976, representing a 72 percent growth.[72] Accordingly, the number of medical schools increased from 88 in 1966 to 120 in 1978.[73]

Specialty choice became the focus of numerous studies as well. In efforts to compile a profile of the type of student likely to choose primary care practice, social scientists examined student characteristics such as backgrounds, individual attributes, medical school admission criteria, and the medical education process.[74] These studies were based on an assumed correlation between background and specialty choice. In this way, admission policies were viewed as a potential means of balancing the division of labor.[75]

By the mid-1970s, deficiencies in manpower legislation and (the resulting) increased physician supply were evident. An increased number of physicians did not remedy the problems of geographic and specialty maldistribution.[76] The passage of the Health Professions Educational Assistance Act of 1976 (P.L. 94-484) sought to address these

imbalances. Primary care was the main focus of this legislation.

This act represented a major shift in federal funding policy. (This act also represented major debates in Congress.) This legislation set up a "shared schedule" of payment for primary care training. It continued construction of teaching facilities and grants for primary care programs. Modifications, criteria, and further provisions were made in student assistance programs and the National Service Corps. In addition, Congress claimed the right to direct and control personnel, curriculum, instruction methods, and administrative concerns of institutions receiving government assistance.[77]

The main objective of P.L. 94-484 was to increase the number of primary care practitioners in order to improve specialty distribution. Capitation granted to medical schools was based on a percentage of filled primary care residency positions.[78]

Grants were allocated to medical schools for the expressed purpose of establishing family practice departments, medical schools, and residency training programs. Money was also aimed at recruiting disadvantaged individuals. Medical schools were obligated to increase their annual enrollment by five percent. In addressing the problematic issues of foreign medical graduates, a competency requirement was instituted. Immigration and nationality provisions were also formulated.

The implications of this act involved controversial issues. It established a precedent, where Congress became entrenched in the domain of the medical profession. Student choice, opportunities, and financial support had now become subject to federal mandates. Through P.L. 94-484, the government assumed responsibility for health manpower.

The year 1976 also marked a change in outlook regarding medical education financing. Congress began to think that students should bear more of the costs of their education despite the fact that the average tuition and fees per medical student increased by almost 240 percent between 1969-70 and 1976-77.[79] Loans became limited to students of exceptional need, and efforts were made to terminate capitation.[80]

The year 1976 marked an increase in family physicians for the first time in fifty years.[81] Yet, federal concerns over physician distribution were increasingly superseded by concern over costs. Medical expenditures became a primary issue. In 1977, the total national health expenditure was more than $162 billion.[82]

Recruitment

It was intended that family practice would meet the need for primary care. "Few hospitals and few existing specialists consider comprehensive and continuing medical care to be their responsibility and within their range of competence."[83]

It is one thing to carve out a niche; but this niche must be filled by recruits. Past efforts to establish general practice training programs had failed to interest students. By 1968, only two percent of all medical school graduates were entering a general practice residency.[84]

Designating family practice as a specialty was one way of enticing recruits. The Folsom report recognized that it was essential to designate family practice a specialty of comparable training, status, remuneration, and privileges to other specialties.

Yet, the 1960s had instilled youth with different social values than their predecessors. Prior to the 1960s, specialization in all sectors of society was held in high regard. Specialization represented a higher form of medicine. In a poll conducted by Becker et al., medical students who had decided not to go into general practice residencies claimed that general practice was too broad, involved too much work, left little time to know patients, lacked specific definition as a specialty, and lacked acknowledged professional and social status.[85]

In contrast, society in the late 1960s had experienced a loss of faith in experts. The medical profession's emphasis on specialization was blamed for a fragmented, dehumanized health care system. Medical students were increasingly disenchanted with increased specialization and were committed to meeting the public's needs and improving the delivery of health care.[86] Compared to their

predecessors of the 1950s, medical students of the 1960s and early 1970s were more socially concerned.[87] They expressed a determination to eliminate inadequacies and inequities in health care delivery. In fact, some observers maintain that a "new [type of] medical student" emerged, committed to changing both the medical profession and the health care system.[88] Young people of the 1960s had been injected with idealism.[89] Some studies suggested that family practice attracted more idealistic physicians than other specialties.[90]

Personal interviews of family practice residents lend strong support to this finding.[91] Although the interviews with residents were conducted on a one-to-one strictly confidential basis, residents, independent of each other, repeatedly stated that they had chosen family practice because they thought they were going to "save the people." One resident explained: "How was I going to save the world if I didn't know a little bit about everything?"

Family practice was perceived as a more humanistic approach to medical care. A resident described his perception: "Most specialties are too cold, too isolated and aloof. I wanted to help people with their everyday lives." He wanted to be a healer, not a hero.

Physicians wanted to focus on healing rather than on cure, as exemplified by the following impression of a resident in training:

> Contemporary medicine is based also on the belief that machines are as accurate as humans, that data can be hard, that numbers and statistics and graphs can faithfully represent a human being. This kind of practice excludes intuition, sensitivity and mutuality. It thereby deprives both the physician and the patient of their power to heal and be healed.[92]

Several residents felt commitment to the community. As one resident expressed, "Being a doctor just isn't a job. I feel I'm an essential part of the community." Another resident imagined his ideal for the future as "working in a clinic in the Sierra foothills or something, being part of a small community. . . . Community is a feeling. It's grass roots socialism."

Family Practice: The Spirit of the Times

In examining the key elements of family practice, it can be seen that family practice was the embodiment of the 1960s ideals, values, and public expectations. The tenets of family practice were developed in relationship to the public demand for primary care and the economic realities of the times.

Family practice encapsulated the sixties notion of justice, equality, and equal opportunity.

> The family physician provides continuing and comprehensive care in a personalized manner to patients of all ages and to their families regardless of the presence or absence of disease or the nature of the presenting complaint.[93]

One almost expects the statement to go on to read "regardless of race, color, or creed"! The Willard report states

that the family physician will help "remove barriers . . . [including] economic, emotional, social, and occupational."[94]

The sixties notions of authenticity, ethics, personal involvement, and commitment were repeatedly emphasized in the family practice literature. The family physician had a responsibility to the patient. He managed the individual's total needs, maintaining an intimate, confidential, and personal relationship with the patient.[95] A family practitioner pledges a patient-oriented commitment.[96] Some authors even claimed that the essence of family practice was an attitude.[97] The family physician was distinguished not only by what he does, but how he does it.[98]

Family practice was predicated on the 1960s sense of community. The family physician was to be the physician of the community, familiar with community culture, services, and social milieu. He would adapt his practice to fit the community.[99] Moreover, family practice was going to be practiced <u>in</u> the community, in neighborhood health centers.

This sense of community was also applied to the system of health care delivery via the concept of the health care team. In fact, Carmichael suggests that the term "family" in "family practice" reflects the intimate, family-like relationship between the team of health care providers and the patient.[100]

Family practice sought to undo the image of doctor as monopolistic, dominant, and profit motivated. Family

practice promoted the team concept. Granted, the family physician was designated as "captain of the team," but a team participant nonetheless.[101] As paraprofessionals and allied health workers battled over occupational boundaries, roles, and rights,[102] the team concept was a way to incorporate these workers rather than alienating or excluding them. All health care workers were (theoretically) recognized as essential to health care. The team represented a group of equals working together to ensure the patient's well-being. The importance of group--of mutual cooperation--was paramount in the 1960s. By working together, it was thought, all things were possible.

As health care analysts observed that personal behavior was a major contributing factor to the nation's health problems, family practice rose to incorporate this realization. Family practice claimed its uniqueness in emphasizing both behavioral and clinical sciences. Family physicians were to be trained to specifically identify and examine the social, environmental, and cultural influences of the patient's behavior.[103]

Such an orientation also relinquished control ultimately to the patient rather than to the doctor. Such an orientation was compatible with the self care movement, consumer movement, and self help movement. Consumer participation and personal responsibility became powerful concepts in the 1960s.

The emphasis on behavior and preventive medicine focused the attention of care on the person rather than on the cure of the disease. Medicine had been criticized for its sole focus on curing disease rather than caring for the person experiencing ill health. In contrast, then, family practice promoted the notion of comprehensiveness, emphasizing patient care rather than cure.[104]

> It became apparent to a startling degree during the 1960's that our methods of delivering health care services were grossly inadequate. . . . The shift toward family practice, with its attendant reappraisal of medical education, represents a positive step by the medical profession to respond appropriately to the needs of society. This shift can be viewed as one away from primary concern for diseases and systems and toward the whole patient, his family, and even his community.[105]

It becomes evident that the 1960s holistic health movement and humanist movement[106] were assimilated into family practice. The family physician was to be "a personal physician, oriented to the whole patient." He was to practice "both scientific and humanistic medicine."[107] Family practice was an effort to counter attacks that characterized medical care as dehumanized and narrowly focused.

Family practice theory found its basis in the family systems approach to care. Family practice focused on the ecology of the relations among individuals, families, and their environment.[108] This sense of interconnectedness was

important in the 1960s. An ecological approach was indicative of the era.

The systems approach also maximized the optimism of the sixties. Systems theory holds that if any part of the system is altered, the system itself will change. So if the system is positively altered, positive change is possible. The systems approach supported a therapeutic intervention such as family practice.

Critics charged that American medicine had been "unable to deal with simple day-to-day medical needs of the population."[109] Family practice emerged to fill this gap. The family physician was portrayed as the common man ready to handle everyday common problems. It was claimed that the family physician was committed to dealing with the common illnesses and health problems of man.[110]

Furthermore, this notion of "common" denoted an anti-intellectual, antitechnological attitude. Family practice projected a more anti-intellectual image, allowing the physician to, as one family practice resident put it, "get back to practicing medicine the way it used to be." Family practice represented a return to the "old fashioned" personal type of care.[111] Family practice was people-oriented medical care.

Not only were these new physicians ready, willing and able to treat common problems, but they themselves were "of" the common people. Medical students were recruited from "the people," if you will. Intense efforts were

directed to recruiting disadvantaged and minority students into medicine and to attracting these students to primary care, a strategy viewed as guaranteeing that physicians would understand the people they served. The profession had been criticized as not understanding the people they served.[112] Thus, family medicine was practiced "by the people" "for the people." It was a people's medicine.

Family practice was not only philosophically, morally, and intellectually compatible with the 1960s; it was also economically compatible with concerns arising in the late 1960s. Family practice came to represent a remodeling of the health care system.[113] It was expected to prove cost effective, a vehicle for regulating patient utilization patterns, limiting specialty consultation (and thereby eliminating both higher costs and inappropriate usage of the health care system). Family practice's emphasis on community referral, utilizing allied health professionals and services outside of medicine, promised to reduce costs. This was appealing to an increasingly cost-conscious Congress.

Moreover, family practice recognized the importance of personal behavior in maintaining health. Inducing behavioral change and promoting preventive medicine would certainly be less costly than expensive medical treatment and hospitalization.

Taken in sum, family practice was expected to integrate the fragmented health care system. It was to be

a "synthesis" of care.[114] Conceptually, the theoretical foundation of family practice was also a synthesis, a synthesis of 1960s ideals, values, and expectations.

CHAPTER FIVE

THE FAMILY PRACTICE MOVEMENT: AN EMERGENT PROCESS

The previous chapters have demonstrated how the decade of the sixties--as a social movement--was a necessary condition for the emergence of family practice. It is the intent of this chapter to reveal aspects of the process by which a specialty, namely family practice, was established, illuminating some of the main social processes by which these changes occurred. In order words, this chapter will explore how this specialty got off the ground.

To illuminate these processes, this chapter will include numerous excerpts from personal interviews, roundtable transcriptions, and first-person narratives of the "beginnings." In the interest of guaranteeing anonymity and confidentiality to interviewees, specific names, places, and other identifying characteristics have been intentionally omitted.

This analysis will build upon the process model introduced by Bucher and Strauss (see pages 33-35). When rendering an historical synthesis, it is tempting to assume unity of interest among an emergent group. The process model serves as a reminder that diversity and change continuously occur within any given group, which gives rise to further segmentation.

Family practice provides an excellent laboratory for studying the segmentation process. Family practice represents a segmentation movement within general practice.

Staking the Territory

The formation of the American Academy of General Practice (AAGP) was essentially an effort to fight arbitrary hospital restrictions increasingly imposed on general practitioners throughout the country. Hospital privileges had become a constant issue and growing concern among practitioners. William Lotterhos highlighted this experience:

> Early in the formation of the AAGP, the prevailing attitude was trying to protect hospital privileges or obtain hospital privileges. I remember going to Cleveland for a meeting [1954] and that was the main thing I heard. I said that didn't bother me because we didn't have that problem, but it wasn't long before we did have, and had it bad.[1]

This perspective was reinforced by others who participated in the roundtable discussion. Carroll Witten credited the American College of Surgeons (ACS) and Paul Hawley, executive director of the ACS in the early 1950s, with the establishment of the AAGP. Malcolm Phelps concurred, "The ACS had more to do with the founding of our organization than almost any other factor."[2] Thus, the formation of the Academy was a defensive move against competing specialty encroachment and control. Generalists were being nudged out by the rapid and cumulative

specialization of surgery. What was once considered general surgery was no longer general.

Convincing physicians of the urgent necessity of joining such an organization was difficult. General practitioners

> who were doing surgery would hesitate to join the Academy because they would be classified with general practice and [feared][3] their surgical privileges [would be] rescinded.

But as more and more general practitioners faced increasing restrictions on their privileges, support for the Academy grew.

So, as conditions of practice changed, support for the Academy changed. There was a realignment of support as more and more general practitioners were having to contend with restrictions on their surgical privileges. General practitioners began to view a formal organization as a means of protecting their rights to privileges.

Julius Michaelson stressed this point:

> The formation of the Academy was not where a group of good fellows got together in a spirit of altruism who were out to raise the standards of medicine for general practitioners, but they banded together because there was an economic need, and pressures. . . . It was that people were being threatened all over the country.[4] Raising the standards was not the point.

Internal Segmentation

One might imagine that in light of the threat of specialty domination, general practitioners were

unanimously united in their push for specialty certification. But it was quite the contrary. One of the most difficult obstacles to specialty designation was the disagreement among general practitioners themselves. The family practice movement represents a clear-cut example of segmentation within a professional group. Within the Academy, two major segments were coalescing: the generalists and the specialists. The generalist group was anti-specialization and anti-board certification, whereas the specialty group saw these steps as essential to their cause.

What the two segments shared in common was the recognition that the continued survival of general practice was at stake. Both groups valued general practice as a form of medical care. Yet, even the degree of this recognition varied greatly between them.

The same condition which motivated general practitioners to form the AAGP, namely the issue of surgical privileges, impeded the family practice movement. Mac Cahal commented,

> I've had a conviction for twenty-five years that the only reason there was a delay regarding certification was that there was an overriding concentration on surgery. I think most people realized in the back of their minds that no way was the general practitioner going to get a certifying board that would qualify general practitioners for major surgery . . . and realized that no way would the ACS or the ABMS [American Board of Medical Specialties] permit that. Those groups felt they would be giving up something if they advocated a certifying board in general practice. And there was the other group

> that felt we'd all go down the drain if we don't get one, and we'd better give up something and get a certifying board before the whole discipline becomes history.[5]

Thus, the two segments diverged on what they were willing to negotiate.

Maynard Shapiro commented on how the majority of the Academy was against certification: "In the late '50s the Academy as an organization wanted no part in certifying. . . . The Academy was adamant against anything whenever the term 'certification' was used."[6]

The two segments diverged on what they saw as centrally problematic. For the generalist group, the central problem was how to retain surgical and staff privileges within the hospital system. This group perceived their battle as chiefly against specialists who comprised medical staffs and controlled hospital privileges. By contrast, the specialist group looked to what the increasing loss of privileges signified. Their concern was more about what their eventual role in the health care system might be. The specialists began to reconceptualize general practice, daring to consider the possibility that surgery might not be within their domain. If this were inevitable, they asked, then just what was their domain?

Even on issues where the two segments saw the same conditions as relevant to their fate, the segments diverged

on what course of action to take. Each segment differed on what it viewed to be the consequences of a chosen path.[7]

The specialist segment, that is, those arguing for a board, claimed that a board would clearly define family practice both to the public and to other medical specialties. It would identify the family practitioner as an expert in his field of medical practice.

The concept of primary care was developing within other specialties as well, such as in internal medicine and pediatrics. Proponents of family practice viewed certification as essential in their laying claim to the area of primary care. They deemed certification as essential in identifying who was qualified as a family physician and what a family physician did in contrast to other specialists claiming to provide primary care.

The specialist group also emphasized the importance of a board in establishing set standards and training programs. The specialist segment maintained that a board would not only improve the quality of care given by the family physician, but also would "erase the present status-caste system."[8] Since every other specialty had certified diplomates and had instituted extended training, board certification for family physicians would eliminate first-class and second-class distinctions.

This issue of specialty status represented more than just ego gratification. The issue was critical to the future of family practice, both in terms of its future as a

discipline, and in terms of everyday practice for the individual practitioner. Proponents saw specialty status as critical in saving general practice from extinction. A board would help to secure medical school faculty appointments which would force other specialties to accept family practice as an equivalent specialty. Moreover, faculty appointments were viewed as essential to the recruitment of students. Faculty representation and student exposure to family practice faculty would enable family practice residency programs to compete with other training programs for outstanding medical school graduates. Exposure to family practice role models would also help to generate student interest in the discipline.

The specialty proponents argued that a board was essential to the practicing physician. Certification would make it easier for the family practice diplomate to secure hospital staff appointments. A board would also provide a group identity for practitioners and would strengthen the Academy. Physicians would have a strong voice within the medical profession.

However, the generalist segment, opposing board certification, feared that certification would weaken rather than strengthen their position within the medical system. First, approval by the AMA Council on Medical Education and Hospitals and the Advisory Board for Medical Specialties would be necessary. In order to gain approval, a precise area of competency would have to be delineated.

The generalists feared that the scope of general practice could be redefined so as to exclude surgery. A large portion of the AAGP membership was actively engaged in surgery as part of their general practice. These practitioners did not want to be forced to surrender a portion of what they regarded as general practice.

The generalists contended that the Council on Medical Education and Hospitals did not truly regard general practice as a specialty. Generalists felt that family practice policies would be dominated by other specialists who would limit family doctors to office, home practice, and preventive medicine, excluding family physicians from the hospital domain. Thus, they saw the situation of hospital privileges as becoming worse rather than improving. Practitioners would be forced to accept reduced privileges
or none at all.

Generalists remained unconvinced that board certification would, in actuality, raise the status of the family physician. They saw certification as deterring rather than attracting recruits. They contended that if students had to undertake three additional years of training, students would rather complete other specialty programs. Formulating a board would have a reverse effect to that intended: A board would drive more students into other specialties.

Generalists did not see how a board would promote medical school faculty appointments. This could only

occur, they argued, if there were a basic change in the medical school deans' concepts of medical education. They predicted such a change was highly improbable.

Generalists also feared that board certification would further divide the Academy. What would happen to the many practitioners who might not qualify or choose to qualify for the board? A divisive caste system within the Academy itself would be created, separating those who were certified from those who were not. Rather than unify and strengthen the Academy, board certification would weaken the organization.

Edward Ciriacy admitted,

> Most of us at the time didn't really see what a 'board of family practice' would do to accommodate the goals that we had in mind. So most of us were rather opposed and the basic comment--one of mine and many, many people--was: 'I don't need another piece of paper on my wall.' It was some time before we recognized, as a mechanism of obtaining credibility in the eyes of our students, that such a board and such a piece of paper were indeed a very important aspect of growth and development of general or family practice.[9]

The attitudes of many physicians in not wanting a specialty "was because they were fighting specialties."[10] They did not want to be co-opted by the prevailing specialist domination. They had identified themselves as nonspecialists.

It is important to recognize that segmentation does not merely unfold on a start-stop basis. Segmentation, and controversy surrounding segmentation, continues. The

controversy regarding board certification still continues today. Loren Amundson notes, "I think it's important to realize that some [general practitioners] never took the boards and are still wondering why the whole thing ever happened."[11]

Within a given segment, further segmentation occurs. For example, within the specialist movement, one may delineate a divergence in the conceptualization of family practice: the technician and generalist models.[12] Essentially, the technician model views the family practitioner as a well trained general practitioner, a super-doc. Accordingly, family practice is

> a horizontal specialty in the tradition of other specialties, a discipline of synthesis. Family physicians exercise skills originating in other disciplines, which learn and exercise them in greater depth. Added to this is a special appreciation of the patient as a person, the patient's family, community and culture. In this model, insights and techniques from the behavioral sciences are useful because they both add to the physician's repertoire and provide some degree of assistance in sorting through and understanding what are seen as the contingencies introduced by psychological and social reality--factors that obscure the process of diagnosis and interfere with optimum treatment. This approach leaves the biomedical model unchallenged and seeks instead to expand it and make it even more complex. 'Psycho' and 'social' are added to 'bio,' but all are flattened out along the same logical plane. There are simply more variables to include and more skills to learn.[13]

On the other hand, the generalist model views the family physician as a new type of physician. This model rather turns the biomedical model on its head. The

> meaning of the patient's condition and the patient-family-community relationship is hierarchically prior to any technical exchange that shall occur between them [the doctor and patient]. From this perspective the insights and methods of the behavioral sciences are welcomed as a commentary on the nature of health and illness and practice. The aim is to contribute to a reconstructive basis of primary care and the development of new habits of thought and behavior. . . . It seeks to reverse the logical typing of discourse which finds biomedical reasoning and technology dictating the subject of practice. It provides a broader umbrella under which science and technology assume their appropriate place.[14]

This generalist model is a person-and-problem-centered medicine. The person and problem are primary. Each

> problem is contextually integrated from the reference point of each particular patient. One must come to know the relevant situation in a broader set of terms, how it hangs together--how personal existence, social process, the availability of resources, and the physician are all linked together and embodied in the problem which initiated the contact in the first place.[15]

Territorial Boundaries

Sociologically, the complex issues surrounding privileges can be seen as representing issues of territoriality. The struggles of the general practitioners represent territorial struggles. The family practice movement is a process of <u>claiming a territory</u>, <u>justifying such a claim</u>, and <u>creating descendants</u> to defend and carry on such claims.

Claiming a Territory

First and foremost, a logical question arises: Why even claim a territory?

Many of the original leaders concur that the bottom line was economics. Their prime motivation was political and economic. To them, proclaiming general practice as their territory--a process of delineating and defining boundaries--was essential for survival. Competition with other specialties had become intense. World War II had taught general practitioners their comparable worth with respect to other specialties. Specialists were automatically assigned higher military rank than general practitioners; specialists were not assigned front line duty as were general practitioners; specialists were deferred for training while general practitioners were not.[16] When physicians returned from the war, the lesser status of the general practitioner was further accentuated. General practitioners could not take advantage of the GI bill; those seeking specialty training could. General practitioners were being denied hospital privileges to perform surgical procedures which they had commonly and competently performed prior to and during the service.

The denial of surgical privileges or obstetrics privileges had far-reaching implications for the general practitioner. First, denial implied <u>incompetency</u> on the part of the general practitioner. Such implications were

infuriating to general practitioners who had track records of proven capability.

Second, the curtailing of privileges fully entrenched the second-class citizenship of doctors. General practitioners were not represented on specialty hospital boards. They were viewed as undertrained, second-rate practitioners of inferior skill and intelligence. They were transformed from the cornerstone to the cobblestone of medicine.

Third, specialty-oriented hospital boards prevented general practitioners from decision-making power. General practitioners were excluded from participation in hospital policy-making.

Fourth, a denial of privileges was essentially a denial of practice. Medicine, in its emphasis on procedural and technological skills, had become a hospital-oriented, as well as hospital-dominated, practice. Surgical procedures had become essential to the practice of medicine.

Fifth, the loss of privileges meant a monetary loss. Procedures and surgery earned the physician a high monetary return. The reimbursement structure in medicine is geared toward procedures.

Sixth, loss of privileges also meant a loss of patients. Bearing a reputation as "incompetent" would ultimately mean a loss of patients. What patient would willingly choose an incompetent physician? Patients would defect to specialists who claimed superior expertise.

Moreover, how was a general practitioner to maintain his patient pool? A general practitioner had traditionally followed the expectant mother and delivered the child who then became an additional patient in his practice. Thus, obstetrics privileges had not only maintained, but increased, his practice. If the general practitioner were now to refer the expectant mother to an obstetrician, and then refer the newborn to the pediatrician who would follow the child into adulthood, what patients would be left for the general practitioner? Again, economic viability was at stake.

The threat of the loss of patients also related to the loss of public status. If the general practitioner began referring out patients to specialists who were deemed to have more expertise, then the general practitioner would be seen as a second-rate doctor and a second choice by patients.

Justifying Claims

In justifying their claim, family physicians rallied around a new mission. The family physician was to assume responsibility for the patient's total health care within the context of the patient's family and community. This was to be the family physician's unique contribution to the practice of medicine.

In formulating a mission, family physicians had to clearly delineate their role, both to patients and other medical specialists. This tactic was seen as essential to

the ultimate success of family practice. John Millis, as chairman of the 1966 Citizens Commission on Graduate Medical Education, recognized that the failure of general practice was actually a failure "to make a place for itself within the organization of medical education and medical care; that is to say, it developed no necessary role within the system."[17]

Formulating a role was a strategic undertaking. How could family practice negotiate a role without threatening other (competing) specialties? How could family practice stake a claim that would not threaten to "steal" patients from existing specialties? Family practitioners masterfully negotiated this by emphasizing their role as the physician of first contact, the means of entry into the health care system. The family physician would evaluate the patient's total health needs, provide personal medical care, and refer the patient when appropriate (while preserving continuity of care). In this way, it was anticipated that family physicians would hold an integral role within the medical care system. By proclaiming rights as the physician of first contact, the family physician would secure his position in the complex web of specialist care. Patients would be relieved of the anxiety of trying to figure out what kind of doctor would be appropriate to go to. By claiming (and pledging) referral responsibility, the family physician assured both the patient and other specialists that appropriate referral would be made. It

was a way of both recruiting patients and reassuring specialties. In addition, by emphasizing a network of referral, the family physician strategically relocated his position in the health care system. Other specialists would be dependent upon the family physician for referrals. The family physician's referral role could conceivably move the family physician away from the periphery of health care.

Various strategies were used to define family practice to further justify territorial claims. One strategy for justifying family practice claims was to develop a new knowledge base. The development of a conceptual base for family medicine as an academic discipline was seen as a means of securing a place for family practice within the university system. Another tactic was to define family practice by function. Still another was to take advantage of the social demand for primary care and humanistic care, distinguishing family practice by its difference from the prevailing medical profession. This approach defined family practice by its differences--its different approach to problems and management of people's care.

The process of justifying a claim involved the need to create a professional identity. Part of this process involved disassociation from the older image of the general practitioner. General practitioners had suffered low status within the medical hierarchy. Specialist training was heralded as the hallmark of medical competency.

General practitioners were viewed as inferior practitioners, poorly trained and medically incompetent. They were at the "bottom of the totem pole."[18] If left intact, older general practice images would be detrimental to the success of family practice.

The challenge of family practice, then, was not only to create a new image, but also to put forth counterimages. Family physicians needed to clearly distinguish themselves from general practitioners. This was not an easy task, considering that family practice had its roots in general practice. According to one family practice faculty member, many early leaders both acknowledged and regretted they had to denounce general practice in order to advance the "new" specialty.

First, relabeling had to occur; hence, family practice. Then in order to aspire to equal status to other specialties, family practice had to become a specialty. This represented additional years of training equivalent in years to most other specialties. Family practice even one-upped the certification process, introducing two innovations: There would be no grandfather clause and periodic recertification would be required. Those two features were novel and very strategic in establishing a separate identity for family practice.

> These two points were departures from policy in any of the nineteen specialty boards existing at that time, and have been cited as major factors in the eventual decision to grant approval for the American Board of Family Practice."[19]

The Political Process

Professional movements occur within institutional arrangements. Steps toward certification in organized medicine involved a political and legislative process, both within the AAFP and with the Advisory Board of Medical Specialties.

The application procedure for approval of establishing a board proved to be challenging. First, the so-called "established" steps for approval proved to be archaic. Family practice's application to the Liaison Committee for Medical Specialties was the first submitted in nearly twenty years. Family practice presented a new situation, one for which the approval committees were unprepared. In a roundtable discussion, several of the leaders involved in the application process could attest to the complications involved:

> We had a lot of difficulty because we had to apply to the Liaison Committee for Medical Specialties--which was a liaison committee between a loosely organized group of all existing boards and the Council on Medical Education of the AMA--and they had not approved a (new) board for fifteen years (actually, 1949). So they really didn't know quite how to do it, and we couldn't find anybody who was responsible for (authorizing) a new board or where we could get an application.[20]

This experience was confirmed by Edward Kowalewski in another discussion:

> It was not easy to find out the methodology to go about finding out how to establish a new specialty. We tried to find out ourselves and

> couldn't and went to the AMA and found that there was nobody really around who participated actively in the last one. I served on a committee to find out how other disciplines set down their parameters of influence. We thought we could go to their records and find out what surgery is, and what obstetrics is, and what we did find out was that there was no specialty at the time that had set down parameters of their practice."[21]

Three applications were necessary before the Liaison Committee for Medical Specialties approved a board of family practice. The first application to the committee was rejected. The committee demanded additional requirements. William Ruhe pointed out that ". . . family practice was required to supply information of a kind which other specialties had not been required to provide . . ."[22]

Those leaders active in the process recalled how the stresses and strains in satisfying directives for the liaison involved a lot of political manipulations, bargaining, accommodations, modifications, trade-off, revisions, compromises, and directives to perform often seemingly impossible feats. Burket recalled the frustration:

> One of the things they demanded the third year was that we have 15 programs in operation. Well you can imagine what that was like, when we hadn't had board certification and there was no way we could certify programs and yet we had to produce 15 of them.[23]

A large portion of the process involved political persuasion and cultivating influential allies. Family practice encountered additional obstacles because of its overlapping relationship to many other already existing,

fully entrenched specialties. Again, competitive boundary demarcation was the underlying issue. Family practice could not succeed without the cooperation and approval of the other specialty boards. In fact, this was required in the application itself: The notice of deferment by the Liaison Committee stated,

> The applicant is advised that, if it wishes to modify the application for further consideration, it should consult with appropriate specialty boards and professional societies, including the organizations of appropriate department chairmen in medical schools. The purpose of this consultation should be (1) to define in further detail the appropriate body of knowledge and content of family practice; (2) to solicit the cooperation and support of these organizations in the conduct of training programs and development of specialty examinations . . .[24]

Many family practice leaders considered this mandate one of the most difficult obstacles. Lotterhos commented, "I think probably the toughest one [requirement] was the fact that we as a board were going to be asked to have representatives on our board from other disciplines."[25] Furthermore, many of the boards were opposed to the concept of specialty status for family practice.[26]

Training

The issues of training and recruitment are vital links between the establishment of a specialty and the sustainment of a specialty. These are essential processes in creating descendants. The numbers of general practitioners had declined and continued to decline. The few

established general practice training programs had failed to attract many trainees. Board certification was a competitive strategy for attracting recruits. Hence, medical education became a key issue in the family practice movement. Specialty designation meant specialty training. Recruitment of both teachers and students was critical to the survival of the specialty and represented another crucial battleground.

Since family practice had been given a mandate to train family physicians and funding to establish training programs, interesting analytic questions arise: Since there were no certified family practitioners, from where did faculty come? Who were to be department heads and teachers of this new specialty?

Recruitment of Faculty

Interviews with university educators and family physicians provided insights into the process of faculty recruitment. The establishment of family medicine departments within the university system required the "pulling-in" of other specialists. In order to gain an academic appointment in a university environment, a person needs to have certain credentials which include teaching, publishing, and research. General practitioners had not been university faculty members; they were not academicians and researchers. General practitioners were practicing physicians, not university professors. As a consequence, department heads and teachers had to be recruited from

other specialties such as internal medicine, pediatrics, surgery and obstetrics. Today, many faculty members continue to hold dual appointments, teaching part time in their specialty department and also providing instruction in the department of family practice. This pulling-in of other specialists was of course partially necessary because of the university system of appointments.

Some faculty members were recruited also from community medicine. Departments would recruit whom they thought to be outstanding people in practice and get them appointed as professors. However, other programs tried to find somebody within their faculty and "relabel" them.

The pulling-in of specialists was also necessary due to sheer numbers of students and programs. At first, there was not an abundance of residency trained general practitioners willing and able to teach. Yet, within ten years, almost four hundred family practice residency programs were established, and each program had to have faculty.

In contrast to university hospitals, residencies established in community hospitals were often headed by general practitioners. Some programs had already been in existence as general practice programs. Others were newly established. Many of the teachers of these programs came from community practice. One big obstacle for general practitioners was the difficulty in leaving their practices in order to take up teaching. In a few instances, new

directors brought their practice into the residency program.

Who taught what (and, closely related to this, what family practice residents were clinically "allowed to do") was also related to where the program was housed--in other words, the institutional position of the program. Many family practice programs which had previously existed as general practice programs had already forged their identities and work activities. Many of these programs existed as independent, community hospital programs. These hospitals did not house any other specialty programs, so there were no competing specialties. In these programs, general practitioners taught surgery, internal medicine, obstetrics and pediatrics. These teachers did not have specialty credentials, but did have experience. Even to this day, some of these programs do not have board certified specialists teaching in various clinical area.

In programs established in hospitals where there were other established residencies, family practice programs were "added on." Residents rotated through the various existing clinical specialty departments. Teachers in the clinical areas were established, board certified specialists who were accustomed to teaching their own residents. Family practice residents were an add-on and sometimes an unwelcomed one at that.

Recruitment of Students

In personal interviews, several residents described how, within the university setting, a medical student gets pushed into specialty fields. "People laugh at you when you go into family practice," remarked one resident. There is a stigma attached to family practice. "People often think that those who go into family practice are people who couldn't get into other specialty programs," commented another resident.

Many students who went into other specialties felt insecure about the prospect of entering family practice. They felt inadequate enough in a single field, and they could not understand how one person could "do it all." One family physician's opinion about this was:

> Now remember the type of people who go into medicine. These people are at the top of their class. They are the type of people who have to know everything about everything. They got As all through school because they would master subjects. So, they logically conclude that mastering all of medicine is an impossibility.

In one resident's opinion:

> People who go into family practice are people who aren't afraid of not knowing everything. They go into family practice because they want to take care of people. Many people who go into sub-specialties don't go into them because of people but because of themselves, because of science and the need to know everything there is to know about that science. People are a side interest who happen to have the disease they're trying to figure out. The focus is more on the disease.

A practicing family physician pointed out the "fallacy" in the focus:

> The fallacy is that ninety percent of the people who see docs are not seriously ill. They have the flu, they feel lousy for two or three weeks, and then they feel better. In fact, they'll get over it whether they come to see the doc or not. The only difference is the doctor gives them something to make them feel better and provides the reassurance that nothing serious is going on. That's the case most of the time. Most things don't require a great deal of specialized expertise. . . . A well trained doc can handle it. The main thing is to be able to recognize when it's something more.

Indeed, another family physician provided a study substantiating this claim.[27] Hospital privileges did not concern this physician. He commented,

> Who cares about privileges:? So I'm not allowed to put in Swan-Ganz catheters. Big deal. I don't care about that. I have a cardiologist that can do that. . . . I'm more likely to see more people in my office who are depressed than who need Swan-Ganz catheters. That's the key point: Look at what is commonly presented in the office. Look at this study comparing what specialists see in their offices. Ninety per cent of the practice in peds, for example, is checkups, colds, and sore throats. Only one out of ten hours of practice involves something else.

Several family physicians expressed how family practice is looked down upon in academics, just as general practice had been. They claimed that university specialists say, "What do FPs do but look at runny noses?" Family practice is viewed as intellectually unstimulating.

In the case of general practice, Hiram Curry attested to this:

> . . . those working within academe at the time [1960s] were well aware of the disdain directed toward general practitioners. . . . I do not believe that those in general practice at that time knew how lowly they were regarded by those in academe.[28]

A family physician explained how this attitude is reinforced:

> Remember, we're talking about a university program that gets cases from all over the country--very difficult cases that no one else has been able to figure out. That's what brings all the academicians here; that's what makes them tick. FP isn't the same caliber; in fact, family physicians are the people who are referring these people in . . . academicians see family physicians as peons putting bandaids on people while they [the specialists] are doing the real job. The thing they don't realize is that the real job is done by the people putting on the bandaids. That's what most people need. Most people need bandaids, not university centers. Certainly research centers have to exist because there are a lot of cases that are very difficult and complicated and require the expertise of these top specialists. But most people don't need that.

It becomes apparent then, that the scale used to measure intellectualism within a medical discipline is not in kind but in degree. Family physicians may well be presented with the largest variety of complaints, problems, and conditions. One might therefore logically conclude that family practice would be the most stimulating of all specialties and that integration of all aspects would be the most intellectually challenging to physicians. Yet, this does not appear to be the case. Rather, intellectualism is assessed by the degree of diminution. More

complicated means reducing a line of knowledge and inquiry to its smallest parts. Knowing the smallest dimension of an objective becomes equivalent to knowing an object best.[29]

G. Gayle Stephens identifies two other beliefs accepted in medical science tradition that also contribute to prevailing perspectives regarding the intellectual challenges of medicine. Stephens contends that the underlying beliefs in modern science are, first, that all complicated systems eventually can be reduced to physics and chemistry, and second, that all human problems have a technological solution.[30] Stephens contends that these fallacies sustain the prevailing model of biomedical reductionism.

These beliefs are passed on from teachers to students. As one resident explained, "These people [medical professors] are famous leaders in the field of medicine. You get funneled into that type of thinking." Another resident agreed, "Think about what's rewarded in medical school: good grades, good presentations, good diagnosis, good quotations from articles--academics."

Thus, family practice challenges the prevailing assumptions in medical training and education. Family practice reflects an evolving ideology. A new notion is introduced, the notion of "real" medicine. Here, conflicting imagery emerges. Academicians view real medicine as difficult and complicated cases (diseases); family

physicians view real medicine as primary care. One family practitioner highlighted this view:

> Many people who put down family practice haven't been out there on the front lines of medicine. They have their own views about it, but they're really not bound in reality as to what the practice of medicine is really about . . . I can't believe that anyone practicing medicine cannot help but think of primary care as practically the whole basis of medicine and practice.

Problems in Establishing Curriculum

Many problems encountered in implementing family practice programs in hospitals where already there were specialty departments. Curriculum and territorial disputes arose, both in medical schools and in residency programs.

Curriculum in Medical School

Getting family practice curriculum into the already crowded and demanding medical school curriculum was--and continued to be--problematic. The curriculum struggle continues today. Family practice is <u>still</u> not a required clinical subject in medical school. In fact, in 1984, family medicine organizations made a concerted effort to incorporate family practice as a required curriculum in medical school. In the LCME's revised <u>Functions and Structure of Medical School</u>, which lists the essentials for medical schools seeking accreditation, family medicine is listed as a recommended but not required clerkship. The LCME and the AMA refused to declare family medicine a fundamental clinical subject in medical schools, as are

internal medicine, obstetrics and gynecology, pediatrics, psychiatry, and surgery.[31]

Hence, exposure to family medicine in medical schools varies from school to school. In some universities, family medicine is a required clerkship; in orders, family medicine is offered as an elective. Many family physicians view this situation as a major obstacle to recruitment. In short, getting family practice legitimated is one thing, but getting it taught--in the face of so many other competing specialties--is another.

Curriculum and Training in Residency Programs

One of the chief difficulties in establishing residency curriculum was to define how a family physician was to be trained differently from a resident in medicine or pediatrics. One faculty member described the problem:

> One of the chief difficulties encountered was trying to get other departments to understand the level of proficiency expected from family physicians versus the level of proficiency expected from internists, pediatricians, etc. The issues of how much to train and what the end product is expected to be were problems in establishing curriculum.

A corollary question arose: Is a family physician trained less well than an internist, pediatrician, etc.? One faculty member interviewed recalled how difficult it was to convince the medical profession, comprised chiefly of specialists, that less depth in specific fields was not equivalent to less well.

Related to this issue is, who is to do what. What are the boundaries? What would constitute the work activities of the family physician, and what were the limits of these activities? For example, what is the amount of surgery appropriate to the family practitioner as opposed to the surgeon? Or, is surgery appropriate at all?

A second territorial problem arises in working out cooperative training arrangements with other specialty departments. Family practice residents were to receive training in surgery, obstetrics and gynecology, pediatrics, internal medicine, psychiatry, and orthopaedics. Yet, what this constitutes is additional competition for a limited amount of "learning material" (i.e., patients and cases). Family physicians are impinging on the patient care and learning of other residents--of surgery residents in terms of cases, of obstetrics-gynecology residents in terms of deliveries and gynecology cases, of pediatric residents in terms of in-house patients (where the number of in-house patients is already low), of internal medicine residents, especially in terms of the procedural aspects of internal medicine. The problem, as one family physician described, was that family practice residents were the newest addition and the low men on the totem pole. They had to take what opportunity was given to them within the established departments which are controlled entirely by specialists. Again, the structural dimensions, such as where the program was housed, its size, and the patient population would

influence the degree of these problems. If, for example, certain services were generally overloaded with admissions and cases, family practitioners were given their share of the workload (and served to help relieve the load). Thus, in an obstetrics program where there are a lot of deliveries, obstetrics residents gladly share their call nights with family physicians. However, when it came to gaining experience in less common procedures, such as C-sections, for example, family physicians are rarely given the opportunity. Opportunity is thus related to statistical rarity.

Marginality

The issue of marginality emerges as a fascinating theme in this study. The constant reference to "second-class citizenship" and "bottom of the totem pole" certainly suggests that general practice was on the periphery of the medical profession. Lester Bibler, in an open forum discussion, comments on the marginality of general practice when he mentions how it "sort of classified you off to one side."[32] Family practice as a discipline was noted for its marginality. Family medicine rejected the strict biomedical reductionist view.[33]

Marginality of Family Practice Faculty

Marginality also describes the location of many of the initial faculty members who had been pulled in to family

practice departments. These people had secured institutional positions that enabled their appointment to family practice departments. Yet, what types of people would want to relocate institutionally, requiring a reshaping of their professional identity?

The specific case of a faculty member interviewed will shed light on this question. This physician was a board certified internist and faculty member of the department of medicine. He had established a division of ambulatory medicine within the department of medicine. Typically, an internist in academia concentrates on research and disease. His marginality was already expressed by virtue of his separation from the main interests of the department of medicine (by his involvement in ambulatory care).

When asked if he considered himself to be a typical internist, he did not seem to see himself (or articulate as such) as markedly different. He expressed how interest in primary care was developing in several departments (such as in pediatrics). "In all of medicine, some doctors are oriented to research and not to practice; others are not."

Asked whether physicians who branched off into other divisions indicated a dissatisfaction with their specialty, he replied,

> It's not so much a dissatisfaction with a specialty, but a dissatisfaction with approach. Medicine's approach generally was, and continues to be, very reductionistic. A patient's problem that presents in a clinical setting is often felt to be based on some disease model, and the whole possibility of illness and disease being based on

> social and psychological as well as biological was not acceptable to a lot of people. I think a number of faculties in a number of universities . . . felt we'd gone too far with the reductionist approach and now we need some generalists who are going to take care of people as people and not simply from an organ system approach.

Here we begin to get a glimpse into philosophical, ideological, and conceptual clashes. This internist recognized that his viewpoint was not unanimously accepted within the internal medicine academic environment. Yet, he did not feel alone in his perspective. Already, he had identified a coalescing segment both within internal medicine and outside of internal medicine, a segment focused on people, practice, and primary care. Strict specialty boundaries between internal medicine and pediatrics began to blur, and a new alliance or circle of colleagueship was emerging around primary care. Primary care began to become a common concern of segments within several specialties. It becomes possible to describe a family physician as a type of physician, a part of a collective group of physicians who share a common identity and organize their work activities around a common category labeled primary care.

It is interesting to examine how a family physician trained under this particular internist's program described and perceived this internist:

> He's an internist by training, but he does not fit into the typical internist mold. He is not an internist that cares about spending his whole

> life learning about one molecule or enzyme in the liver and becoming the world renowned authority on this molecule. He cares more about health care systems, how people access care, and the impact of cost on the kind of care people get. There's no inpatient area in internal medicine where he fit. He had to go to a place called 'ambulatory medicine' [and eventually family medicine] that cared about those things.

Thus, the internist's former student did not perceive the interest to be typical. This description lends support to further substantiate the internist's marginality within his own discipline.

This example further illustrates how professional movements occur within institutional arrangements. The work situation is not simply a place. These locales constitute arenas where roles are forged and developed, where individual careers are intrinsically intertwined with fates of segments.[34] The development of family practice provided a niche into which this internist fit.

It should be pointed out that the issue of faculty marginality does not imply that the recruited faculty were substandard physicians. One physician made this point,

> There were a lot of top-notch people around who felt strongly about this whole concept of family practice. . . . In medical university centers there are an abundance of high level people. It's not like they have to go hire Joe Blow who finished last in his graduating class.

Marginality of Student Recruits

Student recruits identified themselves by what they perceived as their own marginality to the medical

profession. These students did not see themselves as mainstream physicians. They saw themselves as outside of, or marginal to, mainline medicine. Family practice recruits were not entrenched in the prevailing mainstream biomedical model. Family practitioners represented a different type of physician, a physician whose approach was marginal to the accepted and revered disease orientation of medicine.

Academic Marginality

Within the university, family practice is still regarded as a marginal discipline. In personal interviews, several faculty members commented on how other specialists consider family medicine to be a "watered-down" specialty. Other departments question the need for a family practice department. They contend that clinical aspects of family practice are already done by other specialties. Specialty departments claim that family practice does not have an academic and research basis to justify its establishment in the university.[35] Other specialties charge that family practice lacks a theoretical framework.

Indeed, at the time of its inception, family practice lacked research that demonstrated the social basis of disease. Family practice also lacked mature faculty researchers who already had a proven track record in the university. Many of the first people who occupied professorships had come out of practice. They did not have a background in research. Coupled with this were

legislative mandates to train family physicians. So initially, energies were directed to service and training. These factors resulted in problems in establishing academic credibility.

Academic credibility is established and maintained through research. General practice, for the most part, had developed outside of academic research centers. Family practice has its roots in general practice. As one faculty member points out, family practice does not draw "research types." He says,

> People who want to do research tend to get drawn to internal medicine, not family practice. It's rare to find an FP resident interested in research. We've already excluded that group by our self selection.

A conflict exists between university criteria for an academic discipline and the family practice identity. The underlying given is that research is essential in justifying and validating an academic discipline. The standards and criteria are ones that are aspired to and honored even though the family practice vision may be somewhere else.

Traditionally, medical disciplines have grown through generations of research. But since family practice lacked trained researchers, the traditional descendants to carry on research obviously did not evolve. One faculty member described how experts and areas of expertise are traditionally cultivated in medical centers.

> In internal medicine, for example, one might study endocrinology and do a fellowship in endocrinology, spending two additional years in the university working under people on the forefront of diabetic research. This is how experts and areas of expertise are cultivated. Nobody in family practice had anything like that.

Family practice did not have mentors who would both advance the field and pass on a family practice area of expertise.

An additional problem of academic viability and research involves the type of research (i.e., "hard" research) that is respected in medical sciences. Much of what family practice is interested in--behavioral sciences, social and psychological dimensions of illness, family contexts, educational issues--is considered "soft" research. Soft research is not regarded as important or legitimate in scientific medical circles.

Academic acceptance of family practice was further hindered because there was not a great deal of research that in fact demonstrated the social basis of disease. The new approach claimed by family practice had not been proven, had not persuaded the medical majority. One faculty member provided an example:

> It's only in the last ten or twelve years that it has become accepted that if you have two identical individuals, one with a support system and one without, the person with the support system is likely to have less illness than the person without.

Raising money for family practice research is difficult. A faculty member laments,

> Here on this campus you see an announcement that ten million dollars was donated for an eye center or an arthritis center. Nowhere has anybody given ten million dollars to start a center for the study of family and health. The skids are just not greased for that. The hierarchies are set so that family medicine is not linked up to get that kind of money. Family medicine *is not in the mainstream* [emphasis added].

Again we see how the fate of the segments and individuals' careers are intrinsically linked. University academic senates, composed of tenured faculty who are physicians of other specialties, decide tenureship. Appointment is determined by publishing, research, and other indicators which demonstrate that the candidate is advancing his field. The candidate must establish a reputation as an expert in his field.

Tenured positions are important in academic arenas. In order to have your philosophy operationalized within medical training, you need people in power positions within the university. You need to be in positions to effect change.

Although family practice is marginal in terms of the political struggle within academia, it cannot be said that family practice is marginal in terms of numbers and size. Family practice has grown to be the second largest specialty in the United States, second only to internal medicine. Family practice has the third highest number of residents currently in training, third only to internal medicine and general surgery. The American Academy of

Family Physicians, the national organization of family practice, is the second largest specialty group society.[36] If these proportions remain constant or if family practice further expands, one may expect some changes in issues of marginality.

Marginal Reimbursement

The present reimbursement structure also reflects the marginality of family practice values in health care. The reimbursement structure is geared toward procedures, indicating that technology and procedures are what are most highly valued in health care delivery.

One faculty member commented, "A lot of the things that are most valuable and interesting about family practice are reimbursed the least because they involve time and talk." The following story told by a faculty member vividly illustrates this value system:

> A woman had made an appointment with the family physician for removal of a wart. At the time of her appointment, she and her husband came in absolutely distraught. They immediately started talking about how they'd just learned their daughter was lesbian. They had just fallen apart. The family physician talked with them about it, helped them collect themselves and think about what this all meant and what they might do. When the couple left they felt much better and seemed to have pulled it together. The family physician had played a valuable role. As the couple was leaving, though, the woman said, 'Oh, by the way, what I actually came in for was this wart.' So the family physician replied, 'Even though we're running late, I can take that off in two minutes.' So he got the liquid nitrate, popped it on there and removed the wart. Yet, the most he could charge for that 45-minute conversation was $35; he got something

> like $40 for taking off the wart in two minutes. . . .

The sacredness and value of twentieth century technology is reflected in the procedure-biased reimbursement structure. It is also reflected in the rise of the consumer concept in health care in which health care is viewed as a product. The emergence of prepaid health care corporations advance this perspective. "Objective" therapeutics basically become technological. The physician as healer is transformed into the physician as technician. Corporate procedural directives and

> developments in physician accountability, such as peer review, medical audit, recertification, and litigation against the physician are focused almost entirely on the technical and economic aspects of practice.[37]

Corporate procedural directives seek to standardize disease as well as medical care. There is little room for the individual and individual situations. One practitioner describes how regulations interfere with the practice of what he considers quality care:

> Recent impositions like utilization review and Medicare and MediCal restrictions are trying to standardize medical care in terms of saying certain diseases only require a certain amount of time in the hospital or only require a certain procedure. That's antithetical to the practice of quality care which takes into account the human elements, the person and his emotions, support system, circumstances, and countless other factors. Such limits on payment produce limited health care.

His opinion is shared by many other physicians, both family physicians and others.

Using Marginality to an Advantage

One could advance a thesis that it was this very marginality on which the family practice movement originally capitalized. The 1960s decade was an era of reform. Students were infused with idealism and motivated by humanistic, antiestablishment values. It appears that leaders in the family practice movement took advantage of the sixties movement to advance their specialty. Spokesmen accentuated, rather than minimized, differences of family practice from traditional medicine. Family practice essentially was packaged as antiestablishment. A new public image was created. The family physician was to be a new type of physician, a medical revolutionary, if you will. He was to be person-oriented rather than disease-oriented. He was going to connect health care in a different way, in a humanistic way.

The construction of a new image and a new professional identity proved successful. In contrast to despair and discouragement felt by many general practitioners in the mid-1940s,[38] family physicians took pride in their "outgroup" status.[39]

Just how far to accentuate differences was a strategic question. In order to attain institutional position, family practice would have to work with and be approved and accepted by the existing medical profession. How far was

family practice to align itself with the dominant medical profession in order to be successfully institutionalized within that system? Stephens, in presenting a view of family medicine as counterculture, asks, "We have gotten a lot of mileage out of our minority, sectarian status. Why do we want to abandon it so quickly?"[40]

Sustaining the New Discipline

In the initial stage of development, the overriding concern was acceptance, acceptance as a specialty vis-a-vis other specialties and acceptance as an academic discipline in medical university settings. Except for a few visionary voices, those two concerns were paramount. Money and numbers became a way of measuring success. During an interview, a faculty member recalled how there seemed to be an ongoing tally of how much (a department would receive) and how many (departments, divisions, and graduates of family practice there were).

Family practice is now in a different phase of development. Concerns now involve intellectual issues, research issues, and questions of how to train differently.

New Wave of Leadership

Family practice is now undergoing a transitional change of leadership. One faculty member describes this change:

> Family practice membership, both those in academics and in practice, is like a two-humped camel. You have the older group who are now retiring [or who are deceased]. Then there is a hiatus with few people in family practice between the ages of 45 and 60. Now we're getting a second hump.

Seventeen years have passed since the first family practice programs and departments were created. The first group of family practice residency graduates is coming up through the ranks and taking over leadership positions. The initial group had come out of practice; this new group is coming up through the ranks.

This wave of leadership presents a unique array of possible career moves for the new generation. One faculty member estimated that there are presently twenty-five chairs open around the country and not enough people with enough years of experience to fill them. "But," he noted, "in five years it will be different."

Thus, individual careers are closely related to the segment to which one belongs and the temporal location. Career possibilities that exist today for the new generation of family physicians probably will not exist for the next generation of family physicians.

Segments are continually undergoing change. The new generation of leaders that is emerging is engaged in spelling out what this specialty segment in medicine is about and where it is going. The different loci of this new generation inspire different definitions both of what is problematic and of the work situation. Thus, family

practice is in a different phase of development. A young faculty member enthusiastically describes how

> teachers of family medicine are beginning to rethink what family practice is and what family physicians are. They are not only looking to family practice but to all of medical practice and saying, 'We can be leaders for the whole field of medicine.'

Such a view reflects how leaders in family practice are constructing new images, seeing themselves as leaders in all of medicine. They envision taking on leadership to rehumanize all of medicine, reorganize undergraduate curriculum, and redesign residency programs. Conceptually, they are expanding and changing the boundaries of their specialty. They are moving away from the periphery of contemporary medical care. They are seeing themselves at the center of medicine--a new medicine.

CONCLUSION

THEORETICAL APPLICATION

Chapter One summarized the literature on theories of specialization in the hope that an understanding of these theories would illuminate understanding of the emergence of family practice. This section will relate family practice as a specialty to various dimensions of existing theoretical perspectives. This analysis will show how the case of family practice does not fit any single theory.

The Evolutionary Model

The evolutionary model deems that the explosion of knowledge and technology, and the resulting complexity, makes specialization inevitable. Specialization is seen as the natural movement from the simple to the complex.

Moreover, the evolutionary model would suggest that specialties are founded on epistemological grounds. Yet, family practice did not represent a new knowledge base. A treatment approach was being formed which did not have a knowledge base. A cognitive base was formulated after--rather than prior to--specialty designation. The sources of its founding were ideological and structural rather than cognitive.

Family practice represents a specialty which ideologically defies the evolutionary model. First, family practice challenges the explosion-of-knowledge notion.

Stephens asserts that what has been deemed a knowledge explosion in science is in reality an information explosion, and that not all information is informative.[1] Second, family practice rejects the notion that subdivision of a subject necessarily results in more understanding. Family practitioners contend that clarity of the whole of a discipline is often obscured by specialized fragmentation.[2] From this viewpoint, specialization often becomes fragmentation. The explosion of knowledge and technology makes a synthesis all the more essential to medical care. Family practice claims that the focus on specialty divisions has fragmented care and has caused physicians to lose sight of the whole person.

Structural Functionalism

The functionalist perspective primarily focuses on the cohesiveness of a given profession. Functionalism stresses shared identity, values, definitions, interests, and beliefs of a professional organization.

In the case of family practice, segmentation occurred within the organization of general practice. Family practice was a marginal concept whose own constituents were clearly divided about its very formation.

Functionalism predicts that a specialty would emerge to fill a need that was not being filled by other specialties. This need fulfillment is seen as essential to the survival of the system. However, if family practice had not been designated a specialty, it is entirely

unlikely that the whole medical system would have collapsed. Primary care functions were in fact being met by general internists, pediatricians, and obstetricians.

Historically, specialties had justified their claims primarily on one of five features: (1) patient characteristics, (2) identified body parts, (3) diseases or conditions, (4) technique, (5) technology.[3] One could interpret each of these bases as a justification of function within the organization of medicine. But what function could family practice claim? After all, no one had discovered a family practice organ. Family practice defined its function in terms of its role in health care delivery. One could argue that family practice actually filled a void rather than a need. This void was a void in the marketplace. Family practice took advantage of a market function. Such an argument, then, would lend support to a political economist perspective. Yet, the market explanation still does not fully account for the emergence of family practice.

The Political Economy Perspective

The political economy approach views medical care as a commodity. Specialism is an outgrowth of conflicts between competing groups. Political economists also contend that the cognitive dimension of any specialty is a later development.

The latter claim, that the cognitive basis does not precede the specialty, does fit in the case of family

practice. In fact, G. Gayle Stephens, a recognized leader in the family practice movement, supports that argument. Stephens asserts:

> We should first recognize that none of the certifiable medical specialties were established on epistemological grounds. Most of them sprang up like Topsy and exist by virtue of political, economic, and technological factors that have little to do with a theory of knowledge. . . . We should stop trying to solve political problems among medical specialties as though they were knowledge problems.[4]

Family practice does offer an interesting twist. While specialty groups often arose to claim an established area of practice or a new area of practice, the challenge of family practice was how to reestablish its claims. The formation of family practice was an act of survival, a defensive move against encroaching specialties.

In light of this, a seeming contradiction appears with the assertion that family practice did not emerge in a totally hostile environment. Certainly it is clear that many other medical specialties were opposed to the concept of family practice as a specialty. Other specialties did not see where family practice as a specialty was going to fit in with the already established specialized network of care. Indeed, the rise of the American Academy of General Practice posed a threat to the American Medical Association. Cahal claims, "History should record that the AMA move to create a section on General Practice had one motive only, and that was to stop the formation of the AAGP."[5]

Concern within the AMA arose over who and what this new group was and where they intended to go.[6] And certainly the three-time rejection of the application for approval of family practice board certification is not exactly an indication of a friendly environment.

Yet, another environment must be taken into account: that of the social environment at large. This social environment was not only receptive, but also was supportive of family practice. As elaborated in previous chapters, the 1960s lent support for asserting and justifying family practice territorial claims. Burket correctly notes that,

> Up until 1966 . . . this [family practice] was sort of an intraprofessional argument we were having. . . . But when these reports came out, and the public, the consumer, the patient became involved, . . . they began to notice it. This I think was the turning point, when the consumer and patient got behind this change, then it moved.[7]

Territorial claims were strengthened and reinforced by public support and federal funding. Not only was the money essential for establishing departments and training programs, but the money was symbolic as tangible evidence of the public's support and demand for such a specialty. Federal funding provided a further justification for family practice territorial claims.

Even within the medical profession, the environment could be seen as mixed rather than entirely hostile. The profession saw family practice as a way of appeasing the public demand for primary care and the public pressures to

change the health care system. The profession feared that public discontent could generate forced changes upon it. The profession needed to propose its own solution to health care problems. Family practice represented a "change" without basically changing the existing system of health care delivery. Stephens observed:

> Family practice has 'taken the heat off' the medical profession from the public; therefore the status quo is being preserved. . . . More radical solutions to perceived problems will not be imposed as long as the public thinks that something is being done.[8]

Family practice did indeed take advantage of a market opportunity. This assertion rests on the empirical observation that family practice was already organized (through general practice organizations) and consequently positioned to appropriate the field of primary care at a time when primary care became a public issue.

It has been said that the organization of general practitioners was motivated by an economic agenda.[9] It has also been claimed that family practice was backed by a social mandate. But did family practice seize a mandate, or was it given a mandate? Although there were economic reasons for general practitioners to organize, the ideology of the 1960s helped to push family practice into the limelight. Here was a group whose economic existence was threatened by encroaching specialization. General practitioners had banded together as a collective defense to what they perceived to be a threat to their survival. But these

practitioners were not exactly sure how to go about defending themselves. When the sixties era unfolded, new opportunities presented themselves. General practice was in the right place at the right time. General practitioners were positioned to act quickly to claim a part of the market that had been partially created and defined for them.

> The time was right, the idea was right, and from the perspective of one who has participated almost from the beginning, there was 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.[10]

Family practice could be seen as both fulfilling and filling a perceived void in the marketplace. A political economy perspective would suggest that such a claim in the market could only come about by intense fighting, rivalry, and competition between specialties vying for the market. Such an explanation does not fully explain the family practice scenario. One might boldly assert that other specialties did not even want such a niche in the market. But upon closer scrutiny, we find that the concept of primary care was developing in other specialties. Family practice was organizationally positioned to stake its claims before other groups (such as general pediatricians or general internists) could organize.

Furthermore, family practice represents an interesting contradiction to the market perspective. The general

practice organization itself (AAGP) had long been its own obstacle to specialty designation. Practitioners were divided regarding specialty certification, believing that specialty designation would restrict their surgical privileges. Cahal asserts: "I've had the conviction for twenty-five years that the only reason there was a delay regarding certification was that there was an overriding concentration on surgery [by Academy members]."[11]

Thus, the political economy perspective does not fully explain the emergence of family practice. It leaves too many variables unexplained. The political economy perspective does not explain the why and how of the process of specialization. It minimizes the conception that an infinite number of contingencies play into human life.

The Process Model

The process model directs attention to constant change within professions. This approach focuses on the variation and segmentation within them. The process approach provides the researcher with a model to get at the how and why of specialization. The model insists that the researcher's analysis be grounded in real life and authentic human action. This model is a reminder that occupations are not self-fulfilling abstractions. Professions are comprised of people living in society. All occupations have their own individual histories that are intrinsically linked to society at large. The structural and ideological features of any profession is socially

linked to historical conditions and to the actions, passions, and imaginations of living participants. In a sense, this model is the most demanding of the four discussed. It tests the researcher's integrity: The researcher is forced to substantiate claims with living proof, if you will.

As has been shown, the family practice movement is a case study of segmentation. But any given study is not the final study of any specific segment. Segments are not static; they continually undergo change. Within a segment, boundaries become diffuse and new groupings emerge. Implicit in the conception of ongoing segmentation is the interplay between ever-changing structural conditions and the ongoing segmentation process. As conditions change, members within a profession will develop new conceptions of the way things ought to be. Various members will adopt new modes of thinking, new ways of defining their discipline and their world. In turn, these new ideas and groupings will generate new conditions. Thus, the process model renders a multidimensional picture of social process.

The process model is invaluable to the study of specialty development and needs to be expanded and supplemented. What was missing from the model to date was explicit attention to value shifts in the larger society as a contributing factor to the segmentation process. The process model implicitly recognizes the importance of historical and structural conditions as integral to the

development of segments within a given profession. This thesis makes such assumptions explicit, revealing how certain prominent features of family practice evolved from certain historical and structural conditions. In this study, social and historical dimensions are not merely regarded as a contextual backdrop to the emergence of family practice; rather, social and historical features constitute necessary conditions for the emergence of a specialty. By making structural conditions explicit, and by highlighting the interaction between structural conditions and ongoing segmentation within the profession, this thesis demonstrates the inherent explanatory power of the process model.

Summary and Conclusion

Chapter One briefly summarized predominant sociological theories of specialization, describing four theoretical perspectives traditionally used by sociologists to explain medical specialization. Yet, in reviewing these theories, one may conclude that there may not be one single explanation to account for the emergence of all medical specialties. It seems likely that there are different explanations for different time periods and different specialties. The social conditions which propelled surgery to become a specialty in the early part of this century were different from the social circumstances of today. In line with this conception, this thesis examined the

empirical case of the emergence of family practice and its designation as a specialty.

Chapter Two revealed how certain features which characterize medical specialization have evolved historically. The relationship between generalists and specialists, for example, becomes clearer once historical and structural conditions are analyzed. The role of the generalist is actually a core issue in American medicine. The issue of generalism and specialism has been consistently raised and debated for over forty years. The problem of whether and how general practice is organized is a problematic theme.

The role of the generalist was at the crux of the entire medical profession in America. The early reform movement, under the banner of the Flexner report, legitimated general practice, heralding generalism as the cornerstone of health care. Generalism was the foundation--the knowledge base--of all medicine. Hence, the oft-asked question, Why was family practice not formally instituted until 1969?

This thesis has proposed that a more revealing question is, Why 1969? The announced crisis in health care in the 1960s certainly was not new. In the 1920s, the Committee on the Costs of Medical Care met in Washington to discuss such a crisis in medical care: problems of high costs, inadequate care, maldistributed services, and the need for more generalists rather than specialists in

practice. The crisis in the 1960s represented virtually forty years' worth of unresolved issues.

Although the problems in health care were not unique to the 1960s, the social climate, politics, and economic environment were. Socially, the ideology of the 1960s was essential for the promotion, acceptance, and reception of certain ideas. Politically, a consensus developed among a great number of interest groups who shared similar ideological dispositions toward collective solutions to medical problems. Economically, the government played a major role by providing and allocating monetary resources for specific training of primary care physicians. The 1960s were times of financial abundance, and, therefore, the government could play a financial role--unlike the 1930s. During the Great Depression, these same medical needs were identified, but other priorities took precedence over primary care. The simultaneity of developments in these three areas and their social intersections constituted favorable conditions for the emergence of family practice.

Thus, Chapter Three and Chapter Four demonstrated how the 1960s era was not merely the context for the emergence of family practice; rather, the 1960s were a necessary <u>condition</u> for the emergence of family practice. The 1960s constituted intersecting philosophical, moral, intellectual, and economic conditions in which family practice could be politically, publicly, and professionally accepted

and institutionalized by the majority of interest groups simultaneously.

Yet, a specialty does not emerge simply because certain conditions exist at a given time and place. The sixties movement, while essential to the birth of family practice, was not sufficient in and of itself. Although the sixties era was indeed a necessary condition for the emergence of family practice, it was not the only necessary condition. There had to be an organized group of people ready, willing, and able to take on primary care. One could never understand the emergence of family practice without understanding the segmentation process within general practice. Chapter Five illuminates this process, revealing the internal battles, ideological strains and evolution, intense debates, and emerging coalitions arising within the profession. From this perspective, family practice is viewed as a relatively new emergent group, a segment arising from within the larger general practice group. This family practice segment was essential to the emergence of family practice as a medical specialty.

As evidenced in Chapter Five, the elaboration of macro-structural conditions, while all-important, renders only a partial--and thereby limited--explanation of the specialization process. One cannot fully explain the emergence of a specialty without detailing the segmentation process which occurs within any given profession.

The process model pays special attention to specialization as an interactive social process. Medicine does not exist in and of itself exerting domination over all of human life. Nor does it exist in a social vacuum. The process approach, once expanded, leads the investigator to both identify structural arrangements and explain how and why such features exist. The process model provides the researcher with a perspective which enables him to see the emergence of family practice as an interactive social process between the general movements of the 1960s and the specific movements within the medical profession. Certain general movements and conditions within society both excited and incited certain segments within the medical profession, allowing the specialist segment within general practice to conceptualize and defend family practice as a legitimate and equal specialty in medicine. Without the process model, the attributes and meanings of the many general and specific conditions could not have been delineated and developed into an explanation of the emergence of family practice.

Thus, this thesis has presented persuasive evidence to suggest that the creation of family practice was a complex social, political, and segmentation process which culminated as part of an interlocking social movement labeled by a time frame called the sixties. Essentially, family practice was an interactive process representing

both the spirit of the times and the segmentation of a profession.

APPENDIX

Methodology

In order to accomplish my objectives in this thesis, I used a wide range of research methods. This included historical and contemporary readings, observation in the field, and in-depth interviews with family practice residents, practitioners, and faculty members. In addition, I examined descriptive statistics, historical timetable charts, and other illustrative materials.

To accomplish this thesis, I needed to examine in detail three sociological areas: (1) the history of medical specialties, (2) the emergence of family practice, (3) the sociocultural climate of the 1960s.

To understand the first of these three considerations--medical specialties--I read primary and secondary materials. This included historical accounts written by sociologists and historians of medicine. Furthermore, I used primary historical data in the form of original documents, records, minutes, debates and articles of the time. For example, I read the Flexner report, AMA Proceedings, and congressional reports from 1960 to 1975. I read newspapers and magazines from the 1960s and focused on the 1960s in terms of social climate and social movements. I read many social commentaries on this period.

With respect to the second consideration--the emergence of family practice--I also used primary and

secondary historical materials. For example, I reviewed the Willard report, the Folsom report, the Millis report, and the Witten report. I read transactions of sessions of the American Medical Association. I read contemporary articles in professional journals, including commentaries, editorials, and first person renderings of the "beginnings."

Furthermore, from 1978 through 1980, I observed and interviewed family practice residents in a county hospital situated in northern California. For over twenty-five years, this hospital had been a training site for general practitioners. The hospital had begun its family practice training program three years prior to my entree. For that reason, it was an ideal arena for an inquiry into the emergence and evolution of family practice.

As it was my interest to explore what goes on in residency training, I observed the eighteen residents in their daily activities. My observations included following residents in the family practice clinic, in the labor and delivery service, in the emergency room, and in the pediatrics ward.

I also interviewed in depth fifteen family practice residents. Because I sought to gather a wide variety of data, these interviews typically lasted two and a half hours. During these interviews, I asked residents such questions as how they chose family practice, how they chose medicine, how they saw their future ten years hence, if

they were happy with their choices, what problems they had, and how the reality of family practice fit with their prior expectations. I also obtained background data, such as family origins, race, sex, educational attainment, parents' occupations, and other demographic data. I loosely followed a flexible interviewing guideline (see pages 222-23) which allowed the interviewee to talk freely about his feelings and his perceptions. I wanted to see what ideas would be generated from my data rather than approaching the interview with a rigid format.

Despite the wide individual differences between all interviewees, a constant theme emerged from the interviews. This theme became apparent to me as I was coding the transcripts of the interviews. Specifically, the interviewees continually referred to the 1960s as critical to their perceptions. They talked about their idealism and the idealism of the times. They talked about the Medical Committee for Human Rights instead of the AMA. They talked about how, while they were in medical school, they had volunteered at neighborhood free medical clinics that delivered medical services to the poor, to minorities, and to street youth. Just as the young idealistic lawyers of the times had provided storefront legal aid for the poor, these young doctors had worked long hours in such places as the Haight Ashbury Free Clinic, the Black Man's Free Clinic, La Clinica, and other idealistically-oriented nonprofit organizations that virtually existed on volunteer

time and donations. These young doctors also served as medics at rock concerts and at peace demonstrations. From these interviews, I became sensitized to the importance of how the spirit of a time influences individual choices and actions. It also occurred to me that the values of the 1960s inevitably affected major institutions. Finally, the interviews sensitized me to the ideology and mission of family practice.

I supplemented this data with additional interviews in 1986. I interviewed four practicing family physicians and four family practice faculty members within a large university system. In these interviews, I specifically sampled for perceptions and retrospective views regarding the initial stages of family practice. (See interviewing guideline, page 224.)

With respect to the third requirement for this project, that is, the social climate of the 1960s, I read newspapers, popular as well as academic literature, and researched the geist of the times.

My own autobiography shaped my sensitivity to these issues as well. I was a college student in the 1960s and was personally involved in many of the sixties causes. I tutored Chicano youth to prepare them for college admission. I supported the peace movement. I volunteered at a neighborhood walk-in clinic which provided primary care services. Finally, I worked for the State of California social service department.

Within my personal autobiography, there are two especially relevant circumstances that influenced my selection of this thesis topic. First, my job prior to this research required me to develop family practice curriculum in the area of health education. This gave me insider's access to the issues that were central to family practice. Secondly, I married a family practice physician and was a witness to his socialization through his residency and eventual medical practice. I heard firsthand accounts which illustrated the disparity between the idealism of the residents and the realities of everyday practice and training. My exposure to these data was invaluable.

To manage the vast amount of reading required for this research, I organized the primary and secondary historical materials in a manner that is consistent with qualitative research methodology. This allowed me to get at both facts and process. I divided my data according to time periods that reflected actual shifts in medical practice. From my reading, I generated groupings which I then used for each time period.

Following this initial step, I then read intensively within each cluster and coded for categories, properties, and conditions according to the guidelines of grounded theory.[1] I identified objective informational data as observational notes (ON). Observational notes would generate theoretical thoughts and linkages (TN) and

methodological ideas and plans (MN). Analysis was an ongoing process throughout all phases of this research.

I applied the same techniques to my interviews. I used the system suggested by Schatzman and Strauss for recording and interpreting the interview data.[2]

The major problem I encountered in this research was the paucity of specific information on my topic. I spent many futile hours doing computer searches in medical, medical history, and social science libraries, attempting to track down, without success, specific information on my topic. There were no specific materials correlating the cultural aspects of the 1960s and the emergence of family practice. Next, I attempted to track down the history of residencies to understand how they developed. To my astonishment, subject card files did not contain information under residency training, internships, training, history, specialization, medical education, or family practice. Indeed, several writers have remarked on the scarcity of records and studies regarding the development of residency training.[3]

The angle I used was to locate books on the oldest American hospitals where I found vague references to residency training. I had to piece bits of information together in order to construct a history. Although residencies are an integral part of the process of specialization, I was unable to find many references dealing directly with that subject. I finally located two

books, Paul Starr's The Social Transformation of American Medicine and Rosemary Stevens's American Medicine and the Public Interest, which I relied upon heavily for the initial part of this study.[3] In short, the dearth of literature was the major problem I encountered in this research.

One interesting and minor problem in this research occurred during the interviewing phase. This problem concerns the lay public's definition of what a sociologist is and does. Most people related to me as if I were a psychologist or a medical doctor. During the times I observed physician and patient interactions, some patients asked me if I would be their doctor and supervise their medical case. Patients thought I was the supervisor observing the doctor at work, even though they were previously informed that I was a sociologist. The doctors also had problems conceptualizing my role. In spite of the fact that I called myself a sociologist, I was frequently introduced by them to others as a psychologist. From these experiences, I concluded that the public does not yet have an understanding of what a sociologist does.

Interview Guideline for Family Practice Residents

1. How did you choose medicine? How did you choose family practice?
2. How did you choose where you wanted to do your residency?
3. How did you rank this residency program?
4. What constitutes a good family practice program?
5. What are the top five programs in California and why?
6. Where did you go to medical school?
7. Is the transition from medical school to residency difficult?
8. Is the residency as you imagined it to be?
9. What have you learned? How are you taught? Do you feel that the teaching is adequate? What is quality teaching?
10. How are attendings selected?
11. What expectations/ideas of yours have changed as a result of the residency?
12. Opinions about residency--quantity of work, responsibility, pay, supervision, teaching, nurses, hospitals, patients.
13. What are the differences in responsibility and work load between first-year, second-year, and third-year residents?
14. How is work assigned?
15. Is there anyone on the staff who is the kind of doctor you'd like to be or that you'd send your family to? Why?
16. What is the ideal patient?
17. What is the problem patient?
18. What kind of patients do you see here?
19. Of the patients you have, why are they sick?
20. What is a good nurse?

21. What is a good day?

22. What is quality care?

23. What are the realities here of providing such care?

24. What do patients expect of you?

25. What are some of the expectations of others of you, such as those of staff, nurses, family?

26. What are your own expectations of yourself?

27. How do you deal with all of these expectations?

28. Are you married, or do you have a partner? For how long?

29. Does you partner work? What at? Education?

30. What are some of the effects of the residency on your personal life? On your partner?

31. What is an ideal partner?

32. Do you think that being a doctor separates you from other people?

33. What are some of the hardest adjustments to make during a residency?

34. What keeps you motivated?

35. What is your ideal picture of practice?

36. Ten years from now, what will your work day be like?

37. If you had to do it over again, and knew what you know now, would you still become a doctor? Still go into family practice?

Interview Guideline
for Practicing Family Physicians and Faculty

1. Why were so few people doing general practice before the specialty of family practice was created?

2. What were some of the major problems and debates family practice faced in getting off the ground?

3. What problems do family practice programs encounter while being established at university centers, county hospitals, and community hospitals?

4. In medical school, is there a required course or clerkship in family practice?

5. Where do family practice department heads and clinical faculty come from?

   What were their training backgrounds?

   How were they recruited?

6. What was it about family practice that attracted these people (faculty)?

7. What problems were encountered in establishing curriculum for family practice residencies in relation to other specialties?

8. Do you feel that family practice has been accepted as a specialty by the medical community?

9. Are family practitioners able to practice what they have been trained to do?

Table 1

LIST OF APPROVED MEDICAL SPECIALTY BOARDS

	Year of Approval	Year of Incorporation
American Board of Allergy and Immunology		
American Board of Anesthesiology	1941	1938
American Board of Colon and Rectal Surgery	1949	1935
American Board of Dermatology	-	1932
American Board of Emergency Medicine	1979	1976
American Board of Family Practice	1969	1969
American Board of Internal Medicine	1936	1936
American Board of Neurological Surgery	1940	1940
American Board of Nuclear Medicine	1971	1971
American Board of Obstetrics and Gynecology	-	1930
American Board of Ophthalmology	-	1917
American Board of Orthopaedic Surgery	1935	1934
American Board of Otolaryngology	-	1924
American Board of Pathology	1936	1936
American Board of Pediatrics	1933	1933
American Board of Physical Medicine and Rehabilitation	1947	1947
American Board of Plastic Surgery	1941	1939
American Board of Preventive Medicine	1949	1948
American Board of Psychiatry and Neurology	1935	1934
American Board of Radiology	1935	1934
American Board of Surgery	1937	1937
American Board of Thoracic Surgery	1970	1950
American Board of Urology	1935	1935

Source: American Board of Medical Specialties. Directory of Medical Specialists, 1985-1986, 22d ed, Vol. 1 (Chicago, 1985), xix-xx.

NOTES

INTRODUCTION

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CHAPTER ONE

THEORIES OF SPECIALIZATION: A REVIEW OF THE LITERATURE

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CHAPTER FOUR

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CHAPTER FIVE

THE FAMILY PRACTICE MOVEMENT: AN EMERGENT PROCESS

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5. Ibid., 20.

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CONCLUSION

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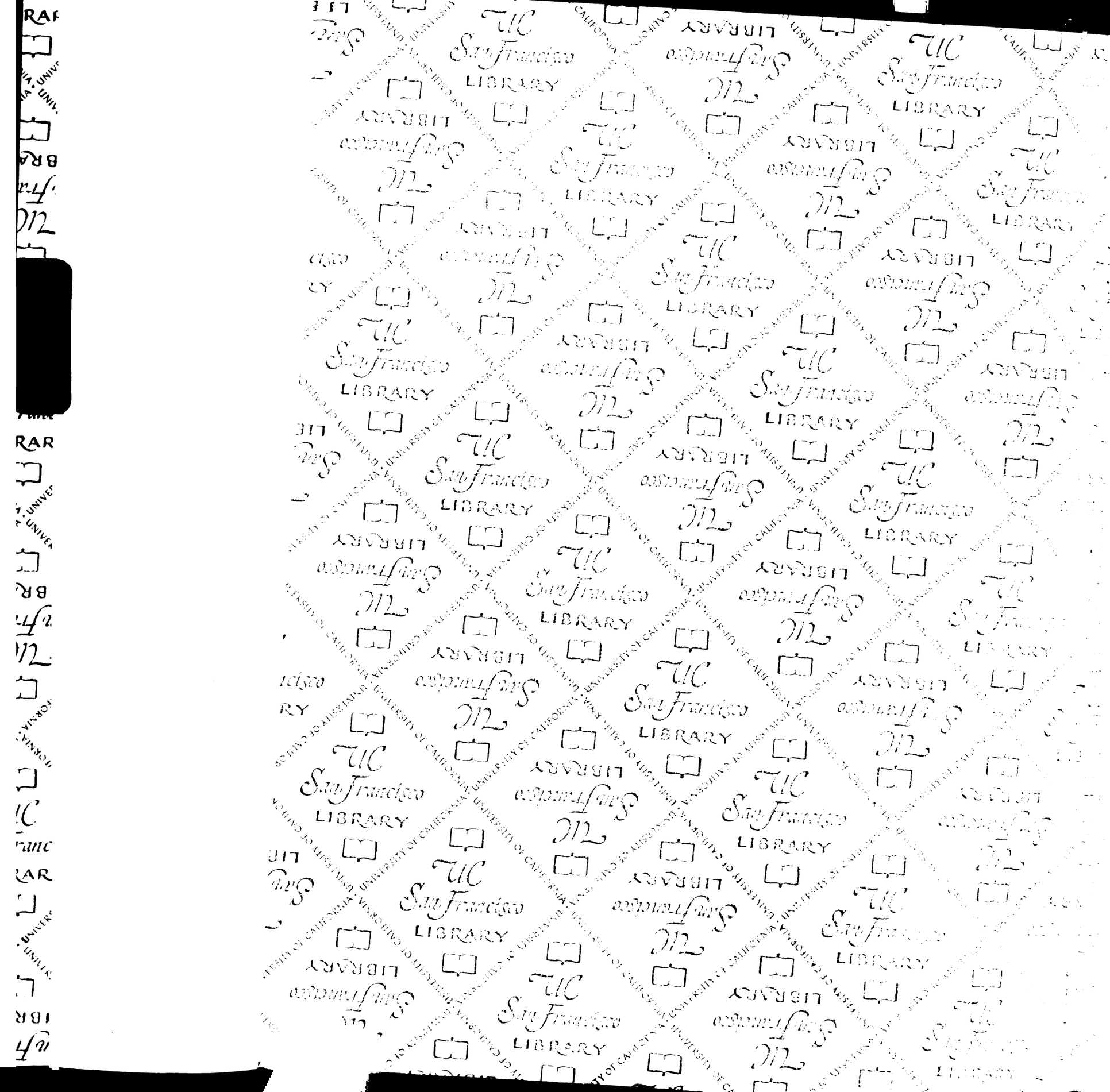
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