What a privilege it has been to have known and learned from many of the founders of family medicine and to have been a participant-observer in the evolution of family medicine commencing in 1971 as a medical student! My perspectives on family medicine and health care in general have been sculpted by more than four decades of lived experience that has included rural and urban practice as a family physician and a spectrum of educational, research, administrative, and policy endeavors emanating from various academic and professional roles. The manuscripts assembled in this theme issue of Family Medicine enrich the celebration of the 50th anniversary of the Society of Teachers of Family Medicine's (STFM) and evoke hosts of memories of friends, events, and both finished and unfinished business. Mine are only a few of many “rival memories” that legitimately vary because of different points of observation and interpretations. My first aim for this commentary is to stimulate others to reflect on their own experiences and interpretations to consolidate their own stories of what family medicine and STFM have done in their first 50 years. Then, from a host of possibilities, I want to offer one perspective about where lie substantial, immediate opportunities to build from the successes of the first 50 years and continue to evolve family medicine in behalf of individual and population health.

Looking Back from the 50-Year Mark

Hiding in plain sight is the lack of some scientific or technological breakthrough to propel the creation and development of family medicine. Instead, it seems clear that protection of the turf and legitimation of the role of rapidly disappearing general practitioners was a prime motive to establish family medicine, including at a personal level a quest for a little respect from the rest of rapidly specializing medicine. However, it didn’t take long for a grander and much more important vision to emerge of what family medicine could be and do, expressed later as: “The initial promise of family medicine was that we would rescue a fragmented health care system, put it together and return it to the people.” There is widespread agreement that family medicine emerged as part of social movements of the time, concerning human rights, racism, sexism, social justice. Such inward looking and outward facing motives for family medicine still co-exist and persist 50 years later, incompletely resolved, but still motivating family medicine’s development.

One of the most striking features of this 50-year period to me is how it began with large, intimidating aspirations and few resources, relying to a large extent on community support and courageous leadership. As STFM was being born in 1967 there were no academic departments of family medicine, no family medicine residencies, no academic family medicine journals, no faculty development programs, no certification standards for family medicine, and no family medicine academic organizations. It should be recalled that many communities, state legislatures, and some federal agencies were ready to help, medical schools and academic centers less so—a situation manifested today in the large majority

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of family medicine residency programs being community-based.

The last 50 years was a period of replacing general practitioners with family physicians and building needed infrastructure for family medicine, and there is much success to celebrate: approximately 99,800 family physicians providing direct patient care (Petterson and Wingrove estimate 2/17, Robert Graham Center); 87,784 American Board of Family Medicine certified family physicians (American Board of Family Medicine February 2017 monthly report); more than 550 Accreditation Council on Graduate Medical Education (ACGME) accredited or newly accredited family medicine residencies with a future effective date; more than 100 additional American Osteopathic Association family medicine residencies working on ACGME accreditation; 130 allopathic departments or divisions of family medicine (personal communication Ardis Davis, Association of Departments of Family Medicine 2/17), a large medical school-based teaching force, a buffet of professional family medicine organizations and societies supporting the practice, teaching, and discovery of family medicine, a portfolio of journals receiving a steady flow of original manuscripts. This multi-billion dollar enterprise was nonexistent at the beginning and now constitutes a precious stewardship opportunity.

In my view, family medicine is also responsible and credited for some important developments during this 50-year period that can be seen to have had far-reaching impact well beyond family medicine, for example: (1) professional re-certification of physicians now maturing into continuous certification for all medical specialties, (2) redirecting medical education from the hospital and its limited access to clinical phenomena toward community practice settings where the full spectrum of illness and disease can be addressed and learned, (3) embracing the behavioral sciences as indispensable to proper family care and welcoming behavioral health specialists into education, practice, and research, and (4) elevating practice-based research from an exceptional effort by a heroic few individuals to institutionalization through regional, national, and international practice-based research networks.

It is also interesting to me how almost all of the founding leaders of family medicine were men, most of whom had strong, enabling wives, many of whom I have had the privilege of meeting and coming to admire. These founding leaders were quick to acknowledge their dependence and gratitude to these “founding women.” I suspect all of these founders would applaud the feminization of family medicine during the last 50 years and the emergence of women as leaders of family medicine making family medicine stronger and better than it would otherwise be. STFM’s persistent commitment to women in medicine is another thing to celebrate as part of STFM’s 50th anniversary.

Lean Forward From the 50-year Mark

It is satisfying to reflect on what has been achieved, but it is also humbling and frustrating to note that while development of family medicine occurred, the US health care system has continued to fragment into more pieces, neglect many people—often those who need help most, perform with mediocrity on many measures of health care and health, and marched to dead last among peer nations in terms of the hard-edged outcome of life expectancy at birth for both boys and girls. Some of the grander dreams of 1967 remain elusive but are still valid, inviting renewal of a collective commitment to persist and prevail.

Correcting the sorry state of severe under-investment in family medicine and the primary care function is already a high priority for STFM and all family medicine and primary care organizations because it is necessary to advancing frontline care for all. I certainly have no monopoly on insight about other priority areas and represent no institution in nominating from many possibilities revealed in this theme issue three opportunities that seem to me to be foundational for the future, within the reach and scope of STFM and the rest of the family of family medicine, and not hugely dependent on uncontrollable external developments.

1. Redesign family medicine residencies.

The current model of family medicine residency training was established 50 years ago adopting only some of the possibilities recognized at the time. Much has changed, particularly in the knowledge base and technology necessary to integrate mental health, public health, and primary care in behalf of population health. Considerable residency experimentation has established the existence of creative leadership within family medicine residencies and the feasibility of substantial redesign. Regardless of one’s
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opinion as to the sufficiency and elegance of current family medicine residencies, an open-minded, thorough re-consideration of any enterprise is probably a good idea at least every 50 years or so. The paper by Carek et al rings the convening bell.

2. Establish the data infrastructure necessary for delivering and measuring comprehensive, continuous care of families in the context of local communities.

The disappointments of decades of un-kept promises for electronic records should not hold family medicine back from revisiting its early, somewhat neglected classification and data system work and continuing vigorously work under-way to define measures and test practical, multi-purpose technology customized to the needs of family physicians and their patients. Family medicine and primary care probably comprise medicine’s most complex data management problem, and coping with it requires much more than practice billing operations plus an adjustment or two. Normalizing information processing to integrate care in the context of families and communities and to measure what matters to people at the frontlines of health care is a prerequisite for both superior care and the discovery of how health is won and lost in families and communities. This is an “all hands on deck” issue that will continue to compromise further advancement of family medicine until it is solved, hopefully in the early phase of the next 50 years.

3. Refresh and cultivate strong, collaborative working relationships with others, and not just the usual suspects.

Fifty years ago, family medicine was so fortunate to have the help and encouragement of other medical specialties, particularly pediatrics and psychiatry, and other organizations, eg, the farm bureau, many state legislatures, and some federal agencies. It may be time for a comprehensive reconsideration of whom family medicine needs to work with in medical schools, the broader university, communities, and government. An aim for such an initiative within medical schools could be face to face discussions with other specialties’ leaders to create mutual understanding of what robust primary care is and to consider where lie opportunities ripe for action together. Another aim might be a reconsideration as to where family medicine actually belongs in the university and what its basic sciences are and will be. And it also might be time to create and consolidate a nationwide system of university-community infrastructures that reliably connect the needs and preferences of local inhabitants with health and health care solutions achievable when the right people can work together over time. STFM’s proud history of inter-professional and community collaboration positions it to fuel such enterprise.

In my view, an aggressive commitment to these three areas, all of which are exposed in one or more of the papers in this special issue, includes some invention work but is mostly about recovery of ideas and principles, engaging others, and mobilizing resources not previously available to re-engineer with willing partners innovative, adaptive solutions. I am optimistic this can be done because of instabilities and deficiencies in the current environment, so much relevant new knowledge that can be harnessed, and because I have seen highly skilled young leaders with commitment to timeless values coming to these challenges.

Let me end this commentary asserting my gratitude to STFM for its many accomplishments and my confidence that its best anniversaries lie just ahead.

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References


