“The farther backward you look, the farther forward you can see.”—Winston Churchill

Much has been accomplished by family medicine since its advent as a specialty in American medicine 35 years ago in 1969. The steady decline in general practice has been arrested and its ranks replaced by graduates of family medicine residencies. Family medicine has gained a foothold in most of the nation’s medical schools, and family physicians still account for a larger proportion of office visits to US physicians than any other specialty.

Despite such progress, however, the country’s health care (non) system has undergone a major transformation to a market-based system largely dominated by corporate interests and a business ethic. The goal envisioned in the 1960s of rebuilding the US health care system on a generalist base, with all Americans having ready access to comprehensive health care through a personal physician, has not been achieved. Primary care has become splintered into many competing interests, and public policy concerning health care reform is confused. Clouds now obscure the horizon as all of the primary care specialties look to their future, and each is actively involved in internal reassessment and strategic planning. In their insightful analysis of current threats to generalism and primary care itself, Sandy and Schroeder even pose the question whether primary care in this new era is in a state of disillusion or dissolution.1 As family medicine now undergoes its own self-assessment, it is therefore worthwhile to revisit its generalist roots. This paper has four objectives: (1) to identify four streams from the literature of the legacy of general medical practice, (2) to briefly assess some major trends as they relate to our generalist legacy, (3) to describe the current chaos in primary care, and (4) to compare two alternative scenarios for the future of family medicine, primary care, and the health care system itself.

Streams in the Legacy of General Practice

Today’s tension between the generalist and the specialist has a long history dating back more than 4,000 years. In the Nile Valley of Egypt before 2,000 BC, Herodotus noted that “The art of medicine is thus divided: each physician applies himself to one disease only and not more.”5 At no time over the centuries, however, has the generalist disappeared from the landscape of medical practice, though generalist practice has been forced to reinvent itself on many occasions as a phoenix rising from the ashes.4 Despite variations from one period of history to another, four streams sort out in the ongoing legacy of general medical practice.

Broad Scope of Clinical Skills and Orientation

Although clinical knowledge and skills change markedly from one time to another as the science and technology of medicine advance, the generalist invariably retains an orientation to apply a broad range of clinical skills to the majority of illnesses presented by patients to his or her care. As Gayle Stephens, MD, has observed:

The sine qua non is the knowledge and skill that allows a physician to confront relatively large numbers of unselected patients with unselected conditions and to carry on therapeutic relationships with patients.6

The natural climate favoring the emergence of family medicine from general practice was well stated by Ian McWhinney, MD, in the 1970s in these words:7

From the Department of Family Medicine (Professor Emeritus), University of Washington.
It is no accident that family medicine is emerging at a time when the interrelatedness of all things is being rediscovered, when the importance of ecology is being forced on one’s awareness—when scientists, especially those in the life sciences, are beginning to react to the scientific bias against integration, synthesis, and teleology—when human values are being asserted over technology and when the importance of enduring and stable human relations is being discovered anew.

**Being There With a Community Perspective**

As part of the community, generalist physicians need to have a community perspective to prevent, recognize, or manage illness presented by patients in their practice. These characteristics of family medicine, as elucidated by McWhinney, bring this point home (Table 1).8

Many illnesses cannot be effectively managed without dealing with their larger sociologic, cultural, and economic realities. The work of Jack Geiger, MD, and the Broad Street pump provides an excellent illustration of this point.9

The bond between commitment to community and the social contract to provide medical care is well exemplified by the experience of the apothecaries in England more than 400 years ago. Originally general shopkeepers in the early 1600s, apothecaries earned public acceptance to treat the sick during the plague of 1665, when many physicians left the community, together with their more affluent patients, to less risky locales in the countryside. Despite strong opposition from the Royal College of Physicians of London in later years, apothecaries extended their roles of compounding over-the-counter prescriptions to prescribing for and treating patients at home. From the mid-1800s on they acted as general practitioners, with their medical roles and training requirements firmly established by law.10

**The Healer**

As Hiram Curry, MD, observed in his classic article on the phoenix, the mythical bird of ancient Egypt that arises generation after generation from its own ashes, every society for thousands of years has had its own version of a medicine man or healer living in its midst. Examples include the shaman of primitive tribes, the scholar-physician of ancient Greece, the granny woman of the American frontier, and the general practitioner in 20th century Western society.4 Lewis Barnett, MD, reflecting on his experience as a rural family physician in more recent years, carries the healer tradition forward with this observation:11

In each of us, there probably is a touch of the artist. The medium through which we work is the human body, mind, and spirit. The personal touch remains the key to unlocking the secrets of the moment.

Edmund Pellegrino, MD, views today’s trends as raising three basic options for the future role of the physician vis-à-vis the patient: (1) the physician as scientist, with the ethical imperative being competence (ie, a craftsman’s ethic, the predominant one today), (2) the physician as businessman, with medical care a commodity transaction reduced to contract or business ethics, and (3) the physician as healer, involving a covenant with and concern for the patient as a human being: concern for illness, not just disease; and ethics based on obligation to the patient’s needs. Based on its commitment to care for the human person both scientifically and with compassion, Pellegrino suggests that family medicine can only choose the covenantal model.12

**Research**

Despite a widespread misperception to the contrary, there is a long history of important research in the legacy of general practice, especially in its earlier years. These examples make the point.

- James MacKenzie, MD’s systematic observations of his patients over 20 years in the late 1800s as a general practitioner in Burnley, a cotton manufacturing town in Lancashire, Scotland, laid the foundation for modern cardiology. As a result of close observation and careful record-keeping, he was able to classify presystolic murmurs by prognosis, determine the prognosis of extra systoles, and elucidate dyspnea as a symptom of heart failure. As part of his continuous studies, he invented the polygraph. He later conducted a world-famous cardiology practice in London, and upon retirement returned to St Andrews, Scotland, to establish a medical research institute for the study of the natural history of disease.13,14

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**Table 1**

Characteristics of Family Medicine, Elucidated by Ian McWhinney, MD

1. The pattern of illness approximates to the pattern of illness in the community, ie, there is:
   a. A high incidence of transient illness
   b. A high prevalence of chronic illness
   c. A high incidence of emotional illness

2. The illness is undifferentiated, ie, it has not been previously assessed by any other physician.

3. Illnesses are frequently a complex mixture of physical, emotional, and social elements.

4. Disease is seen early, before the full clinical picture has developed.

5. Relationship with patients is continuous and transcends individual episodes of illness.
• William Pickles, MD, as a general practitioner in England during the early 1900s, carried out continuous epidemiologic studies of infectious diseases in the rural communities of his district. His work determined the incubation periods of several infectious diseases, including measles and varicella.15

• Jack Medalie, MD, as a general practitioner in Israel, studied angina pectoris in 10,000 men, demonstrating a marked increase in its incidence in men with lower levels of wives’ love and support as well as men in families with the most family problems.16,17

Concerning process and opportunities for research in family medicine, these observations provide timeless and helpful guidance. Kerr White, MD, longtime primary care investigator and author of a landmark 1962 article on the ecology of medical care,18 offers these suggestions:19

We should consider addressing five types of generic questions at the primary care level: onset circumstances, concomitant factors, predisposing factors, precipitation of help-seeking, and therapeutic environment. Two examples:23 How frequently is the perception of inability to control fundamental aspects of one’s job associated with the development of an illness such as coronary heart disease? and why do mortality rates increase substantially after personal, religious, ethic, and statutory holidays and anniversaries?

How Do Some Major Trends Relate to Our Generalist Legacy?

If we accept these four streams as guideposts over a long generalist tradition in medical practice, how then do current trends in family medicine in this country relate to these streams? Or more specifically, to what extent do today’s trends nurture, or threaten, the future of family medicine?

Broad Scope and Orientation

There is no question that the scope of the family physician’s practice is becoming more circumscribed in recent years as compared with earlier years in the United States. This goes well beyond the expected and necessary reduction of surgical and some other procedures in the practice of family physicians in metropolitan areas, where consultants are readily available to perform needed procedures and services in all of the medical and surgical specialties. Only about one quarter of graduates of family medicine residencies now provide obstetrical care,20 and the proportion of family physicians who see patients in the hospital has dropped from 63% in 1999 to only 45% in 2003, according to a recent survey by Medical Economics.21 The hospitalist movement is spreading rapidly across the country, mostly within internal medicine, and is projected to more than triple in size in coming years to the approximate size of the specialty of cardiology.22 A counter-trend in some family medicine teaching centers has been to develop 1-year fellowship programs, with an emphasis on more advanced obstetrical and procedural skills needed in rural practice, but these are few in number and have not influenced the overall decrease in scope of practice within family medicine.

Being There in the Community

Perhaps the best indicator for the success of family medicine over the last 35 years is its effective distribution to underserved and rural areas of need. As the best distributed specialty in American medicine, it provides the bulwark of care in these communities. The 2000 National Ambulatory Care Survey revealed that family physicians and general practitioners accounted for 199 million, almost one quarter, of the nation’s 822 million visits to physicians’ offices in that year, compared with 126 million and 104 million visits to general internists and general pediatricians, respectively.23

Despite its successful distribution pattern, however, personal continuity of care with patients has been seriously eroded as a result of the trends listed in Table 2.25

The Healer Role

In view of the pervasive and multiple reasons for erosion of continuity of care in family medicine today, new concerns are being raised over the extent to which the healing capacity of family physicians will be adversely affected. A recent comprehensive review of the continuity of care literature by John Saultz, MD, described three hierarchical levels of continuity—informational, longitudinal, and interpersonal—noting that interpersonal continuity over time, while the essence of an intimate and trusting physician relationship, is

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Table 2

Trends That Have Eroded Continuity of Care With Patients

- Increasing mobility of both patients and physicians
- Increasing numbers of family physicians opting for part-time practice
- Decreased physician after-hours continuity within call arrangements of larger group practices
- Growing numbers of family physicians now practicing in urgent care or emergency settings without any continuity of care
- More family physicians refusing to see new Medicare patients (27% in 2002)24 or patients on Medicaid due to low levels of reimbursement by these programs
- Progressive withdrawal from inpatient care as the hospitalist movement grows
- Instability of health plan coverage, with typical annual turnover rates of 20%, often resulting in change of physicians
still poorly understood. He called for further research to examine such questions as to how informational or site-specific continuity through team-based care will affect long-term interpersonal continuity so necessary for healing relationships.²⁶

As a family physician and ethicist at the Center for the Humanities and Bioethics at Michigan State University, Howard Brody, MD, PhD, has called attention to the therapeutic value of stories of illness. As he points out:²⁷

We are, in an important sense, the stories of our lives—when sickness is more or less chronic, we cannot understand a right and good healing action without understanding what the sickness is doing to the person’s self-respect, to his life plan, and to the narrative account of his life.

Interpersonal continuity of care is necessary for the physician to be in a position to help patients develop therapeutic stories of illness. Informational continuity, even if longitudinal over time, will likely compromise the capacity of family medicine to play the healing role of which it is capable unless interpersonal continuity can be assured.

Research

Trends over the last 30 years concerning family medicine research in the United States represent a mixed story. On the positive side, some research fellowship and faculty development programs have been established, a cadre of family medicine researchers is growing, academic journals have been created for publication of their work, and practice-based networks have been organized to facilitate bidirectional translation of research into practice as well as community practice into research.²⁸ Progress has been made in development of coding systems and research tools for the study of primary care problems, and the growing use of electronic medical records has the potential to further increase the field’s research capability. The North American Primary Care Research Group effectively nurtures the research enterprise, and Congress has created in statute within the Agency for Healthcare Research and Quality a center devoted to primary care research.²⁹ And, there are some excellent examples of important primary care research accomplished by family physicians in recent years.³⁰ ³⁵

On the negative side of the ledger, however, the 30-year track record for family medicine research has so far been disappointing, a clear research agenda is yet to evolve, little attention has been directed to the natural history of disease, and comparatively low research productivity has raised questions of academic credibility in many medical schools.³⁶ Attempts to carry out population-based research of primary care populations are seriously hampered by the amorphous structure of primary care within our fragmented health care system and high annual turnover rates among health plans.

In sum, current trends in family medicine, as they are compared to our four inherited historical streams of generalism, threaten the future of family medicine. That is, unless major course changes can take place within the field, together with major changes in the health care system to strengthen primary care itself.

Current Chaos in Primary Care

Primary care in the United States is more fragmented and weaker structurally today than ever before. The general practice base of the first half of the last century has been largely eroded by a surfeit of providers, each attempting to provide some aspect of primary care. The “contract” for primary care has become so splintered as to be almost unrecognizable. Consider the trends shown in Table 3.

Collectively, the trends in Table 3 lead to less efficiency, higher costs, and compromised quality of care. Many services are provided that are of doubtful efficacy or even harmful. The concept of a “personal medical home” is being advanced by the primary care specialties as a means of improved integration and coordination of care, but the ranks of primary care physicians are thinning and under increasing stress as our growing population ages, and the pipeline in training is contracting rather than growing. As health care costs escalate in the aftermath of the failed managed care experiment, primary care is in disarray and public policy is adrift. Meanwhile, the health care (non) system is being progressively split along income and class lines into tiers, with an upper tier of concierge and boutique services for more affluent patients.¹

Future Projections for Family Medicine and Primary Care

Market-based policies, supported by the government at federal and state levels, have led to weakened primary care in this country to the point that the primary care specialties find it difficult to fully serve patients in the ways in which they are trained, qualified, and committed. To the extent that historical traditions of generalism in medicine will eventually prevail, the phoenix will again rise from the ashes of primary care. The question, of course, is what form the next phoenix will take. As family medicine considers its future, both introspection and internal course changes are called for, but to be successful will also require structural system reform as well.

Concerning internal course changes open to family medicine, there is reason to be concerned about some current trends. Stephens in 1982 noted two ways in which family medicine could fail—splintering into special interest groups or putting its own self-interest above
Table 3
Trends Demonstrating the Disorganization of Primary Care in the United States

- In aggregate, the proportion of family physicians and general practitioners (now only about 10% of the US physician work force) has actually declined since 1970.29
- Internal medicine and pediatrics are expected to see another surge in subspecialization.36
- The 6-year period 1997 to 2003 saw a continuing decline in the numbers of US seniors matching into primary care residency positions in all three primary care specialties (a decline of 47% in family medicine over those years).37
- By 2000, there were more nurse practitioners in the United States (about 102,000) than general practice/family medicine combined, with 90% working in primary care and licensed in many states to practice independently from physicians; physician assistants are another rapidly growing group of nonphysician clinicians (about 45,000 in 2000), with about half of that number working with primary care physicians.29,38
- Alternative medicine providers are estimated to account for more visits each year in the United States than visits to all primary care physicians, with out-of-pocket expenditures exceeding those for all US hospitalizations.39
- Psychologists are now authorized in New Mexico to prescribe psychotropic drugs40 and are lobbying to pass similar legislation in more than 20 other states.41
- Medicaid reimburses chiropractic in 33 states, biofeedback in 10 states, acupuncture in seven states, hypnotherapy in five states, and massage therapy in two states.42
- Naturopaths are now licensed in 12 states, and insurance companies in Washington and Connecticut are required to cover their services.43
- “Pharmaceutical care” by pharmacists is a steadily growing trend, with more than 30 states now allowing some form of collaborative management with physicians for selection, initiation, monitoring, or modifying a patient’s drug therapy; pharmacists are authorized to give immunizations independently in 30 states.44
- Self-care by patients is now taking many forms as diagnostic and screening tests, as well as drugs, are marketed directly to the public; patients can now obtain full-body CT scans without their physician’s involvement45 and directly purchase drugs without their own physician’s prescription through rapidly growing mail-order pharmacies or Internet sources.46

The report, however, is less compelling in strategies to implement its recommendations and is hardly a counterculture document. A name change from family practice to family medicine, together with a rejuvenated marketing effort for the specialty, seems unlikely to make a big difference among the larger sea changes occurring in primary care, and there is no way that family medicine by itself can achieve its goal of a personal medical home for all Americans given the realities of numbers. Moreover, the FFM report’s failure to reject incremental approaches to universal coverage as already failed policies, and to sidestep endorsement of public financing of a private delivery system, falls far short of effective system reform.

The question before family medicine and primary care is therefore not how to accommodate to a failing market-based system as part of the reactionary responses of organized medicine but to advocate for structural system reform to make health care accessible and affordable for all Americans. The sixth report of the Institute of Medicine (IOM) on the uninsured has just been released, Insuring America’s Health: Principles and Recommendations, calling for health care coverage by 2010 that is universal, continuous, affordable, sustainable, and enhancing of high-quality care that is effective, efficient, safe, timely, patient centered, and equitable. The IOM describes four basic approaches to that goal: (1) major public program extension and new tax credits, (2) employer mandate, premium subsidy, and individual mandate, (3) individual mandate and tax credits, and (4) single payer national health insurance (NHI). While stopping short of advocating a specific approach, the IOM’s Committee on the Consequences of Uninsurance acknowledges that the single payer model is the most effective in ensuring continuous, universal coverage that would remain affordable for individuals and for society.49 This case has already been well established in a number of recent articles,50–54 as well as in comprehensive analyses of incremental versus single-payer alternatives in California,55 Maryland,56 Massachusetts,57 and Vermont.58

Against this background, it is now possible to sketch out two alternative future scenarios for family medicine and primary care in 2020, as summarized in Table 4. Given the unsustainability of present trends in our market-based (non) system, which are increasingly pricing health care beyond the reach of the middle class, some form of social health insurance seems inevitable—it is just a matter of time until political will and neces-
Family medicine and primary care need that kind of system to strengthen their roles and fulfill their mission. The opposite is equally true—when NHI does arrive, generalist primary care physicians, working with teams of other health professionals, will be in high demand as the foundation of an improved system.

It is now fully documented that primary care is essential to an effective and efficient health care system. In her extensive studies of primary care around the world over many years, Barbara Starfield, MD, MPH, has found that countries with strong primary care have lower overall health care costs, improved health outcomes, and healthier populations. In a 1992 report comparing 11 features of primary care in 11 Western countries, the United States ranked lowest in terms of primary care ranking and per capita health care expenditures and also performed poorly on public satisfaction, health indicators, and the use of medication. In the United States, states with more primary care resources have been found to have better health outcomes even when income disparities are taken into account. The higher the family physician-to-population ratio in an area, the lower the hospitalization rates for both adults and children.

To the extent that family medicine can build on its long traditions of general practice, its future can be bright. To do so, it must develop and retain a wide range of generalist skills (admittedly different by 2020) needed to provide ongoing care for unselected patients of all ages. If family physicians are to be effective healers, they must know their patients well enough as persons to understand and interpret their stories of illness. Continuity of care through reengineered practice systems, involving more teamwork across disciplines, integrated collaboration with consultants, and widespread use of electronic medical records can open new horizons for much needed primary care research. But for family medicine and primary care to achieve their goals, the system must be reformed to provide universal coverage for the entire US population.

How to get there from here? For starters, we must see and move beyond our own specialty’s blinders. We need to reach out to our allies across primary care and build a growing coalition advocating for real system reform. The primary care specialties have much more in common than their differences. Over a generation, they could even coalesce into a single primary care specialty following the single generalist model seen in most other industrialized Western countries.

In advocating for publicly financed social health insurance, we will be at odds with organized medicine (perhaps even including some of our own organizations). To do otherwise, however, will desert the public trust and weaken our claims to put the public interest above our own self interests.

When the phoenix next arises, as it surely will, family medicine needs to be a key part of that renaissance of primary care, under whatever name best describes its role. Concerning names, there was considerable debate and confusion in the mid-1960s, as illustrated by three national groups. All three proposed rebuilding medical education and the health care system upon a generalist physician base, each with a different name—primary physician (Millis Commission), family physician (Willard Report), and personal physician (Folsom Commission). Many in the American Academy of General Practice resisted the name change to family practice. John Frey, MD, recently suggested that “general medical practice” would be an appropriate name if it describes our role at the center of a system of care for individuals, families, and communities. That would honor and draw from a rich heritage of general practice and extend its legacy into a new era, while serving the larger public interest in building a solid generalist base for a sustainable and improved health care system.

Table 4

Family Medicine and Primary Care: Alternative Scenarios for 2020

<table>
<thead>
<tr>
<th>Family medicine</th>
<th>Without NHI</th>
<th>With NHI</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Less in demand</td>
<td>More in demand</td>
</tr>
<tr>
<td>Marginal system role</td>
<td>Strengthened system role</td>
<td></td>
</tr>
<tr>
<td>Less continuity of care</td>
<td>More continuity of care</td>
<td></td>
</tr>
<tr>
<td>Mainly rural and underserved</td>
<td>Broadly distributed</td>
<td></td>
</tr>
<tr>
<td>Lower career satisfaction</td>
<td>Higher career satisfaction</td>
<td></td>
</tr>
<tr>
<td>Marginal reimbursement</td>
<td>Stabilized reimbursement</td>
<td></td>
</tr>
<tr>
<td>High practice overhead</td>
<td>Lower practice overhead</td>
<td></td>
</tr>
<tr>
<td>No population-based research</td>
<td>Population-based research growing</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Primary care</th>
<th>Weak and dysfunctional</th>
<th>Strengthened, more effective</th>
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</thead>
<tbody>
<tr>
<td>Weak primary care workforce</td>
<td>Larger stabilized workforce</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Health care system</th>
<th>Severe access problems in lower tiers</th>
<th>Universal access, less tiering</th>
</tr>
</thead>
<tbody>
<tr>
<td>Soaring cost inflation</td>
<td>Reasonable cost containment</td>
<td></td>
</tr>
<tr>
<td>Degraded system performance</td>
<td>Improved system performance</td>
<td></td>
</tr>
<tr>
<td>Increased public dissatisfaction</td>
<td>Increased patient satisfaction</td>
<td></td>
</tr>
<tr>
<td>Increased bureaucracy</td>
<td>Simplified administration</td>
<td></td>
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</tbody>
</table>

NHI—national health insurance
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