SPECIAL COMMUNICATION

A Brief History of the American Board of Family Practice: The Second Annual Nicholas J. Pisacano, MD, Memorial Lecture

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Origins of General Practice

Family physicians have evolved from general practice. General practice had its roots in Great Britain when the class systems were dominant. While formally educated physicians limited their practice to the landed gentry and royalty, general practitioners responded to the health needs of the poor and underclasses. General practitioners offered counsel and prescribed treatment in exchange for monetary or other rewards, which was not dissimilar from the barber-surgeons of the day.

This tradition was carried to the United States, where most general practitioners received little formal training but instead depended on apprenticeship arrangements to learn medical lore and techniques. In response to public and professional concern about the inadequacies of health care delivery, the Carnegie Foundation, with cooperation of the American Medical Association (AMA), commissioned Abraham Flexner to examine the state of medical education. Partly as a result of the 1910 Flexner Report, medical education was shifted to colleges and universities, with Johns Hopkins serving as a model for medical education.

Specialism in US Medicine

With the advances in medical science, largely emanating from Europe, there developed an increased interest by some physicians to limit their practices and to become recognized for their special competencies in certain areas of medicine. Specialty societies were formed for exchanging information and for protecting and enhancing political and personal careers.

The concept of a specialty board was first proposed by Dr. Derrick Vail to the American Academy of Ophthalmology and Otolaryngology in 1908. The first meeting of the American Board of Ophthalmic Examinations was in May 1916. It was incorporated in 1917 and changed its name to the American Board of Ophthalmology in 1933. Early boards were responsible for accrediting training as well as certifying candidates.[1]

In his 1982 monograph entitled "The Intellectual Basis of Family Practice," Dr. G. Gayle Stephens describes the integration of family practice into modern-day medicine. He specifies three phases, which are distinct but have overlapping factors. The first is the political phase, the second is the administrative phase, and last, the academic phase.[2] In my view, these phenomena also have occurred in the development of the specialty itself.

Political Phase

As with all major conflicts and civil disasters, World War II had an important impact on American medicine and on general practice specifically. In 1940, the AMA was petitioned to approve a general practice specialty board, and the request was refused. Following World War II, however, specialization flourished. Medical schools and training programs were rewarded for producing specialists and subspecialists who could apply a burgeoning amount of new knowledge and techniques. This trend did not extend to general practice. Few students were choosing to be general practitioners, and many general practitioners were abandoning their practices to train as specialists in other fields. Other specialists were demanding and receiving much higher fees and were receiving more adulation and attention from the public. Medical schools, moreover, were

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eliminating general practitioners from their teaching faculties.

When the Section on General Practice of the AMA met in San Francisco in 1946, its participants concluded there was need for a national organization to "provide and maintain high standards of general practice of medicine and surgery; to encourage and assist in providing postgraduate study; to perpetuate the relationship between the family doctor and patient; [and] to protect the right of the general practitioner to engage in medical and surgical procedures for which he [sic] is qualified by training and experience."[3] As a result of that action, Atlantic City in June 1947 became the site for the first organizational meeting of the American Academy of General Practice (AAGP).

During the 1950s the AAGP was able to hold its own among the primary care professions, but the leadership seemed unable to influence the steady growth of traditional specialization. Internal systems were developed, but the number of students choosing general practice as a career was not greatly affected. The ratio of general practitioners to the general population continued to wane.

The general public also noticed that their family physicians were becoming scarce, and access to their services was difficult. Legislators at both state and federal levels became increasingly concerned, and the national press devoted extra attention to what *The New York Times* categorized as a national crisis. Scholars such as Kerr White recognized the problem of overspecialization. In the mid-1960s, the Citizens Commission on Graduate Education (Millis Committee) and the Ad Hoc Committee on the Education for Family Practice (Willard Committee) published their findings, which declared the need for a health care delivery system that emphasized comprehensive continuing care rather than the postwar emphasis on specialty care.

In response to the general political environment and in anticipation of subsequent events, the American Board of General Practice (ABGP) was established in 1960. Membership came from the ranks of the AAGP and was generally controlled by the AAGP. In 1964 another organization, the American Board of Family Practice Advisory Group, was formed by some younger and perhaps more aggressive physicians. It was from this latter group that the American Board of Family Practice had its origins in 1969.[4]

Change Agents

One of the first promoters for a family practice board was Dr. Charles McArthur of Olympia, Wash, who in 1962–1963 tried to persuade the AAGP that a board was necessary and appropriate. He used generally accepted diplomatic means to try to achieve the goals, and he even suggested that a new board could be formed which would be quickly large enough to exert political pressure on the AMA. The AAGP polled state chapters with equivocal results.[4]

Thomas Rardin of Ohio also was an avid supporter of change in general practice. He predicted that the medical profession would eventually recognize two distinct types of family physicians. One would be a group with little or no graduate training, and the other would be a group trained in "AMA-approved graduate programs." McArthur and Rardin both believed there should be no grandfathering; ie, only graduate-trained physicians should be certified.[4]

In 1964 Dr. Nicholas Pisacano authored an article in *GP* in which he said, "Most of us now recognize that the species of physicians known as the general practitioner is all but extinct."[5] He also attacked what he perceived to be a fatal flaw of general practitioners when he wrote, "No general practitioner, unless he [sic] has been thoroughly trained on a par with the board-certified surgeon, should be allowed to perform major surgery on any human."[5]

Pisacano believed discussions were fine, "but we are reaching the point when it is about to become a charivari. It is time for action, not more lip homages."[5] He proposed not only a joint board with other specialists or the creation of a subboard of internal medicine, he also called for "periodic recertification." These proposals were not well received by the AAGP, and the ensuing debate attracted worldwide attention.

In April 1964 supporters of a new board met in Lexington, Ky, to develop some unifying principles. This group strongly criticized the AAGP and expressed their views directly to Dr. Amos Johnson, who was then among the leaders of the AAGP. As a result, McArthur and Rardin formed the Advisory Group, whose purpose was to develop strategy. They prepared a "full-court press" on the AMA and the AAGP by outlining their objectives for a family practice specialty board. Amos Johnson bluntly advised the AAGP that they were

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doomed to "wither on the vine" if they failed to support the concept of a board.[4]

McArthur and Rardin were sent back and forth among the AMA Counsel on Medical Education, the American Board of Medical Specialties, and the AMA Board of Trustees in that they all denied jurisdiction to assist in development of the new specialty. The Founding Group, as the Advisory Group now called itself, had to walk a fine line between the AMA and the AAGP, as the support of both was necessary to achieve specialty status. Yet it was clear that there were powerful individuals in both organizations who were opposed to creation of a specialty in family practice.

Dr. Arthur Nelson of Temple University played a key role in 1964 in that he represented the connection of the Founding Group to academic medicine. Ultimately the new specialty would need the recognition and support of academia if it were to survive. Nelson favored high standards and sufficient flexibility to adapt to rapidly evolving sociopolitical forces. He was committed to establishing the new specialty in the academic environment and urged Pisacano to join him.[4]

Another powerful ally in academia was represented by Dr. Ward Darley, then president of the Association of American Medical Colleges. Darley saw the inadequacies that existed in internal medicine and pediatric training. He urged the Academy and the Association of American Medical Colleges to support the development of a new specialty in family practice.

In 1966 a preliminary application for a primary examining board in family practice was submitted to the Liaison Committee for Specialty Boards. Some thought the application was premature. Action was deferred for 1 year because the application was not clear as to what organization would certify the family physician. There were several options: The American Board of Internal Medicine, the AAGP, or some combination; the AAGP and the American College of Physicians; or finally a reorganized or reconstituted American Board of Family Practice (ABFP). The application was denied by The Liaison Committee for Specialty Boards in 1968 because the practice-eligible group was not adequately defined and the core content of training was too broad, lacked depth, and failed to define the special skills of the family physician. Because the Founding Group had not worked cooperatively with other boards, other specialties challenged the claims that family practice was the only specialty to provide comprehensive care to all ages.[4]

Only after considerable pressure from several sides and revision of the application did the Liaison Committee for Specialty Boards approve the application of the ABFP on 6 February 1969. This approval did not end the political struggle, however. AAGP officials proposed to offer practice-eligible candidates a "fellowship examination" with the obvious intent to preempt the ABFP. This attempt was foiled by the American Board of Medical Specialties, which strongly advised against the AAGP acting like a certifying board.[4]

The fledgling American Board of Family Practice was opposed with passive aggression by the American Board of Pediatrics and the American College of Physicians. The American College of Physicians was especially resistant. Their official position was that the new specialty was unnecessary because internists and pediatricians provided continuous comprehensive primary care. There were some in the American College of Physicians, however, who doubted that position and favored the development of family practice.

Nonetheless, behind the scenes the American College of Physicians attempted to influence the AMA Council on Medical Education to support internists and pediatricians as the answer to the social issues of the day. It also emphasized to government officials that federal support should be given to internists rather than family physicians. The American College of Physicians asserted that family practice faculty would undoubtedly be inferior to faculty in internal medicine, pediatrics, and surgery, and that family practice instructors would not be of adequate caliber and would not attract students in competition with colleagues in the established specialties. The American College of Physicians was willing to support the development of a version of family practice only if the American Board of Internal Medicine and American Board of Pediatrics would sponsor it. In 1968 the American College of Physicians softened its position somewhat by declaring that internal medicine should be at the core of family practice.[4]

Academic internists and practicing internists were appalled at the softer position of the American College of Physicians. Both groups made

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strong public statements in opposition to family physicians both on a practical and theoretical level. It seems evident that their attitudes have seriously retarded the institutionalization of family practice in academia. In my opinion, their position was, however, based solely on dogma and did not reflect the needs and expressed desires of the population. Leadership in surgery also took a position similar to that of internal medicine. Nevertheless, after a short time, they were persuaded that younger, residency-trained family physicians were not seriously interested in retaining privileges in the operating room; in addition, the surgical specialties did not want to arouse federal intervention in the family practice issue.

Because of the action taken by the Liaison Committee for Specialty Boards, the ABFP became the gatekeeper to the new specialty of family practice. The original bylaws outlined practice eligibility and residency eligibility and also specified mandatory recertification. This accomplished two things; it separated family practice from general practice, and it differentiated family practice from other specialties. It also demonstrated a commitment to high standards of training, examination, and practice.

There was considerable adverse response to recertification standards. Chapters of the AAGP attempted to exert strong political pressure on the ABFP to eliminate mandatory reexamination, but the ABFP held firm.

A major problem arose initially between ABFP and AAGP about the selection of board members. The president of the AAGP believed that the ABFP should comply with the will of the Congress of Delegates. The ABFP thought that the certifying body must be autonomous. There followed a rather bitter struggle between AAGP and ABFP as to the limits of authority of both organizations. The ABFP stood firm and carried out its intent to appoint its own members in accordance with guidelines from the American Board of Medical Specialties. This act was interpreted by many as bold defiance of the authority of the Congress of Delegates and initiated a cascade of events that changed the shape of primary care in this country.[4]

Administrative Phase

Once the specialty took on the mantle of certification, there was required a means to accredit graduate training. There existed training programs in general practice that were evaluated by the AMA Section of General Practice. In the early 1970s, the AMA relinquished its sole control of accreditation to the Liaison Committee for Graduate Medical Education. There were Residency Review Committees appointed that were subject to the constraints of the Liaison Committee for Graduate Medical Education. Later, in the 1970s, under pressure from the Federal Trade Commission, the Liaison Committee for Graduate Medical Education was reformed and renamed the Accreditation Council for Graduate Medical Education. It is controlled by equal representation of the AMA, the Association of American Medical Colleges, the American Hospital Association, American Board of Medical Specialties, and the Council of Medical Specialty Societies with resident, government, and public members as well. The Residency Review Committee for Family Practice became a 10-member group with 3 members nominated by each of three organizations: the AAGP, now the American Academy of Family Physicians (AAFP), AMA, and ABFP. The 10th member is nominated by the National Organization of Family Practice Residents and Students. The Residency Review Committee for Family Practice was the first to submit proposed changes in the "Special Requirements" to program directors for their comments and suggestions. Currently, the Residency Review Committee for Family Practice enjoys the respect of the profession for its openness and its firm commitment to quality.

In 1969 there were 15 family practice residency programs accredited by the AMA. Today there are more than 440 accredited programs. The AAFP occupies a leadership position among specialty societies. It has received recognition for the quality of its publications and has been recognized for its extraordinary organizational accomplishments. In addition, it is regarded as an important consultant for federal policy formation.

The ABFP has also grown in stature during its first 25 years. It is currently the second largest specialty board as determined by its number of diplomates. Administrative counsel is regularly sought by other boards, and it leads the profession in the development of new and innovative techniques of evaluation.

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Academic Phase

The Society of Teachers of Family Medicine was developed almost single-handedly by Dr. Lynn Carmichael. After a beginning characterized by a number of tumultuous events and several years of searching for self-identity, this multidisciplinary organization has matured into a powerful academic force. It provides a critically important network service and encourages the academic development of faculty in undergraduate and graduate education. It is characterized by an aura of free expression and stimulation of original thought. It has continued to grow and reaches new membership records annually.

The Association of Departments of Family Medicine was also stimulated by Dr. Carmichael. At a time fortunate for me, he was unable to attend one of the founding meetings and asked me to chair the meeting in his place. This opportunity led to my assembling the elements of an organization that could be recognized by the Association of American Medical Colleges, and I became the founding president of the Association of Departments of Family Medicine. Since then, it has had highly effective leadership and now serves a very important role in assisting department chairs to survive in a sometimes hostile environment.

The Association of Family Practice Residency Program Directors was a natural development spawned by the AAFP through its annual meeting for program directors. Dr. Pisacano frequently commented that the Program Director's Workshop was the best conference the AAFP sponsored. Now, of course, the program directors have their own organization and are taking their proper place among the academic organizations within the specialty.

Another important contribution has been the development of the Residency Assistance Program, which was originated from the fertile mind and tireless effort of Dr. Thomas Stern. The Residency Assistance Program has contributed immensely to the development of high-quality training programs in family practice.

In spite of these achievements, there is a long way to go in the academic phase. We have a few textbooks, some important monographs by authors such as Dr. G. Gayle Stephens, and several journals. Unfortunately, the journals that try to publish original clinical research are in some difficulty because of the economic environment. At least three of them must find some alternative funding or other resources to continue serving as refereed journals for family practice faculty and investigators. I believe this is a major threat to our specialty, and a solution must be found soon.

The resistance of medical centers to provide support for family practice academic efforts continues. In some situations, it has reached crisis proportions. We could be forced to consider alternative sources of support, eg, managed care. This approach, too, is fraught with potential hazards.

We cannot afford to sacrifice certain principles. Among these principles are those that have sustained us from our very beginnings:

1. Comprehensiveness—we must continue to serve basic social units to provide preventive, anticipatory, acute, and chronic care, as well as management of life crises.
2. Continuity—we cannot abrogate our responsibility to teach and practice continuity of care. To do otherwise robs us of the essence of the specialty.
3. Relevance to community—we must continue to be responsive to the changing needs of the community. We must be driven by the needs of the patients and not by our own ambitions.
4. Avoidance of hubris—we must weigh our decisions carefully. The dangers of hubris have nearly ruined our profession.

It is my firm conviction that if we as a specialty and as a kind of counterculture in the profession adhere to these basic principles, our patients and the patients of those who follow us will be well served. I believe that Nicholas Pisacano would have settled for no less.

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