Big Doctoring in America

Profiles in Primary Care

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Photographs by John Moses

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CHAPTER TWO

The New GPs

The Family Physician Comes of Age

In 1940, three-quarters of America's physicians were still general practitioners. World War II provided a huge boost for specialization, as board-certified physicians received higher rank, more pay, and, in consequence, higher status in the military. Following the war, the G.I. Bill covered medical education, providing an instant subsidy for young doctors pursuing specialty training. The rapid development of employment-based health insurance in the postwar period also stimulated specialty practice by providing much of the population with a payment system for care that was increasingly procedure-oriented and hospital-based. By 1970 only 20 percent of America's physicians counted themselves as GPs.

Through much of this period the GP was a passive player, an increasingly rare victim of what many believed to be a kind of medical Darwinism—a species of practitioner no longer adapted to the world of medicine. The term GP had become a default definition, largely a role that characterized what a practitioner was not. Although the country doctor who took care of Granny and the baby still held a Norman Rockwell appeal, it was the specialist whose image was now celebrated. Facing dwindling numbers, the absence of residency training programs, and the prospect of the loss of hospital privileges, general practitioners began to organize, in 1947 founding the American Academy of General Practice (AAGP) dedicated to improving the fortunes of their discipline.

The next two decades engendered intense conceptual and political debate over general practice. What exactly was the GP of the future to be?

If general practice was to be saved from extinction and revitalized as a competitive discipline amid the proliferating specialists, it would have to make some tough decisions about itself. Many older GPs opposed the idea of expanded residency training and board certification on the grounds that they themselves would not qualify. Some argued for the importance of surgery and obstetrics in the training of GPs while others favored a new emphasis on psychology, community medicine, and family dynamics to educate what was increasingly being called the family physician.

By the mid-1960s, there was general agreement that the idea of a formally trained family physician was a good one. In rapid succession over the next several years, the AMA approved a specialty board for Family Practice, the AAGP became the American Academy of Family Physicians, and family medicine residencies sprang up all over the country. The family practice curriculum maintained surgical and obstetrical training but emphasized the physician-patient relationship and the sociological elements of medical practice. In the 1970s, substantial federal support was provided to family practice residencies to assist in their start-up and maintenance, resulting in growth from 150 programs early in that decade to more than 450 today. Between 10 and 15 percent of medical students choose to train in family medicine each year, making it among the most popular of residency programs. (For a more complete discussion of the history of general practice, see chapter 1.)

General practice has not so much been saved, as it has been reborn. The idea of family practice carries on the tradition of the GP but has a new identity of its own, a set of quantified capabilities, and a vision of the medical future. The continuity, nonetheless, between the GP of the past and the family physician of today provides a strong, clear, central legacy to primary care in America.

The story of Eugene McGregor, M.D., of Lisbon, New Hampshire, is a bridge back to the roots of family medicine. Having practiced for forty years in the community where he grew up, he is a reminder of the continuity and connectedness of the rural GP and the spiritual grounding for the family physician of today. Fifty miles to McGregor's west, Connie Adler, M.D., carries on his legacy, but from dramatically different conceptual roots. Urban, feminist, and consciously political in her upbringing, she has migrated to a rural family practice that picks up, in many ways, where the GP of the past left off. A residency-trained family physician, she exemplifies the same principles of continuity and availability practiced by McGregor and his colleagues.

Armed with the same values, Neil Calman, M.D., has reentered the city—in his case New York City—which, like so many areas, had seen the virtual demise of general practice. Using a blend of family physicians and nurse practitioners, Calman has constructed a network of family practice delivery sites that are active in training family physicians as well as delivering care in many poor and working-class neighborhoods. Wrestling with managed care, trade unions, and academic health centers, Calman has led a resurgence of urban general practice.