Reform in the United States: Its Impact on Medicine and Education for Family Practice

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The historical concept of reform is useful as an aid to understand the modern rise of family practice education. Beginning about 1890, historians have identified several themes of reform in the United States which have been expressed culturally, politically, and socially. Each of these themes, agrarianism, bureaucratization of the professions, and utopianism, has influenced medicine and medical education – first at the turn of the century in the activities of the AMA in promoting public health and in establishing the natural sciences as a basis for medical education and practice.

Since the end of World War II, additional reform themes have become visible which are also influencing medicine. Among these are humanism, consumerism, and the women's movement. It is the author's thesis that the present vitality and future development of family practice as a discipline is more dependent on its capacity and willingness to be identified with these expressions of reform than on its negotiations and compromises within the medical education establishment.

How is one to understand the development of the family practice education movement in the United States in the latter half of the twentieth century? The time is over when it could be dismissed as trivial or evanescent. Too much has happened in the past decade for that. Legitimate questions remain, however, about the significance of the movement, its present and future growth, and its ultimate place in American medicine.

It is naive to assume that the "causes" of the development of family practice education lie mainly within the medical profession or the medical schools. The medical establishment itself is created to a considerable degree by forces that originate in the larger social order – forces of political, economic, and cultural significance for society as a whole. It is my belief that family practice education bears a special, perhaps even a unique, relation to these external forces, and that its current significance and its future development lie in our understanding of these forces and relationships.

This paper was presented as the John G. Walsh Memorial Lecture to the Sacramento County Medical Society, Sacramento, California, on April 20, 1976. Requests for reprints should be addressed to Dr. G. Gayle Stephens, Dean, School of Primary Medical Care, The University of Alabama in Huntsville, Bank of Huntsville Building, Suite 202, 101 Governors Drive, S.E., Huntsville, Ala 35801.

Reform as a Subject of Historical Study

One idea which may contribute to this understanding is that of "reform." The notion of reform has been used by scholars in American history to explain much of the change that occurred in this country in the last decades of the nineteenth century and the first decades of the twentieth. Richard Hofstadter designated the period from 1890 to the beginning of World War II as "the age of reform," and noted that it was during this period that the United States "which was born in the country moved to the city."[1]

Reform as used by historians refers not so much to change itself as to the underlying causes of change – the deeper shifts in values which create and shape the external phenomena of change. Nor does reform suggest a single-minded, clearheaded, grand design for change. Rather, it suggests responses on the part of many elements in society to the disintegration of one cultural style and its replacement by another. Reformers are a diverse lot who often disagree with each other, but they share a common role as agents of change within society.

I wish to use the notion of reform, as developed in the study of American history, as a basis for considering changes that have occurred in medical practice and medical education, and then employ this perspective to elucidate certain aspects of family practice education.

The Age of Reform

The characteristics of reform in American life have been defined by Hofstadter,[1] Wiebe,[2] and Goldman[3] in separate works that emphasize particular aspects. They identify three main themes that have shown remark-

able persistence in this century: (1) a return to a rural way of life (agrarianism); (2) the search for order (bureaucratization); and (3) the quest for an ideal society (utopianism). Each of these can be identified in politics, economics, education, literature, and other aspects of national life. They wax and wane but never disappear. They cut across party lines, and reformers are to be found at all points on the political spectrum.

At the turn of the century Populism was a political movement that represented the discontents of farmers and small businessmen who were concerned about the prices of wheat, cotton, and silver. A little later Progressivism expressed the enthusiasm of a growing middle class to restore a type of economic individualism and political democracy which they believed to have existed earlier, and which was destroyed by giant corporations and corrupt political machines. In the 1930s the New Deal represented the demands of a large, organized working class for pragmatic answers to their social needs. Since the 1960s we have experienced the demands of minorities for equity, the press for greater personal freedom, the concern with ecology, and the rise of consumerism. Each of these has affected the practice of medicine and medical education.

Reform and the AMA

It is interesting and instructive to review the reform activities of doctors at the turn of the century. The American Medical Association, which was organized in 1846, had a membership of 8,400 in 1900, but by 1910 it had increased to 70,000! There was a frenzy of activity aimed at purifying the profession of quackery, promoting public health and sanitation laws, and establishing an orthodoxy for medical education based on natural science.

The nineteenth century had witnessed a decline in professional standards, and there was an oversupply of "doctors of the people," such as homeopaths, naturopaths, and eclectics, who roamed the land at will. When the discoveries of Pasteur and Koch finally reached the United States the decline of quacks and nostrums was assured. Wiebe states, "After the introduction of diphtheria antitoxin during the nineties, no more honorable men tried to cure it from a bottle." He further described the activities of the reformer-doctors: "like religious men . . . who believe in their own vision . . . and wish to go among others, the new doctors descended upon the cities and towns with a scientific gospel."[4]

Until the mid-1920s the AMA was clearly on the side of reform.[5] It supported a Pure Foods and Drug Act and, with some reluctance, supported the Harrison Narcotic Act of 1914. It favored the establishment of the Children's Bureau (1912) and even promoted a Federal Department of Health.

The issue of compulsory national health insurance first arose around the year 1912, and the initial reaction to it was not entirely negative. After eight years of debate and extensive study of European systems, a resolution to oppose it was passed in 1920.[6] In 1924 the AMA opposed the World War Veterans Act and its political record on social legislation has been mostly reactionary since then. In the years 1949 to 1952 the AMA spent $4,678,000 lobbying against federal health insurance. Until 1962 it also successfully opposed all forms of direct federal aid to medical education, and found itself across the fence from the Association of American Medical Colleges on this issue.

Reform and the Medical Schools

The story of medical education is generally more familiar. With the publication of the Flexner Report (1910) there was a sharp decline in the number of medical schools. Premedical requirements were established, medical school curricula were standardized, full-time faculties were employed who engaged in research as well as teaching, and medical schools became attached to universities. The stage was set for a period of relatively uninterrupted development until World War II. Then federal participation in funded research became a dominant activity in the schools. There was a huge increase in the average number of full-time faculty from 70 in 1949 to 1950, to 250 in 1968 to 1969.[7] The position of Dean became a full-time administrative job with major fiscal responsibilities for federal grants.

In spite of this burgeoning prosperity of the medical schools, the number of medical students and graduates increased slowly. As a matter of fact, the number of medical schools in the United States was the same in 1960 as in 1920 (86), although the population increased by 73,000,000 during that period.[8] The physician/population ratio was maintained by increasing the number of graduates per year from 3,047 to 6,994, and by the immigration of foreign medical graduates.

One of the dramatic correlates of the Flexnerian reform was the rise of specialism. These events have been documented exhaustively by Rosemary Stevens.[7] The American Board of Ophthalmology was established in 1917 and Otolaryngology in 1924, but in the 1930s 13 new Boards appeared, and four more in the 1940s. General practitioners constituted 85 percent of practicing physicians in 1935, but less than 30 percent in the late 1960s. In addition, the new specialists were heavily oriented towards surgery.

The Doctor Shortage

During the Eisenhower administration there was an early reappearance of reform directed mainly at issues of physician manpower. In the Bayne-Jones Report[9] (1958) and the Bane Report[10] (1959) there was the first hint of disenchantment with research and a clear call for a major expansion of the medical schools. It is uncanny to compare the recommendations from these reports to what actually occurred – the recommendations of 1958 were only achieved in 1971, namely the creation of 20 new medical schools and an increase in admissions to 11,000 per class.

The AMA insisted at first that there was no shortage of doctors, but public clamor was insistent and by 1962 the AMA was willing to acquiesce to Public Law 88-129, Health Professions Education Assistance Act of 1963. This legislation authorized a program of matching grants for construction and improvement of medical schools along with a plan for loans to students of medicine, osteopathy, and dentistry.

At the same time that the federal government was focusing on manpower, a number of authors were beginning to critique the quality and availability of medical care in the United States. From "war on poverty" theorists came the unwelcome assertion that important subsets of Americans – the poor, the aged, the rural,

the ghetto dwellers – did not have access to adequate medical care. Perhaps more unwelcome were other writers who complained about the appropriateness of modern medicine's emphasis on high-cost technology. David Rutstein[11] spoke of the "paradox of modern medicine" by which he meant that the health of the whole population was not being improved proportionately to the dramatic promises from research. Moreover, there were those who complained about the costs and the impersonality of care. The public also was beginning to express hostility towards doctors in increasing litigation.

Rosemary Stevens has summed up the situation:

Seen in terms of the natural history of professionalism, recent developments in medical education represent a striking success. The average doctor has been transformed in 60 years from an incompetent physician, whose strength lay in the "bedside manner" of his mystique, to a specialist internist, surgeon, or endocrinologist whose own competence is buttressed by an array of diagnostic and treatment aids and techniques. American doctors are among the best trained, perhaps *the* best-trained technological physicians in the world. Together, however, they are not providing optimal medical care; and it is this factor which has become the educational paradox – the manpower crisis – of the 1970s. Traditional goals of professionalism are no longer enough. If the medical schools are to meet their role as public service corporations, the inbuilt conflict between the goals of professionalism and the improvement of health services has to be resolved.[7]

Reform Revisited – AMA

In the mid-1960s the AMA recaptured some of its earlier reform ethos by creating a new Flexner-style Commission to study graduate medical education, and a new Committee to study general/family practice. The former was chaired by John Millis, PhD,[12] and the latter by William Willard, MD.[13] These two study groups, though functioning quite independently, addressed many of the same issues, and quite fortuitously both published their findings in late 1966. Among other things, these reports called for the training of increased numbers of physicians who would be capable of providing primary and personal medical care to people on a continuing basis, and who could serve as a focus for the coordination of health services for their patients. It was hoped, though not predicted, that such new physicians would distribute themselves geographically in proportion to need.

While it is too soon to assess the long-term impact of these two reports, the early results have been phenomenal. Family practice has emerged as a newly credentialed clinical discipline with 278 graduate training programs containing almost 4,000 residents. The first 500 graduates of these residencies did, in fact, distribute themselves appropriately, in that 42 percent went to towns of 15,000 or less population, with 17 percent of them in towns of 5,000 or less.[14]

Reform Revisited – The Medical Schools

Beside the emergence of family practice, there are other important manifestations of change in medical education.

A number of new medical schools have been established. Most of these have developed outside the big cities and there is a definite trend to decentralize the loci of education. On the other hand, states have been concerned about the interrelationships of their medical schools and have tried to centralize governance and funding. There has been a marked increase in the size of medical school classes and a significant increase in total number and proportion of blacks, women, and other minority students.

Curricula have been shortened to three years in a number of schools, and there has been a trend towards the earlier introduction of clinical experience. Organ-system approaches to basic medical sciences have replaced traditional discipline-based courses. Almost all schools have added curricular elements in behavioral sciences, community medicine, and psychiatry. Overall, there has developed a new interest in primary medical care with special attention to ambulatory care, preceptorships, and special courses in health-care delivery.

These modern reforms have not been without trauma and it is not yet known whether they will alleviate the conditions which inspired them. As with all reforms, they are fragile and vulnerable – to their friends as well as their enemies. Their rapid growth has attracted opportunists as well as idealists and there is a bandwagon effect, but it would be a mistake not to see the deeper meaning of their emergence. Their importance will be in proportion to their faithfulness to ideals that are broader than their own self-interest.

Family Practice and Reform*

I wish now to examine the family practice movement from the perspective of reform. It is my hypothesis that future development of family practice is directly related to the degree to which it qualifies as reform within medical education. If it does not tap the deep-running currents of reform, it will surely fade as merely an idiosyncratic epiphenomenon of the turbulent 1960s.

The criticisms of family practice have been persistent. "It's a fad." "It's a role without academic content – it cannot be defined." "The role will prove to be professionally unfulfilling and its practitioners won't last." "Family physicians fundamentally are not good doctors." "They will be unable to obtain proper hospital privileges." "They are O.K. but I wouldn't want my daughter to marry one."

Many of these predictions are being falsified by experience. The election is not over, but the early returns suggest a trend in favor of family practice. I believe that this is happening because of the relation of family practice to the following elements of reform currently at work in American society.

Adaptability to Rural Settings

The attempt of family practice education to meet the desperate need for family physicians in rural areas can be seen as part of the most recent outbreak of the recurring American fever to return to the farm. But like all reform movements that have a permanent effect, the move of the medical care system (spearheaded by family medicine) back into rural areas will be characterized by more that is new than old. Family practice is part of something more novel and profound than mere nostalgia.

There is an impetus in American life to decentralize human and material resources from a few very large urban centers to smaller regional centers. Most people's usual needs in medical care, education, cultural activ-

*The author wishes to acknowledge the contributions of Ms. Thalia Haak to this section of the manuscript.

ities, and other services and goods, are and will be increasingly met in these regional centers, with only the least frequently called-for services and goods supplied in the truly big cities. Most of the time most people do not need (or increasingly do not want) the esoteric and expensive skills and equipment available in the super-sophisticated medical centers. People are realizing that the benefits available only in big cities do not have to be experienced daily (and indeed are not experienced regularly or frequently by most inhabitants of metropolitan areas). The proliferation across the country of small but thriving theater companies, museums, and orchestras has or will have its counterpart in small but thriving regional centers for both medical education and practice.

While family practice never has been considered by its leaders to be *limited* to a rural setting, many of its supporters in state legislatures seem to think so. If family practice is good for anybody it is good for everybody – both rural and urban – however, its chief financial support has come from legislatures in states having major rural health problems. It is clear that, given a choice, rural people prefer an accessible physician over other models of health care based on co-professionals or transportation to the big cities. A well-trained, modern version of the country doctor is what most rural people want and think they need. A "world famous, humble, country doctor" is a powerful fantasy for many people besides Charlie Brown.

The return to a generalist role in medicine (though this is not really a return) is just one manifestation of a turning-away in many areas of American life and thought from over-specialization. Since over-specialization in any field tends to rob activity of meaning, particularly of moral meaning, the swing away from narrow specialization back to putting professional activities in larger contexts may rightly be regarded as a reform. Family physicians cannot shun responsibility because they do not have the requisite knowledge. They do not have what Harvey Cox called the "permission to ignore" whatever lies outside their specialty, nor can they participate in what Michael Balint called the "collusion of anonymity" in which the patient has many doctors but none of them is in charge.

The facts are that a family physician, as now defined by the American Academy of Family Physicians, is the type of doctor most adaptable to the organization of rural practice, whether solo or small group. No other specialist or group of specialists can compete with family physicians in terms of range and appropriateness of services, convenience, cost, and management of practice. Small multispecialty groups of internists, pediatricians, and obstetricians have a very elementary problem of deciding how to handle night calls and how to cover for each other. Until these specialties decide to provide cross-training in the other disciplines this will remain a problem. If they do decide to cross-train, they will be emulating family practice.

Concern for the welfare of rural people is a powerful theme in American life and as long as family practice remains faithful to this theme it will be supported by the people and their elected officials who, in my opinion, will not accept an alternative unless and until it becomes clear that they *cannot* have family doctors.

The Concern for Humanizing Medical Care

Perhaps nothing about the family practice movement is so misunderstood, or so resented, as its interest in the personal nature of medical care. There are those who insist – correctly – that all physicians *should* provide personal care, and – incorrectly – that all physicians *do* provide such care. There are those also who equate personal care with "bedside manner," or with a trivial or commercialized view of the "art of medicine."

I will be the first to admit that family physicians have no franchise on personal care, and that the best doctors throughout history have practiced the art skillfully; but the family practice movement has attempted to teach and value this art as an essential element in the curriculum – not as an elective.

The role of the family physician in first contact care allows him/her the opportunity to understand and share in the patient's earliest experiences of sickness, at a time before the sickness has become organized and defined. Sharing and managing uncertainty is the art that has earned for all physicians such honor, trust, and affection as the profession now enjoys. The responsibility of insuring that the physician becomes a humane practitioner is truly the legacy and potential encumbrance of *all* physicians. Nonetheless, the primary (comprehensive, continuing, personal) care delivered by family physicians *as the everyday norm of their practice, not sporadically when the occasion demands,* adds a dimension of time to compassion that requires special attention in medical training. The family physician's compassionate concern is a constant over time that assists the individual in freeing himself from diseases of body or mind that hinder his self-expression or completion of his human purpose. It is a professional heresy of the greatest importance to trust technology more than we trust the power of personal relationships, and to suppose that we can separate the technics of medicine from the doctor who uses them. In Biblical terms this belongs to the genre of idolatry, which is worshipping the creation over the creator. But even non-Biblical men now recognize that the world needs a new perspective on technology. In medicine, no less than in agriculture or in military weaponry, we have to learn that technology can hurt as well as help and that it should never be entrusted to the technologists.

Sometimes this less-than-worshipful view of technology is called anti-intellectual or obscurantist. It is neither. It is a plea not to abandon the human dimensions of medical care for machines. The doctor must decide when and under what circumstances the machines are to be used, and in making these decisions he/she considers his/her patients one by one. Nowhere is this more true than in clinical conditions involving the beginning and the ending of life. Kierkegaard wrote long ago, at the beginning of our technologic era,

> When death is the greatest danger, one hopes for life; but when one becomes acquainted with an even more dreadful danger, one hopes for death. So when the danger is so great that death has become one's hope, despair is the disconsolateness of not being able to die.[1 5]

There is a great deal more that can and should be said about this important topic, but for present purposes I assert that there is a strong strain of humanism in American society and that family practice is attempting to deal with human values in medical

care. To the extent that the person is able to survive at all in modern society, I suppose that we will always have need for a personal doctor. If family physicians continue to serve the public well as personal doctors, they will have one leg up on the future.

Commitment to Consumerism

Americans have yet to make a basic decision regarding the extent of their own responsibility for their health. There has always been a strong anarchistic strain in American life, but there are really few people at any time who want to supply all their own goods and services, including government and medical care.

It is not surprising that in a society committed to the production of consumer goods, the consumers should demand protection and equity under the law to insure that they get what they pay for. As medical care has become more institutionalized and technologized it has come increasingly to be considered a product, and therefore subject to the demands of consumerism.

The roots of consumerism go deep into American character and have to do with honesty, openness, craftsmanship, and fairness (a cynic might add greed). The Yankee trader was clever but his roots were in the rectitude of Puritanism.

The current indeterminate nature of the relationship between doctor and patient is one of many confused relationships between suppliers and consumers of services and goods. Should the government (federal, state, or local) be asked to assume a continuing and active role as mediator and watchdog? Should consumer and supplier work more directly to establish a mutually satisfactory and trusting relationship? The widespread urge to "do it ourselves," from growing one's own vegetables to performing Pap smears, reflects a general feeling that "we aren't getting what we pay for – so why pay?" Rebuilding trust between the public and its physicians calls for renegotiation and assumption of responsibility for the relationship by both parties.

Consumerism in medicine includes the right to know, the right to be represented at decision-making levels on boards of control and planning groups, and the right to be protected from unnecessary harm. It also includes a demand for quality assurance, a demand for cost-effectiveness, and a willingness to sue physicians and hospitals for unsatisfactory outcomes of medical care.

Another recent manifestation of consumerism is the recrudescence of folk medicine and the rise of self-help lay groups. About two thirds of all instances of ill health are managed outside the medical care system and there is a new interest in home treatment and lay treatment. Books such as "*Our Bodies, Ourselves*" and "*The Well Body Book*" are top sellers alongside the older standards, and magazines are full of articles on medical subjects. Small groups under the auspices of churches, mental health centers, volunteer organizations, or charismatic leaders are providing health services to multitudes for problems of living and special problems such as obesity, smoking, drug and alcohol abuse, rape, child abuse, etc. There is also a new interest in religious healing – even in the main line churches. One might conclude that ours is a society preoccupied with health, a condition foreseen by Goethe, who in 1787 wrote, "I am only afraid that . . . the world will have turned into one huge hospital where everyone is everybody else's humane nurse."[16]

Family physicians in their commitment to patient advocacy often find themselves on the side of the consumer. Their interest in patient education and their willingness to share their professional autonomy with allied health persons and co-professionals as members of a health-care team clearly fits with the spirit of consumer-oriented reforms. The reforming trend in health care would seem inevitably to be leading both the people and their primary physicians into a kind of partnership of responsible consenting adults . . . the kind of partnership that is also a goal of the women's movement.

The concept of the doctor-patient relationship as a sharing of responsibility in partnership for health maintenance implies that the relationship will be constructive and free, insofar as possible, from undue dominance or dependence on either side. Family practice encourages the patient (as part of health maintenance) to enjoy mature and responsible independence from addictions (dependencies) of all kinds – tranquilizers, other drugs, overeating and smoking – not to overlook an unhealthy dependence on the doctor himself. Family practice is nearly the only medical specialty that provides the doctor-patient relationship with the *temporal* framework to make this kind of liberation possible.

Connection with Utopianism

Not many people like to be called utopians. The word often implies unrealistic fantasies and fuzzy-minded thinking about complex problems, but utopianism, too, has been a powerful theme in American history. From the Preamble to the Constitution and the Declaration of Independence to the opening sentence of Lincoln's Gettysburg Address and the inscription on the Statue of Liberty, there is the unmistakable conviction that the United States is destined to be "something special" in the world – a country dedicated to the highest ideals of the human spirit.

A perfect society should not be marred by the sickness of its citizens, and Americans have devoted huge amounts of their wealth and resources to the battle against disease. Not only public monies but staggering sums from private philanthropists and voluntary organizations are funnelled annually into medical research and service programs. Our definition of health is continually being revised to include not only relief from suffering and disability, but also fulfillment of the human potential for psychological and social health. This idea is expressed cogently in the little book by Halbert Dunn, "*High Level Wellness.*"[17]

It is probably true that society's expectations for health are unrealistic, that our knowledge of effective preventive medicine is inadequate, and that we simply cannot afford to provide unlimited medical care for every citizen. We need a sane perspective on the goals of the medical care system and the recognition by the public that much of our "dis-ease" grows out of man's pathogenicity for himself. Man needs not only treatment in a biologic sense but also healing in a spiritual sense.

In its emphasis on psychosocial factors in illness, on the importance of understanding the family and other reference groups, and on environ-

mental and community medicine, family practice shares in the utopian vision. No matter that this vision is not yet come to fruition – it remains a powerful and enticing idea.

Shared Values with the Women's Movement

The women's movement is considered by many observers to be the most important reform occurring at present – not only in the United States but in the world. Jean-Francois Revel stated,

> I certainly do not mean to imply that the battle against sexual repression is the whole of the revolutionary struggle; but it is undoubtedly one of the surest signs of an *authentic* revolutionary struggle.[18]

The women's movement cuts across other reforms such as anti-racism and anti-authoritarianism, and has important implications for family and social life as well as economic organization and foreign policy.

In 1976 the proportion of women admitted to medical schools in the United States will approach 30 percent for the first time. These women will be more "radicalized" than their predecessors, and we can expect that their impact on the educational process and ultimately on medical practice will be considerable. These women have important ideas about birth control, family planning, neonatal intensive care, regionalized obstetrics, childbirth, and gynecological surgery that go beyond our historic concerns with perinatal mortality, monitors, and who is qualified to perform caesarean sections.

Women medical students also have concerns about contemporary processes of medical education, both undergraduate and graduate. They are not willing to give up the possibility of marriage and child-rearing in order to conform to the 70 to 90-hour work week often required in medical schools and residencies. They do not understand why it is not possible for those who choose to be wives and mothers to learn medicine on a part-time basis.

The relationship of family practice to the women's movement is important though not easy to define, simply because both movements are still themselves in process of definition. It is possible that both family practice and the best of the women's movement are part of a larger utopian reform in the second half of the twentieth century. This trend, which in turn relates to the earlier meanings of humanism, is motivated by a concern that the individual human being shall be as unrestricted as is possible in the fulfillment of his or her complete personhood. This trend may be seen as a counterthrust (some might say the last desperate counterthrust) to the threatened submergence of the individual in the mass. Both family practice and the women's movement ask that an individual human being be seen whole.

If by 1980, 30 percent of new family practice residents are women, at least some of whom are radicalized, I predict that there will be a new surge of reform that will go beyond anything we have experienced yet. The combination of these two movements could be enough to move both medical education and medical practice closer to a real responsiveness to the needs of the country and away from the preoccupation with professionalism that has characterized medicine since Flexner.

Conclusion

As I see it there are four crucial questions facing American medicine now.

1. Will medicine become a vast technocracy – institutionally based, mechanized, and automated? If so, who will control this technocracy?
2. Will medicine delegate or abandon its historic identification with caring in favor of an obsession with curing, an obsession that is ultimately destined to be frustrated by the ecologic limits of the earth?
3. Can physicians retain or develop any qualification to serve as counselors to society in matters of health?
4. Will medical education enhance the role of physicians as experts in interpersonal communications, or will it ignore and allow to atrophy whatever inherent communicative skills the medical student may have?

The answers to these questions will not come only from medicine, for society has too large a stake in them. But medicine is developing some answers and the family practice movement is on the cutting edge of those within medicine who are struggling with the questions. What happens to family practice as a discipline, or to professional societies of family physicians, matters far less than that all of medicine be reformed to meet the country's needs. It may be that family practice education will turn out simply to have been a mid-century adjustment in a trajectory whose target remains unchanged. On the other hand, the entire medical care system may be in the process of more radical restructuring. Whatever turns out to be the case, few generations of physicians have been privileged to participate in their own evolution as intimately as we have in the last decade. Let us be generous and kind with each other and with our professional colleagues as we continue to follow our best lights in the decade next ahead.

References

1. Hofstadter R: The Age of Reform. New York, Random House (Vintage Books), 1955
2. Wiebe RH: The Search for Order. The Making of America Series. New York, Hill and Wang, 1967
3. Goldman EF: Rendezvous with Destiny. Westminster, Maryland, Alfred A. Knopf, 1952
4. Wiebe RH: op cit, pp 114-115
5. Burrow JG: AMA: Voice of American Medicine. Baltimore, Johns Hopkins Press, 1963
6. Hirshfeld DS: The Lost Reform. Cambridge, Mass, Harvard University Press, 1970
7. Stevens R: American Medicine and the Public Interest. New Haven, Yale University Press, 1971
8. Lippard VW, Purcell EL (eds): Case History of Ten New Medical Schools. New York, David White, 1972
9. "Bayne-Jones Report," Advancement of Medical Research and Education through DHEW. Final Report of the Secretary's Consultants on Medical Research and Education, United States Department of Health, Education and Welfare, June 27, 1958
10. "Bane Report," Physicians for a Growing America, Report of Surgeon General's Consultant Group on Medical Education, United States Department of Health, Education and Welfare, Publication 709, October, 1959
11. Rutstein D: The Coming Revolution in Medicine. Cambridge, Mass, MIT Press, 1971
12. The graduate education of physicians. Report of the Citizens Commission on Graduate Medical Education. Chicago, AMA, 1966
13. Meeting the challenge of family practice. Report of the Ad Hoc Committee on Education for Family Practice of the Council on Medical Education. Chicago, AMA, 1966
14. Data from the Division of Education. American Academy of Family Physicians, Kansas City, Missouri, 1975
15. Kierkegaard S: Fear and Trembling/The Sickness Unto Death. Garden City, New York, Doubleday (Anchor Books), 1954, p 151
16. Reiff P: The Triumph of the Therapeutic. New York, Harper Torch Books, 1966
17. Dunn HL: High Level Wellness. Arlington, Virginia, Beatty Ltd, 1961
18. Revel JF: Without Marx or Jesus. Saturday Review of Literature, July 24, 1971, pp 14-31