their professional qualifications and if the public safety is not threatened.

Should licensure standards include factors that may be unrelated to professional competence, or safety? To what degree should licensure be used as a regulatory mechanism? These questions and others require careful assessment.

The interface between governmental regulation and professional self-regulation is important and sensitive. We must strive to maintain the intrinsic values of both; compromise and accommodation should not be at the expense of the general public.

Paul R. Young, M.D.
Lexington, KY

New Cover

There is an old adage, "You can't judge a book by its cover"; however, an attractive cover *does* get one's attention. All of us see many journals cross our desk, and as a reader I find that covers do indeed attract my attention. It is also acknowledged that regardless of how attractive or eye-catching a cover may be, it's the content that's important. Our goal for the *Journal of the American Board of Family Practice* (JABFP) has been and continues to be quality content, and with this issue we are introducing a new, bright, and colorful cover while at the same time maintaining quality content for family physicians.

How often have I gone to visit various programs and stressed to residents that outward appearances are important. It's the first thing the patient beholds. The appearance of being clean and neat, as well as a pleasing demeanor, produces a lasting favorable impression upon the patient. It is also true that a sloppy, unkempt physician may be very bright and caring, but to enhance the image of the specialty, we prefer bright, caring, *as well as* decently appearing physicians. So rather than adhering to the adage of not judging a book by its cover, we prefer the old Roman statement that "A good exterior is a silent recommendation."[1]

Nicholas J. Pisacano, M.D.
Lexington, KY

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Our 20th Anniversary Year: Remembering the Willard Report

The first copy of the Willard Report[1] that came into my hands lies open on my desk. Other copies have come and gone, but this one has special meaning because it changed my life in ways I never imagined. Thumbing its pages, noticing underlined sentences, I recall the wholly unexpected feelings of illumination and conviction it produced in me in autumn 1966.

Then 38 years old, I had completed 11 years of contented general practice in Wichita, Kansas. While I prefer to remember myself as a socially concerned and politically observant physician in those days, the truth is that my focus was almost entirely local. I knew that general practice was falling on hard days; our numbers were steadily declining (although we comprised 20 percent of practicing physicians), and periodically we had a crisis meeting about hospital privileges; but none of this touched me directly.

I came upon the Willard Report as a naive reader; it was all news to me. I simply was unaware of the existence of the Ad Hoc Committee on Education for Family Practice, the Citizens' Commission on Graduate Medical Education (Millis Commission), and other national groups that were calling for changes in medical education to meet the shortage of primary, personal, and family physicians. That knowledge came after the Willard Report knocked my socks off and convinced me that I ought to become involved in educating the new breed of family physicians. What presumptuousness!

Less than a year later I had moved my practice 6 miles across town into a remodeled house and was the director of a new style family practice residency at Wesley Hospital. In spring 1968, through the benevolent sponsorship of George (Ned) Burket, I was shamelessly describing this residency before the State Officers' Convention of the American Academy of General Practice in Kansas City. I was not alone in this wild adventure; Lynn Carmichael (Miami), Eugene Farley (Rochester, N.Y.) and Roger Leinke (Oklahoma City) were doing the same things; and 11 other Willard-type residencies were developing elsewhere in the country, even at Harvard. Remembering these heady days and the ideas that used us seems appropriate in this 20th anniversary year of the American Board of Family Practice, the 20th primary specialty board, the first new one in 20 years after 1949.

The practical genius of the Willard Report was its description of the form and general content of

a 3-year residency in family practice, an awesome enough task, but it also hinted of bigger things that escalated its powerful appeal within the social, political, and moral climate of the 1960s. In its brief preface, the Report put itself squarely on the side of reform in medical education and practice. It spoke about "formidable problems to be solved," "fundamental issues," "a new kind of specialist," [a] "significant reorientation . . . and change in attitudes," "the future," and "a bold approach."[1, p 1] This document did not lack vision and challenge; surely, it wanted more than the resurrection of general practice and the aggrandizement of its professional and political fortunes, more than triggering a new round of specialty professionalization.

What gave the Report credibility and enlisted a new generation of would-be medical educators in carrying out its aims was that other prestigious, nationally constituted groups, which had no vested interest in general practice, were calling for the same reforms. Modern medical science was great, but its fruits were not equally available to all citizens. There was a shortage of physicians among large, underserved populations. Personal medical services were lacking, and epidemiological data showed that the U.S. was slipping among industrialized nations in important outcomes of medical care. Rural members of state legislatures were calling for more physicians, and the federal government had roused itself to pass Medicare and Medicaid legislation.

A remarkable consensus grew among politicians, health planners, critics, public leaders, and some physicians and medical educators. We believed that by creating sufficient numbers of primary care physicians, we could alleviate many of the identified problems with what was coming to be known as "health care delivery." The consensus, of course, was not universal, omitting, as it did, many of the most prestigious medical schools and their supporting bureaucracies and lobbies. But the time was ripe for change, and even the skeptics were caught up in expanding medical school enrollments, establishing new schools and branches, experimenting with curricula, training new species of health professionals, beefing up the system for emergency medical care, and feeding at the trough of the Nixon administration's battle against heart disease, cancer, and stroke, the Regional Medical Programs.

For some of us, the Willard Report shone as a clear beacon. Its recommendations seemed doable, as well as opportunistic. Create administrative units for family practice in the medical schools, teach in ambulatory care settings, decentralize medical education into community hospitals, incorporate community medicine and behavioral sciences into the curricula, restore preceptorships, capture the idealism of students at all levels, and educate physicians who wanted to do primary care as their main vocation. Fund it generously, and don't sacrifice traditional standards of clinical competence.

We tried to do it all. Five residents and I, in 1968, were caring for 1000 families in a house-office on the hospital campus: we were team physicians for a local high school, "consultants" to the Ecstatic Umbrella, a church-sponsored safe house for runaway teenagers, and before the year was out, we ran a methadone clinic for narcotics addicts. Moreover, we did not shirk the behavioral sciences. We had two psychiatrists, a medical social worker, a chaplain, and a nutritionist on our faculty. We held a doctor-patient relationship conference at noon on Mondays and devoured Michael Balint's book, *The Doctor, His Patient, and the Illness*, page by page. Each resident had an hour of individual supervision weekly by a psychiatrist. We all went regularly to the local mental health center, where we took turns interviewing patients behind a one-way window, practiced role playing and psychodrama, and learned how to use video tape for interpersonal skills training.

We embraced the new educationism; learned the differences between goals and objectives and how to write and evaluate educational objectives. We adopted the Problem-Oriented Medical Record, designed new charts, kept age-sex registers of our patients, and began to use computers for analyzing our practice activities. We knew that we were God's answer to the problems of medicine and society.

The Willard Report sparked the development of 387 similar residencies in family practice within 15 years of its publication, an unprecedented phenomenon in U.S. graduate medical education, rivalled only by the rapid growth of residencies in pediatrics in the 1930s and psychiatry in the 1950s.

Edmund Pellegrino, the keenest and longest-tenured observer of the origins and evolution of

modern family practice, believes that we probably bit off more than we could chew in the new residencies (not his actual words). He wrote:

> What resulted was a somewhat more sophisticated conception of family practice than was in the public's mind. . . . In a sense then, family practice as it emerged in 1969 was as much a mutant as a stage in the metamorphosis of General Practice. . . .
>
> This "mutation" was an adaptive and functional response to the changed technological environment of medicine that, by 1966, could no longer be ignored. Some subsidiary, but not essential, features of the new strain were its skepticism about medical technology, its engagement with behavioral and social sciences, and the political avenues it used to gain entry into medical academia. But the central characteristic was the emphasis on primary, continuous, and comprehensive care provided within the framework of the patient as a member of a family and designed to meet what was presumed to be a "need" not previously satisfied.[2]

Pellegrino sees the mutation as potentially dysfunctional and destructive. On the other hand, he also sees danger if we revert to general practice or succumb to the temptation to exclusive specialism. He warns us gently that we must stay close to the public's perceptions of its own needs for primary care, which, at the very least, means first-contact care, easily available and efficiently administered at reasonable cost.

The Willard Report clearly contains the elements that Pellegrino considers mutational, and it was not prescient in all respects. It did not anticipate other phenomenal developments affecting medicine at the same time that family practice was growing so rapidly, such as:

- The transformation of a perceived doctor shortage to a perceived surplus.
- A new round of specialty and subspecialty development in the 1970s and 1980s.
- The entry of corporate capitalism into medical practice and the adoption of a policy of competition among physicians and medical care institutions.
- The medical liability crisis.
- The rise in free-standing emergency and walk-in clinics.
- Changing attitudes and preferences of medical students, including diminishing numbers of applicants to medical schools, selection of other than primary care specialties, and increasing debts for medical education.
- The impact of Medicare and Medicaid on medical practice and the rise of geriatric medicine.
- The emergence of AIDS as a new epidemic disease of frightening proportions.

Despite these failures of foreknowledge, the Willard Report was a well-focused and challenging document, more permissive than prescriptive. It stimulated creativity among educators who responded to it because it was too wise to spell out the details. It gave guidance and direction to a generation of teachers and earned a place, along with the Flexner Report, as one of the major reform documents in medical education in this century.

As I re-read its pages, the recommendation that seems most in danger of being lost nowadays is its emphasis on continuity of care, surely as important as first-contact care. We seem to be giving this up without a fight. No doubt, group practice, managed care (paradoxically), commuting physicians, the mobility of patients and physicians, walk-in clinics, and changing attitudes of younger physicians about call schedules all contribute to the dilution of continuity of care. Many of our other ideals are impossible to attain when there is no durable doctor-patient relationship.

Perhaps the best way to celebrate the 20th anniversary of family practice would be to read the Willard Report again. It's not a Bible, but it serves some of the same functions, calling us back to our roots and re-inspiring us to live out its ideals. For one, I feel privileged to have spent the major part of my professional life in its bright glow. It shook me out of complacency and, on the whole, made me a better physician. Not many experiences like that happen in a lifetime.

G. Gayle Stephens, M.D.
University of Alabama
Birmingham, AL

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