



The Conscience of Medicine

A History of Family Practice in Michigan

**Roy J. Gerard, M.D.
and
April L. Allison, M.A., M.P.H.**

Michigan State University Department of Family Practice



1 Introduction

In 1929, Louis J. Hirschman, M.D., president of the Michigan State Medical Society, warned of a growing problem. In his presidential address, Hirschman noted,

The urban trend of population has had its effect in draining the smaller communities of their physicians as well as of other inhabitants. The compactness and apparently more remunerative condition of city practice, along with the advantages of hospital facilities has attracted most of the young graduates of medicine to the cities.

Hirschman went on to introduce themes that have resonated throughout the almost seventy years since he introduced them—the need for training in ambulatory care, a focus on family medicine, and the need to adapt new technologies so that they will lure young physicians into underserved areas.

The nineteen years prior to Hirschman's speech had witnessed a revolution in medical education and health care delivery. The Johns Hopkins University (Starr 1982) model of selective student admissions, a four-year program with two years of basic science and a clinical curriculum based firmly in the teaching hospital had become predominant during those years. The ascendancy of this model throughout the country had been facilitated by Abraham Flexner's famous 1910 critique of medical education and was accompanied by the strengthening of medical licensing regulations around the country.

By 1929, when Hirschman spoke, physician income and prestige had risen dramatically from the turn of the century, with physicians earning approximately four times the income of the average American worker and scoring at or near the top in studies of occupational prestige. But the lure for young physicians was toward the centers of medical innovation and power—not to underserved rural or impoverished urban areas.

Some physicians have resisted this lure. They have struggled to establish a professional environment that will help young graduates also find a meaningful career of service in the context of community—a career in which they can offer individuals and families continuing, comprehensive health care delivered by a physician trained in compassion and communication, as well as in scientific methodology.

This is their story.



2 General Practice through World War II

Life as a general practitioner

The family doc of earlier days—on call 24 hours a day, often accepting eggs or firewood as payment for services—is a popular stereotype, and, according to some senior members of the profession, the stereotype was not too far from reality. Senior members of the Michigan Academy of Family Physicians shared memories of those early days of general practice when the Academy celebrated its 45th birthday in 1993 (Ohl 1993).

As a young physician in 1926, Edgar G. Cochrane, M.D., received \$50/week and the use of a Model T for making rounds. “I made all kinds of calls . . . day and night, and in between office hours . . . I was seldom home . . . I seldom had time to sit down to a full dinner without getting an emergency phone call.”

He added,

It would not be unusual during [one evening] to make a couple of night calls, deliver a baby and be in the operating room at eight o'clock in the morning . . . Actually, most of us who were in general practice at that time, and that was the majority of doctors, were on duty all the time.

He recalled that during the Depression many general practitioners worked in free clinics to assist patients who could not afford medical care. “We were putting in a lot of time outside of our office, to help out with the situation that the society had come into. The doctors in these clinics, of course, received no payment. We didn't expect it. We were doing what we could to ease the pain and stress.”

A. Carl Stander, M.D., longtime Saginaw physician and charter member of the Michigan Academy of General Practice, remembered a similar situation early in his career. “One woman called me up one night and said, ‘I don't have any money but I think I've got pneumonia. Would you come over to see me?’”

I said,

“Oh, sure, I’ll be glad to.” So I went over to see her, and I noticed when I left the house there were people streaming in and out. The grandmother never paid me, but, within three months, I had about 60 patients from that grandmother and her family. So, if you wanted to build a practice in general practice in those days, you could take care of a grandmother who didn’t have any money but saw you doing a good job and liked you, and your practice would grow. In fact, my practice grew so fast I began to wonder about the situation.

Both the working conditions and the content of practice were different 60-70 years ago for general practitioners than they are for family physicians today. Richard I. Haddy, M.D., (formerly of Saginaw) and his colleagues (Haddy et al. 1993) have presented a comparison of rural family practice in the 1930s (prior to the advent of antibiotics and the rise of tertiary hospitals) and today. Haddy gained access to the billing records of Frank W. Brey, M.D., who practiced in Wabasso (1930 pop. 482) in rural southwestern Minnesota. While there were undoubtedly some differences in medical practice between southwestern Minnesota and Michigan, the data provide some interesting insights into rural practice during the Depression.

Brey was born in 1886 and earned his medical degree from the University of Minnesota in 1910. His records, dated June 6, 1934, through Sept. 25, 1935, included 244 consecutive diagnoses. Each entry included a record of the physician’s fee and of whether a house call was made within or outside the town limits.

Most of Brey’s country calls were made while driving a Ford Model T or Model A. When snowfall made roads impassable, he traveled on horseback or on foot, following the railroad tracks for direction. Each of the two cesarean births listed among Brey’s procedures was done in the patient’s home. Tonsillectomies were done in the doctor’s office using ether as the anesthetic.

The four most common diagnoses in Brey’s records were follow-up incision and drainage of abscess, diphtheria immunization, follow-up drainage of mastoiditis, and scrotal tap for epididymitis. Haddy reports that these contrast with upper respiratory tract infection, hypertension, hyperlipidemia, and history-taking/physical examination as the four most common

diagnoses in a comparable sample from a 1989 rural practice in central Ohio.

Much of Brey's practice was devoted to surgical procedures and follow-up, including incision and drainage of mastoiditis, myringotomy for otitis media, tonsillectomy and adenoidectomy, and setting of fractures of major bones— all of which are comparatively absent from the current family physician's practice. Records of patients that Brey had diagnosed with sexually transmitted diseases were kept in a separate book that his widow destroyed upon his death.

Approximately 25 percent of Brey's patient contacts were house calls within the village limit and 15.9 percent were "country calls" up to 10 miles outside the village. His charges were \$2/office visit, \$3/home visit, and \$1/mile for travel outside the village. His surviving family reported to Haddy that during the Depression Brey's collection rate was as low as 10-20 percent, and that he died in 1940 with more than \$100,000 in uncollected revenue on his books.

Additional challenges for African-American general practitioners

While rural general practice promised long hours and comparatively low pay for white physicians, entering and practicing medicine offered much greater challenges for African-American young people seeking a medical career. Detroit physician Lionel Swan, M.D., graduated from medical school in 1939. He has recalled that very few internships or graduate training opportunities were open to black medical graduates, and that once in practice, hospital admitting privileges were almost nonexistent for black physicians in the 1930s. As a consequence of limited avenues for referral or hospitalization, African-American general practitioners were accustomed to providing an even broader range of procedures for their patients, most often carried out in the physician's office located in his house. The American Medical Association was not open to African-American physicians, and they had organized their own medical society in the 1890s, the National Medical Association, which Swan headed during the 1960s (Swan 1996 personal interview).

Shortly before his death, Laurence M. Weinberger, M.D. (1989,16-17), a white neurosurgeon from Akron, Ohio, wrote about an incident that had awakened him to the realities of

racism when he began his internship at Cleveland City Hospital in 1933. Weinberger admitted that he had been raised with little consciousness of racial inequities until he joined his fellow interns for breakfast on the first day of their internship.

It was a new and excited group of young doctors, stiff in crackling, starched, white uniforms, who filed that first day into the large dining hall filled with huge round oak tables seating eight or ten. The occasion was festive. Finally, we were real doctors, no longer barely tolerated clinical clerks or externs. . . . We began to eat our porridge, eggs, and toast.

Spirits were high when late arrivals entered, among them our two black interns. I had known one as a classmate and fellow member of Alpha Omega Alpha. The other turned out later to be a Phi Beta Kappa and AOA graduate of Cornell. No matter. Hardly had the two sat down at empty places when, with a great clatter of implements thrown onto their plates and noisy shoving back of chairs, all of the southern interns and residents, starting with those at one table, stood up and ceremoniously marched out of the room. The gesture, brutal and insulting, was obvious—and shocking. A pall of embarrassment fell upon the room. Worse, much worse, and unforgivable in my eyes, was the behavior of a half dozen interns from northern schools, who got up and joined the southerners in their walkout, in some misguided show of solidarity in bigotry.

A shortage of general practitioners

In the 1920s and 1930s, the movement of doctors away from rural areas and to the city already had become a concern. Louis J. Hirschman, M.D., of Detroit, 1928-29 president of the Michigan State Medical Society (MSMS), commented on this migration in his presidential address, touching on themes that would become increasingly familiar in the ensuing forty years.

The law of supply and demand is very much out of joint in connection with the practice of medicine in our smaller communities. The demand for medical care is acute, insistent and serious. There are many thousands of our citizens residing in small villages, hamlets and on isolated farms whose lives are placed in jeopardy because of the absence of nearby medical assistance. (Hirschman 1929, 669-70)

Noting the attraction that urban practice held for young physicians, Hirschman proceeded to criticize the compulsory hospital internship for imbuing “most of the younger graduates

of medicine with the idea that the practice of medicine must be conducted only, or largely, amid hospital surroundings,” and suggested that the State Board of Registration in Medicine

find it possible to allow substitution of bedside and office training under a qualified preceptor, for at least a portion of the time now devoted to internship and hospital training. This is the only way in which the coming practitioner of medicine can really be trained in bedside medicine, under conditions under which a large portion of his practice will be conducted. . . . He will learn how to meet situations arising in the patient’s home, particularly with reference to his attitude to—and his management of—the various members of the patient’s household.

He also suggested that rural communities work together to provide a modern, centralized hospital for their area as a way of enticing physicians, saying,

With the charming community life and the ideal conditions under which to practice, which obtains in the small town, it will be very easy to attract the graduate of medicine and he will soon realize how much more fortunate he is than his fellow classmate practicing in a metropolitan district.

In 1931, 74.5 percent of the physicians in private practice in the United States were general practitioners (Geyman 1980, 5). However, a decline both in absolute numbers and in percentages was underway.

The first organized specialty, ophthalmology, had been approved in 1917. Ironically, general practice had been proposed as the second specialty in 1919 (Greenwood and Frederickson 1964, 45). The proposal to make general practice a specialty was defeated, but fourteen specialty boards were organized during the 1930s, including pediatrics and internal medicine (Geyman 1980, 4).

By 1938, the Michigan State Medical Society (MSMS) had become concerned enough about physician distribution that it inaugurated a placement service to assist any community that was in need of a physician. It also undertook a survey to discover whether additional medical services were needed anywhere in the state (Stapleton 1965, 25). By 1940, the number of general practitioners had dropped by 2,844, and they comprised only 66.1 percent of the total private physicians in the country. (Geyman 1980, 5).

Against this backdrop, Henry A. Luce, M.D., of Michigan submitted a resolution to the 1941 meeting of the American Medical Association (AMA) urging establishment of a Section on General Practice (American Academy of Family Physicians 1980, 5-6). Sections had already been established for specialties, and it was through its Section that each specialty presented its annual scientific program. Luce was a Detroit physician and 1938-39 president of the Michigan State Medical Society. He was described by a contemporary (Stapleton 1965, 26) as "a true gentleman with a kindly manner toward all" and "a medical statesman."

Although he may have been a medical statesman, his resolution was not completely successful. The reference committee recommended a "session" for general practitioners, rather than a permanent Section on General Practice. The committee said if attendance and interest at the session proved sufficient, it then would consider establishing a permanent Section.

Luce's resolution fared better than did George R. Dillinger, M.D., of Indiana's simultaneous call for a general practice certification board (American Academy of Family Physicians 1980, 5-6). Dillinger's resolution did not pass the reference committee at all.

Family Practice: Its Appeal

“I thought I would be bored doing a narrow specialty. Basically, I don’t like being bored.”

— Louis Constan, M.D.
Saginaw

“I really wanted to emulate my family physician, who used to make house calls. When he came on my block to see patients, I used to run after him and ask to carry his bag. He was the one who wrote the recommendation for me for medical school. He was one of the happiest persons in the world to learn that I wanted to go into medicine. I probably followed in his footsteps because he was the person that everybody could count on, the person that in the true spirit of family practice would be the person to turn to for most illnesses, but also for the emotional needs of the family.”

— Gary Ruoff, M.D.
Kalamazoo

“I was pretty sure—based on my own background, the fact that my spouse was from a small town, the fact that we had this sense of service, the requirement for service which I think in my case came from my religious heritage and my small town background—that we were headed back up north. That limited me to a couple of choices in terms of what would be the most help to people in the communities I was likely to practice in. There was a combination of learning that ob/gyn wasn’t what I thought it was, and simultaneously meeting some really neat family doctors who raised family practice as a possibility. I think by the time I started my third year in medical school, I was pretty well convinced that I was going to be a family doctor.”

— Paul Werner, M.D.
Detroit

Family Practice: The Challenges

“The first baby that I delivered later tumbled out of a car on Bay City Road and was run over by a car coming in the other direction. It’s something I will never forget, in the emergency room telling my first patient that the first baby I delivered in practice was dead. It was an example of a lot of things like that, that you face in family practice. Wonderful experiences, but also terrible personal things.”

— Richard Howell, M.D.
Saginaw

“You have to be able, when the phone rings, to answer the problem that’s on that phone. Now it may be a psychological problem, it may be an emergency, it may be an ob, but you’ve got to be able to be flexible enough. And the family had to be flexible with me. They had to say, ‘Oops, the trip we’re going on, Dad, we’re not leaving right now?’ ‘Nope.’ And I’d go out and deliver a baby, and maybe four hours later we’d leave. For a long time, the practice came first, then the family came second.”

— Charles Zimont, M.D.
Constantine



3 General Practice: World War II to 1960

According to Paul Starr (1982, 342-43) in *The Social Transformation of American Medicine*, large-scale federal involvement in medical research had begun during World War II and accelerated during the postwar years. Between 1941 and 1951, the federal budget for medical research rose from about \$3 million to \$76 million, and much of that funding was channeled into the major medical schools for research targeted at a specific disease. With money and prestige flowing into the medical colleges, the lure to specialization and to academic medicine became ever greater.

As World War II ended, the trends toward specialization and urbanization began to accelerate. According to the American Academy of Family Physicians (American Academy of Family Physicians 1980, 5-6),

General practitioners returning from service discovered that the G.I. Bill of Rights subsidized residency training, but there were no residencies in general practice. It irked them when physicians who did take advantage of the opportunity for additional training returned to the community and exhibited a somewhat condescending attitude toward them. It infuriated them to find that the American College of Surgeons, then the sole accrediting agency in hospitals, was saying they could not perform surgical procedures they had performed before they left for military service. It was the beginning of a long war on the medical home front, with general practitioners battling for hospital privileges on the basis of proven capability, and specialty-oriented hospital medical staffs establishing the line of arbitrary requirements which usually included board certification.

It was becoming increasingly difficult for general practitioners to obtain hospital privileges in any but the most rural areas. This erosion of privileges was especially apparent in

surgery and obstetrics. General practitioners had traditionally practiced in these areas, but they now found the adequacy of their training questioned by the specialists and found lacking.

Everal Wakeman, M.D., (Personal interview, 1996) was among the general practice physicians who experienced these pressures when he returned from World War II service to open a practice in Dearborn, a growing city on the outskirts of Detroit. When Oakwood Hospital was established in Dearborn, a battle ensued between the hospital's chief of surgery and its general practitioners. According to Wakeman,

Shortly after the war, nobody got into the operating room, supposedly, except surgeons. When Oakwood opened there was a big battle, because about half of the staff or more were old-time generalists, family doctors. They'd done appendices; they'd done hernias. A few of them had done a little more surgery, with gall bladders and so forth. The chief of surgeons said, "Nobody's going to come beyond those doors except the surgeons," and, God, he hung himself! Finally, we got the board to say, "No, [the general practitioners] will do what they're qualified to do."

Although white general practitioners were shocked to be denied hospital privileges or training opportunities, this was not a new experience for African-American physicians. Young African-American physicians moved into Michigan after the war seeking a more open climate than they had experienced in some other locations during the wartime years.

Lionel Swan, M.D., (Personal interview 1996) had served the Veteran's Administration in Tuskegee, Alabama, during World War II, along with a number of other young black physicians. According to Swan, it was the only Veteran's Administration hospital available to black veterans, and therefore one of the few places where African-American physicians could offer their services during the war.

As these young physicians left Tuskegee, several were drawn to the more liberal atmosphere of Detroit, where Swan joined his friends in 1951 after practicing for several years in Birmingham, Alabama, a highly segregated community. Unlike the situation in Alabama, in Detroit he was able to join the Wayne County Medical Society, but he soon found himself fighting to gain staff privileges for African-American physicians

at area hospitals (*Detroit Medical News* 1995, 1). Swan has continued throughout his career to be a strong advocate of civil rights and an advocate for accessible health care for the poor.

Likewise, Lansing's first African American physician, William Henry Harrison, M.D., set up his general practice in 1946, after serving in World War II. He continued his practice for 50 years, until his death in 1997 (Lux 1998).

General practitioners begin to organize

Henry A. Luce, M.D., reintroduced his resolution in 1945, and this time the AMA approved establishment of a Section on General Practice. General practitioners soon found the Section to be an inadequate response to their concerns.

As their position within the medical profession became increasingly tenuous and their numbers continued to decline, general practitioners began to organize. W.B. Harm, M.D., and Elmer C. Texter, M.D., both of Detroit, attended the first meeting of the American Medical Association's new Section on General Practice, in San Francisco during July 1946.

Stanley R. Truman, M.D., of California (Truman 1969) was also there, and he reported on the disenchantment of the assembled general practitioners,

I have never attended a meeting where more anxiety, more depression, and more paranoia was expressed. Doctors from all over the country were saying the same thing: "Our privileges are being taken away from us, not because we are incompetent, but simply because we are listed as general practitioners; we can't get on hospital staffs because we are general practitioners; we are coming home from the service and we are cut off because we are general practitioners." It went on and on. It became clear that the Section on General Practice of the AMA could do nothing and could take no action on matters of this sort.

A group of approximately sixteen men, including Harm and Texter, agreed that establishment of a separate organization specifically to promote general practice was essential. In a maneuver that would ensure that the AMA Section on General Practice would not attempt to block formation of this new organization, they nominated and elected a slate of officers for the Section that was committed to the vision of developing a totally new organization. Texter urged that Paul Davis, M.D., of

Akron, Ohio, be named chair, and Harm agreed to be secretary.

A meeting was called for the following day to begin formation of this national organization of general practitioners, and at that meeting the newly elected Section on General Practice officers were also named officers pro-tem of the emerging group. They agreed that the coming year would be spent planning, and the new organization would be formalized during the 1947 AMA meeting in Atlantic City. Texter, as chair of the Committee on Membership and Organization, sent a letter to the secretary of every county medical society in the United States announcing the upcoming organizational meeting in Atlantic City.

Truman later remembered of the 1947 AMA gathering,

Walking down the boardwalk at Atlantic City the morning of June 9, 1947, I ran into Texter with an arm-full of placards which announced the meeting of general practitioners that was to be held at the Claridge the next night at 8:00 p.m. He was distributing these at each of the hotel lobbies. We continued the job on down to the registration area. Here, they would only allow us to post one placard. It certainly seemed small and inconsequential, about eleven by eighteen inches, among the several foot square announcements of the various medical school alumni, fraternity and specialty group announcements.

Among the general practitioners from Michigan that Texter noted in attendance during a two-day ongoing caucus in Paul Davis' Atlantic City hotel room were doctors C. Chandler, E.D. Fenton, A. Forrester, W.B. Harm, L.T. Henderson, E.C. Long, M. Miller, E.C. Texter, and Arch Walls. Long and Henderson were elected to the First Congress of Delegates of the American Academy of General Practice, Texter became vice president, and Walls joined the first Board of Directors. Two hundred and twenty members were recruited at Atlantic City. Six months later, membership was at 1,600 and growing rapidly (Truman 1969). In March of 1948, E.C. Texter became national president (Stapleton 1965, 37).

Although the AAGP became the preeminent organization for general practitioners, it was not the first (American Academy of Family Physicians 1980, 9). The American College of Physicians and Surgeons had already been established, with chapters in Illinois, Minnesota, Wisconsin, and Indiana. Ac-

ording to Mac Cahal, the AAGP's first executive secretary, "Everybody realized that you couldn't have two national organizations with the same purposes, and it really was sort of touch and go for about six months about whether the Academy would be merged with the College or vice versa." A board of general practice also had been established in Indiana, but it disbanded after the AAGP was established.

Michigan organizes

In Detroit, a local chapter of AAGP was soon active. By November 1947, the American Academy of General Practice of Wayne County sponsored its "First Annual Post Graduate Lectures for General Practitioners" at Henry Ford Hospital in Detroit, promising that "all papers will be given by men experienced in the actual practice of medicine with private patients." Among the presenters were Arch Walls, M.D., and E. Clarkson Long, M.D., who would soon sign the charter for a statewide chapter of the national Academy.

Seven men signed the Michigan Academy of General Practice charter, approved by the national office in Kansas City, Missouri, on June 25, 1948. In addition to Long and Walls, there were physicians John S. De Tar of Milan, A. Carl Stander of Saginaw, Luther W. Day, E.C. Texter of Detroit, and W.B. Harm of Detroit. Stander later recalled an early summer meeting with Board of Directors members E. Clarkson Long, M.D., President Russell Fenton, M.D., and Francis P. "Dusty" Rhoades, M.D., in the recreation room of Stander's home office on Court Street in Saginaw where they planned the first statewide Congress of Delegates, which was to take place at the Book Cadillac Hotel in Detroit (Stander c1982).

Concerns mount about rural health care

Concern about the adequacy of rural health care in Michigan continued to mount, and the Michigan State Medical Society, with the cooperation of twenty-five other state organizations, sponsored the first Rural Health Conference Sept. 18-19, 1947, at Michigan State College to explore the needs and problems of health in rural areas (Stapleton 1965, 35). At the conference, John S. De Tar, M.D., (1947, 1274) of Milan called for the establishment of a scholarship fund to be granted to medical students contingent upon their willingness to go into

rural practice after their internships.

In 1948 the MSMS Council requested that the group's Foundation consider the development of a student loan fund to encourage young physicians to locate in rural areas (Stapleton 1965, 36). Among the medical students to accept one of these loans was L. Edmond Eary, M.D., who honored the terms of the loan by entering practice in the small town of Sparta, where he has remained throughout his career combining his family practice with teaching Michigan State University medical students and running an ambulance service for the town (Personal interview, 1996).

Although the Section on General Practice had been approved on the national level in 1945, MSMS did not offer a General Practice Day at its annual meeting until the 1953 Annual Session in Grand Rapids.

The challenges to general practice increase

By 1949, general practitioners had dipped to just under 50 percent of the active physicians in the United States (Geyman 1980, 5). Each year during the late 1940s, general practitioners urged the American Medical Association on the national level to address some aspect of the general practitioners' situation. A report in June 1948 suggested increased postgraduate training and urged programs of at least two years duration to prepare physicians for general practice.

The following year, the situation was revisited and nothing had been done. Therefore, a resolution was adopted urging that graduate and postgraduate education be made more widely available and that two-year rotating internships for general practice be set up as rapidly as possible (AAFP 1980, 11).

It was clear that the traditional model of general practice was no longer working. Rural physicians were in short supply. The long hours and reduced income relative to that of specialists were taking their toll on the morale of general practitioners.

Robert Landick, M.D., began his career in this rapidly changing medical climate. As a young general practitioner, he found the conditions under which he and his colleagues were operating increasingly nudged him to consider specialty training. Landick had joined the service in World War II after receiving his bachelor of science degree. When he returned from the service, he found that the G.I. Bill could pay his way

through medical school. He located his first practice on the East Coast, and soon encountered some of the realities of life as a young general practitioner in an attractive urbanized area which had more than its share of physicians.

Landick remembered,

I went into practice in Marble Head... on the coast. In good part, it's a Boston bedroom. I was there two years as a general practitioner, doing obstetrics. I was dissatisfied with the way the practice was developing. My colleagues encouraged me to persist and everything would turn out all right in the end, but I was a little too young and impatient, I guess.

I can remember that my gross income my first year was \$7,000, which was not as bad as it sounds today, but even then it was not much. I had my office in my home. I converted a sun porch for an examining room and used the living room for a waiting room. I was spending too much time looking out the window waiting for patients to walk up the pathway. It wasn't just the money. We were surviving all right. It just didn't feel right.

I'd heard that things were different further west. A friend took a residency in radiology in Flint. He was back visiting and said, "Gee, Bob, if you want a better opportunity, it's right there in Michigan."

I looked for opportunities around the state. I heard a fellow was leaving a going practice, a solo practice, in Charlotte. I bought his equipment and started off again in general practice, and still doing obstetrics.

My first year there, my gross income was \$23,000, so you can see that it wasn't just my imagination. It was real that there was a big difference in the need for physicians here vs. the need [in eastern Massachusetts]. And it was true anywhere west of New York State. Anywhere you went they were really desperate for physicians.

My practice blossomed, and I was particularly doing a lot of obstetrics. I was solo practice. You're on call every day, every weekend. The load of my practice was getting heavier and heavier, and I just couldn't seem to keep up with things.

I decided to consider going into a specialty. I did a residency in anesthesiology at the University of Michigan. I went through that and eventually became board certified. I joined a group and I was on call every fourth night. It was a comfortable living. (Landick, personal interview 1996)

Moving toward group practice

Many general practitioners clung to the ideal of the solo family physician despite the long hours and isolation. However, other young physicians believed that by working in partnership they could alleviate some of the pressures that Landick and others faced in solo practice. Robert Toteff, M.D., came to Saginaw after his 1955 graduation from medical school at Wayne State University. He and his medical school buddy, Clyde Davenport, M.D., had already decided that they would practice together, and they found that Saginaw offered a supportive environment.

Toteff (Personal interview 1996) recalls,

We began to look for a place that would give us the kind of medicine that we wanted, which was general medicine, as opposed to what was being touted as the necessary kind of medicine in the big centers—internal medicine, surgery, and all those things. We looked for a place where we could practice that kind of medicine. We settled on Saginaw because we liked the Saginaw community of medicine, because we found there a very good, stable community of generalists who were creditable in the community. They weren't looked down on as happened at that time in the big metropolitan areas.

We had always intended to practice as a group because we felt that to give a complete service around the clock would be very hard for a person to do and still maintain a family—any kind of family life. So we elected that we would cover for each other so that when we were off we felt comfortable with who was taking our calls, and also we would be rested. And therefore, we didn't have to give everything to medicine.

From early on, I guess, I had the feeling that I was a family person who happened to be a doctor. That was unheard of at the time, because what you were supposed to be was a doctor who happened to be a family man. The priorities were such that the doctoring took priority.

AMA remains unresponsive

Even though some physicians were adapting to the changing environment, many were not, and the drain of general practitioners into specialties and urban areas continued. In a tongue-in-cheek portrayal of the general practitioner, John De Tar, M.D., (1953, 179) of Milan told the 1952 annual meeting of the American Public Health Association that, “a general practitioner is supposed by some to be a mouse-like individual

with a chronic inferiority complex about his medical status, who sits in the back row at medical meetings taking notes with a dull pencil on the edge of the morning paper.”

In 1954, De Tar was speaker of the American Academy of General Practice. In December of that year, he introduced a resolution into the American Medical Association House of Delegates calling for an exhaustive study of the problems of general practice, including an exploration of adequate educational programs. Again, the American Medical Association was relatively unresponsive to the challenges faced by the general practitioner.

The AMA Council on Medical Education and Hospitals reported to the House in December, 1955, that the major study De Tar had requested would not be implemented. It said that the council had been inquiring into the activities of medical schools and that data regarding graduate residency programs in general practice would be reported in the *Journal of the American Medical Association* (American Academy of Family Physicians 1980, 14-15).

Two paragraphs out of a 43-page AMA report on medical education in North America dealt with graduate training programs designed for prospective general practitioners (Turner, Wiggins, and Tipner 1955, 599-600). The report stated that in autumn 1954 there were 155 hospitals conducting approved graduate training programs in general practice (out of 850 offering graduate training), with a total of 404 participants in these programs. These 155 programs ranged from one year internships to three-year residency programs. The authors circumspectly acknowledged a possible problem by saying, “The broad challenges and needs for preparation in the field of general or family practice have, in the opinion of many thoughtful individuals, been allowed to go by default as those in the narrower specialty areas have received greater attention.”

Generalist training

While there were sporadic attempts to develop a postgraduate experience that would give general practitioners the skills that were needed in the new medical environment, no general agreement was reached by the national medical associations on how best to provide postgraduate training for general practice. Ward Darley, M.D. (Darley 1967, 22-27), had become execu-

tive director of the Association of American Medical Colleges (AAMC) in the mid-1950s and later remembered with aggravation,

On moving to Evanston I immediately became involved in the bimonthly meetings of the first AMA-AAGP-AAMC committee on training for general practice. The members of this committee never did agree upon the content, the length of time, or the resources and methods necessary for the teaching of general practice; and as far as I was concerned, the entire experience was an experience in futility. The report recommended a two-year program, called neither an internship nor a residency, was to begin immediately after graduation . . . A few hospitals inaugurated the program, but student-takers, at least U.S. students, were very few.

Nationwide, six two-year family practice programs were established in 1959, with nine more in 1960, but the programs often were little more than extended rotating internships (Canfield 1976, 907). Despite lack of coordination or agreement on the national level, a few general practice residencies were established in Michigan during the 1950s.

Midland.

Midland Hospital had opened its doors on March 15, 1944. It soon attracted a staff of young physicians recently returned from the service. With the encouragement of Harry Towsley, M.D., of the University of Michigan's Department of Postgraduate Medical Education, a two-year general practice training program was begun at Midland Hospital July 1, 1951.

Towsley was a pediatrician whose father and brother were both Midland physicians (Yates 1994, 55). He also had ties by marriage to the Dow family (of the Dow Chemical Corporation) in Midland. Although on the faculty of the University of Michigan, he maintained a strong interest in the development of Midland Hospital. He was firmly committed to supporting clinical education in the community hospital environment, seemingly at odds with the University of Michigan's philosophy of medical education which emphasized specialty training in tertiary hospitals. Robert Lachance, M.D., (Personal interview 1996) who knew Towsley when Lachance first joined the faculty of the Midland Family Practice Residency Program in 1976, remembers that Towsley "tried to get away from the vision of the major academic medical center as being the Mecca."

For the first three years, Midland's two-year rotating general practice internship was underwritten by the Herbert H. and Grace A. Dow Foundation, and physicians at the hospital took turns as head of the program (Yates 1994, 37). Participants in the Midland program spent half of their time at the University of Michigan Medical Center and half at Midland Hospital. Midland Hospital did not have its own residency approval from the American Medical Association Council on Education in Hospitals, and so the initial participants were carried within the approved quota of the University of Michigan Hospital.

One of the young physicians joining the Midland program in its first year was Richard Howell, M.D. He (Personal interview, 1996) had been attracted by the mix of university and community training that the program would offer. Howell and two other physicians started out their experience with six months in Ann Arbor. They then rotated to Midland for a year, followed by another six months in Ann Arbor. Two other residents were moving in the opposite direction, having started with six months in Midland, then rotating to the university. Howell remained in Midland, gradually tailoring his practice to his special interest in preventive medicine.

Howell recalls the University of Michigan's reaction to Towsley's emphasis on community experience, "He was very unpopular. It was an unpopular concept. They wanted to train people who would go out in academe and be professors of this and that throughout the country."

By 1957, the Midland hospital had been approved for its own first year rotating internship with a quota of six, and from 1957-61, both programs ran simultaneously, although the quota for the rotating internship was rarely filled.

Saginaw.

An advanced training program for general practitioners was established in Saginaw in July 1953, when a general practice residency program at St. Mary's Hospital was approved by the AMA Council on Medical Education and Hospitals (Fisk 1986, 86). The first resident was Vincent J. Hannekin, M.D.



Fig. 1. Michigan's general practice residencies, 1950s.

Saginaw had a reputation as a medical community in which general practitioners were respected colleagues. During the 1950s young physicians such as Roy Gerard, M.D., Robert Toteff, M.D., and Clyde Davenport, M.D., had been drawn there by the opportunity to practice as generalists in a supportive environment that did not exist in the medical schools from which they had graduated.

Toteff (Telephone interview 1996) recalls that there was a strong group of generalists in Saginaw, and that they worked well together, noting, "It was the epitome of how you wanted to work with your own medical community." Donald Sargent, M.D., (Personal interview 1996) described a central credentialing committee for the three Saginaw hospitals that offered experience-based credentialing in lesser/major surgery and lesser/major obstetrics. Those generalists whose experience qualified them were granted privileges that would allow them to perform such procedures as appendices, hernias, and forceps deliveries without specialty training.

Sargent recalled,

As far as I know, nobody [else] had the term lesser/major surgery, and nobody had a central credentialing committee that set up these things... It gave [general practitioners] the right to do some of those things that they couldn't have done in other communities.

Oakwood.

Oakwood Hospital in Dearborn had a strong presence of general practitioners on its medical staff when it was established in 1953, and the hospital developed a tradition of appointing a general practitioner as chief of staff every other year (Battle 1994). The hospital began an approved general practice residency program in December 1958, which enrolled a total of 32 physicians before it evolved into one of the state's first family practice residencies in 1969 (Wakeman 1969, 5).

Everal Wakeman, M.D., who became head of the program, recalls that the program had a limited appeal, and that there was resistance from other specialties even at Oakwood,

You had a problem getting anybody to speak of, because it was something brand new. Medicine and surgery, particularly surgery, had decided no one's going to do surgery in hospitals

but surgeons, so you weren't too well received by anybody else. It was hard to convince a medical student to go into that residency program.

These two programs and other general practice residency programs that developed over the next few years rarely were able to fill their quotas, and of the 32 physicians who had been recruited into the Oakwood general practice residency, only seven completed the full two years (Wakeman 1969, 5). Without board certification after completion of the residency, there was little incentive for physicians to remain in the programs when they could be starting their careers.

Even up to the late 1960s, training opportunities that embodied the ideals of the emerging field of family practice were rare and difficult for young physicians to locate. During the late '60s, Cecelia Hissong, M.D., (Personal interview, 1996) of Dearborn, decided that she should go into internal medicine after noting that the Detroit-area hospital where she was interning had not admitted a general practitioner to its staff in thirteen years. Her plans were turned around by an aggressive recruiting campaign by Frank Caliva, M.D., who was establishing a family practice residency in Syracuse, N.Y.

On visiting the program, she found it offered exactly the approach to family medicine that she had wanted, but assumed she could not find. Although she did not want to leave Michigan, the new program drew her to New York for one year, after which she returned for a second year at Oakwood Hospital. At that time, Oakwood still was operating its residency program on the older general practice model. Although she did not complete the full residency program in New York, attendance in the Syracuse program did give her the assurance that she could mold her practice based on a family practice model.

Family Practice: The Vision

“I always felt that the family was the focal point of the practice. I really tremendously enjoy taking care of a patient or a pregnancy, taking care of the baby afterward, and eventually having the father as a patient. And then as the years went by, it turns out that my babies started having babies, which was quite a thrill. So this whole concept of the family being the unit and knowing the family real well and being able to make intelligent decisions on the basis of knowledge, knowing about them, what their home was like, and so forth.”

— *Richard Howell, M.D.*
Midland

“Some general practitioners wanted to stay general practitioners. I personally felt that I was always a family doc. From the day I started practice, I always encouraged families and did family medicine, so to me the change is transparent. It doesn’t really change anything that I do or did.”

— *Peter Thoms, M.D.*
Flint



4 The Emerging Conversation

The 1960s brought an intense and sometimes contentious exploration of what model of first-contact medical care was needed in the United States. Debates ranged over scope of practice, philosophical orientation, educational requirements, and the desirability of pursuing specialty status. The early 1960s brought a few voices in Michigan calling for development of a specialty board as one step in solving the crisis in general medicine.

Francis “Dusty” Rhoades, M.D., (Rhoades 1961) of Detroit, in an April 28, 1961, address to physicians in Grand Rapids, outlined eight essential steps to ensure the future of general practice. Among his eight steps, he called for “residencies of at least two years duration including operative obstetrics and surgery” and “a certifying board that will attest to this new status.”

Those across the nation who supported the development of specialty status represented a variety of constituents, each of which voiced somewhat different concerns and developed different visions of what family practice could become. Massad and Schorow (1987, 112) itemized some of these constituencies as they were configured in the 1960s: 1) health planners and public officials concerned with geographic and specialty maldistribution, 2) patients and their spokespersons concerned with the fragmented, impersonal, and expensive health care delivery system, 3) politically active students who hoped for socially relevant roles as physicians, 4) medical school faculty who wanted to “humanize” medical education, and 5) general practitioners who “saw themselves as a dying breed, without protégés or successors.”

They summarized the expectations for family practice that developed out of these constituency groups:

- 1) Family practice would be a successful competitor for medical students.
- 2) After training, family physicians would practice in medically underserved areas.
- 3) Family physicians would provide care that was personal, accessible, affordable and sensitive to the psychosocial factors relevant to health care.
- 4) Family practice education activities in the medical school would have the effect of making medical education more relevant and more humanistic.
- 5) Family practice residents would be more concerned with practical and experiential aspects of practice; training would be based more in the “real world” of ambulatory care and would have aspects of an apprenticeship. (Massad and Schorow 1987, 113)

Despite these emerging expectations, there was no consensus — even among general practitioners — that specialty status was the best approach to providing primary care. As the 1960s unfolded, there were explorations of alternative models for delivering primary and preventive care, and advocates of family practice would struggle to position the family practice model within a dynamic search for answers to the primary care crisis.

Increasing the number of physicians

In the early 1960s, many thought that the shortage of primary care physicians could be solved by increasing the total number of physicians in practice. They assumed that through the mechanism of supply and demand, young graduates would gravitate to those communities which needed physicians as well as distribute themselves more equitably among areas of practice. Foundations such as the W.K. Kellogg Foundation in Battle Creek began to channel their money into the development of new medical schools (W.K. Kellogg Foundation 1965, 116). With the encouragement of the Association of American Medical Colleges, they were especially interested in funding new two-year schools which would provide the medical student with his or her basic science background prior to transfer to an established medical school for two clinical years of training. These first two years of medical training were substan-

tially less expensive to provide than were the final two years.

Wayne State University in Detroit and the University of Michigan in Ann Arbor housed Michigan's two medical schools. To some, Michigan State University (MSU) seemed like a natural location for a third medical school in Michigan. The university had expanded substantially since World War II. It became a university in 1955, and grew from a student body of 6,400 in 1941 to nearly 28,000 by 1963. MSU was centrally located and its land grant tradition seemed a perfect milieu in which to develop community-oriented medical training (Hunt, 1972).

Internist Frederick C. Swartz, M.D., a member of the Ingham County Medical Society, was among the early advocates of a medical school at MSU, having discussed the possibility several times prior to 1957 with John A. Hannah, president of the university. An informal committee within the county medical society kept interest in the prospect alive. (Ibid)

In 1957, Charles R. Hoffer, professor of rural sociology at Michigan State, with the assistance of other members of the sociology faculty, published *Michigan State University Medical and Health Center: The Need and Feasibility*. The report was prepared for a study committee that included Milton E. Muelder, committee chair and dean of the College of Science and Arts, and four other members. Hoffer's report identified both a significant shortage and an uneven distribution of health personnel and facilities that seriously affected the rural part of the state. It suggested Michigan State as a viable site for a third medical school that could address these concerns (Hunt 1974, 170).

Following the Hoffer Report, a committee was organized to explore the possibility. On Dec. 16, 1959, the committee outlined a proposal to develop a medical center which would include a College of Medicine, the College of Veterinary Medicine, the School of Medical Technology, the School of Nursing, a College of Dentistry, curricula in public health, and a medical research institute.

According to Andrew D. Hunt, Jr., M.D.,

the report emphasized unofficial and obstructive barriers between the various branches of medicine and suggested that a comparative approach to teaching and learning should

be effective and that it might begin to break down some of these barriers.

The committee's next report in mid-1960 refined its earlier concept into an Institute of Biomedical Sciences that would offer a core pattern of courses from which students in nursing, veterinary medicine, and human medicine would branch off "at the latest practicable stage."

While there was some support from the local medical community and from the national level, there was little public support throughout Michigan for establishment of a new medical school at MSU, according to Hunt. He summarized the arguments against the new school:

- 1) The medical schools of the University of Michigan and Wayne State University needed funding for their commitments to expand medical education and felt that these commitments should be met before any new program was established at MSU.
- 2) Michigan State had grown too fast and was exceeding its mandate by moving into the field of medicine; such an effort would be unlikely to succeed in a "cow college."
- 3) Clinical resources in the Lansing area were quite possibly inadequate to support a full medical program; Detroit or Grand Rapids would be more appropriate sites for a third medical school when such an institution was required.
- 4) Even though a 1962 resolution of the Michigan legislature permitted MSU to proceed with a "two-year program in human biology leading to the M.D. degree," it was the general feeling that the university was planning for a college without appropriate mandate from the body politic. (ibid)

As plans continued to evolve, the two-year medical program was designated a college within Michigan State University, and Hunt, then an associate professor of pediatrics and director of ambulatory services at Stanford University medical school, became the first dean of the College of Human Medicine on July 1, 1964. The two-year program was approved by the Michigan Board of Education in 1965, and was established with the help of W.K. Kellogg Foundation funding.

In the summer of 1965, before his first students had entered the college, Hunt invited several leaders of the Lansing chapter of the Michigan Academy of General Practice to his home for a conversation. Among those invited were Gordon Harrod, M.D., Donald McCorvie, M.D., and Harold “Pat” Crow, M.D. McCorvie later recalled that Hunt wanted to know what general practice was all about and how he could help general practitioners. McCorvie (Gerard and Smith 1979, 1-2) recollected, “We told him that we needed to produce more family physicians — general practitioners in those days. I was the youngest general practitioner to move into the Lansing area, and I had come in 1954. We were a dying breed.”

Although innovative approaches to medical education were tentatively emerging in medical schools across the country, a reservoir of bitterness had developed among general practitioners who felt they had been ignored for too long. In 1966, Edgar G. Cochrane, M.D., (Cochrane 1966, 4) was a general practitioner in Highland Park and president of the Michigan Academy of General Practice. When asked by *The Medical Tribune* to respond to the question, “How can we preserve general practice?” he responded,

For several years the American Academy of General Practice has made numerous attempts to impress upon the deans and professors in medical schools the worthiness of and the need for more general practitioners. When one refers to the medical faculties as “living in ivory towers,” he means that these learned and respected educators are out of touch with the realities of the active practice of medicine. It would be a rewarding experience for any of these educators to step out of character — from the secure offices of a field general to the rigors of the front lines.

General practitioners urge action

In 1965, two resolutions focusing on the concerns of general practitioners were introduced to the Michigan State Medical Society. E.S. Woodworth, M.D., of Livingston urged in Resolution 48 “a full scale hearing concerning the problem of interesting increased numbers of young physicians in general and rural medical practice in the state.”

The president of the MAGP, Fred C. Brace, M.D., of Kent introduced Resolution 50. He argued that,

emergencies of communities desperate for medical aid exist all over this scientifically advanced and superior country . . . it is imperative that the family doctor continue to be the backbone of American medicine because it is economically impossible to supply full-time specialist coverage for the thousands of towns and hamlets with population of 2,000 or less.

Brace urged that the MSMS Council "appoint a committee of key personnel from the Michigan Academy of General Practice, the University of Michigan Medical School, and the Wayne State School of Medicine for the purpose of evaluating and setting up a preceptorship in family practice." (Woodworth 1965)

The Reference Committee on Resolutions, H.M. Golden, M.D., chair, recommended approval with the amendment "and to consider other methods for stimulating, interesting, and training more young physicians in general and rural practice in this state." No action was recommended on Woodworth's resolution, "because its intent is incorporated in Resolution 50." (Brace 1965)

In the 1965-66 Annual Report of the MSMS Education Liaison Committee, Committee Chair Don Marshall, M.D., gave some indication of the accelerated pace at which events were moving. He noted that "The Education Liaison Committee, which met three times between 1961 and early 1964, has met five times during the past 15 months." The work of the committee had included "extensive study and consideration" of Resolution 50, which had been referred to his committee. He added, "The Committee quickly found that the question of 'How can we get more GP's in Michigan?' was diverse, with many, many ramifications."

During the year, the committee had conferred several times with the three medical school deans who, he said, "have not voiced opposition to the proposal but who have said other approaches should be explored." On August 31, the committee sent a recommendation to the council

that the Council appoint a subcommittee of one or more representatives of 1) the Education Liaison Committee, 2) the three medical schools, 3) the MSMS Section on General Practice and the Michigan Academy of General Practice to con-

sider the problems of general and rural practice and its relations to the medical school curricula.

Simultaneously, the Education Liaison Committee was exploring the implications of Resolution 2 which had also been introduced into the 1965 House of Delegates. Resolution 2 called for MSMS to consider the development and use of physician assistants (Marshall 1966). A physician's associate program was launched at Duke University that year (Jewett 1975, 92), and within a few years a program for physician assistants would be instituted at Western Michigan University in Kalamazoo.

The national agenda

While there was a nationwide emphasis on increasing the total number of graduates from medical schools, it became increasingly clear to many that this strategy would not directly impact the continuing problems of geographical distribution, generalist/specialist ratios, secondary status, or inadequate training opportunities for general practitioners. During the mid-1960s, four commissions were convened to study these concerns, all of which issued their reports within a 100-day period in 1966. While there were some differences in emphasis, the degree to which the recommendations of these four national reports were in agreement was considered remarkable.

The National Commission on Community Health Services, known as the Folsom Commission, published *Health Is a Community Affair*, which stressed that every individual should have an accessible personal physician for health care on a coordinated, comprehensive, and continuing basis and called for board certification, with "status and income comparable to that of other specialists." The physician should be skilled in preventive care and in the use of community resources (Geyman 1980, 15; Canfield 1976, 908).

The Citizens Commission on Graduate Medical Education, known as the Millis Commission, published *The Graduate Education of Physicians*, in which the commission called for comprehensive health care under the aegis of a primary physician. It emphasized the inadequacy of the traditional model of a rotating internship and urged the abandonment of the

internship in favor of a residency program of more than two years duration. The report called for training in comprehensive and ongoing patient care rather than simply in the episodic handling of acute conditions (Geyman 1980, 15-16).

The Ad Hoc Committee on Education for Family Practice of the Council on Medical Education, in *Meeting the Challenge of Family Practice*, known as the Willard Report, introduced the term "family physician" for a new specialist in comprehensive health. The report said that both the body of knowledge utilized by the family physician and his/her function would be significantly different from that of other specialists, and that training could be obtained in a three- to four-year residency program. It noted,

The single most important element, critical to the success of the program, is an adequate experience in an appropriate model of family practice. Generally speaking, about half of the time of the basic, integrated program should be devoted to training in the setting of an appropriate model of practice. (American Medical Association 1966, 22)

The report went on to say,

a model of family practice . . . should be based on the idea of providing comprehensive care to a defined population. Ideally it should consist of a generalized clinical service in contrast to one that is organized around conventional specialty services. The generalized service should include not only patients of all income levels in the acute general hospital but also ambulatory patients, patients at home and patients in long-term care institutions such as nursing homes. (American Medical Association 1966, 29)

Harry Towsley, M.D., of the University of Michigan, had been a consultant to the Willard Commission. Towsley, himself a pediatrician, already had a reputation for supporting community-based residency education. He was later reported as having said that his participation on the Willard Commission had caused every primary care pediatrician in the country to be upset with him for helping develop a competing specialty (Lachance, Personal interview 1996).

The fourth report was produced by a joint committee of the American Academy of General Practice Committee on Education and the American Medical Association Section on

General Practice. After intensive study, it outlined and explained a proposed set of essentials for training in family practice. The 1966 publication detailed twenty-six areas of interest that it deemed to be in the realm of family practice, including “the family and community resources,” “allied and paramedical personnel,” “the physician-patient relationship,” and several others not ordinarily covered in residency programs at the time (Canfield 1976, 910).

Michigan response to national reports

In 1966, the MSMS Education Liaison Committee asked its Subcommittee on GP Education to evaluate the recommendations of the Millis Report. Word came back from the subcommittee that it was a “superlative documentation of the need for change in our graduate medical programs, and this is nowhere more evident than in the training needed for family practice.”

However, at the subcommittee’s May 18, 1967, meeting, the members articulated disagreement with the report on a couple of points. One disagreement was with the report’s assumption that premedical and medical school education would continue to produce the same type of graduates that it had been producing. According to the subcommittee, the report ignored the “tremendous tumult within universities all over the country, and the educational trend is toward consolidation of traditional curricular programs with emphasis on preparing graduates who are qualified in comprehensive, continuous personal and family health care.” (Michigan State Medical Society May 18, 1967)

On June 29, 1967, the Education Liaison Committee recommended that the MSMS Council adopt the subcommittee’s response as the opinion of the Council and forward it to the appropriate American Medical Association bodies. Among other recommendations, it suggested that three specific activities be suggested to the MSMS Section on General Practice. These were

- a) that GP’s throughout the state be invited to host a sophomore or junior medical student from a Michigan medical school for an on-the-scene experience some specific weekend,
- b) that county medical societies maintain good rela-

tionships with their local medical students and encourage them to practice in their hometowns or nearby small towns, c) that MSMS encourage the idea that two young GP's go into the same smaller town at the same time and thus help assure some free time for each other. (Michigan State Medical Society June 29, 1967)

These ideas fell far short of the reorientation of medical education deemed necessary by the national commissions.

Family medicine or generalism: What's in a name?

As the conversation on the national level turned more specifically toward the possibilities of board certification and the development of residency programs, Michigan's physicians began to wrestle with the underlying issue of how the new discipline would differentiate itself from the traditional general practice model and define its own identity. Phrases often heard included "comprehensive, continuing care," and an evolving emphasis on the meaning of "family" in family medicine.

In a 1967 address, Francis P. Rhoades, M.D., of Detroit, put forward his view of "comprehensive medicine," one of the building blocks for the newly emerging identity of family practice. Rhoades said,

Comprehensive medicine properly practiced is a coordinated multidisciplinary approach to the complete health care of the individual and his family unit. The emphasis is on the "health," both physical and mental, of the individual and his family unit rather than "medical" care alone. Comprehensive medicine envisions the total wellbeing of the individual human rather than just the proper functioning of his various body systems. (Rhoades 1967, 1)

Cyril M. Worby, M.D., (1971, 198) of Michigan State University College of Human Medicine's psychiatry department, urged a more specific focus on the family as a psychosocial system, and suggested that "viewing the family from the perspective of its life cycle may serve an important orienting and organizing function for the family practice specialist." He noted that "In his daily work, the family practice specialist will be involved simultaneously with families who are at different phases in their [familial] life cycles. He will also, over a period of years, see a particular family through several consecutive phases in its life cycle."

By 1967, some physicians were adopting the title of family physician, although there was as yet no specialty certification. In the 1967 roster of members of the Saginaw County Medical Society, four physicians identified themselves as family physicians, forty-seven as general practitioners, and 117 as specialists (Saginaw County Medical Society 1967).

Osteopaths in primary care

There had been a long-entrenched antipathy between the osteopathic profession and allopathic medicine, and early attempts at cooperation had been firmly rebuked by the American Medical Association. In 1952, the Bay City Commission had voted 5-4 to allow osteopathic physicians to practice in the city-owned Bay City Hospital. Allopathic response was swift and unambiguous. Within a week, the number of patients in Bay City Hospital had dwindled to 32, as the 70 physicians on its staff began admitting their patients to other area hospitals rather than work alongside osteopathic physicians in Bay City. One week after accepting the osteopaths on staff, the City Commission reversed its decision, again by a vote of 5-4 (Stapleton 1965, 40).

Considering that the number of osteopaths in Michigan had increased almost sixfold between 1930 and 1967, that Michigan at that time had more osteopathic physicians than any other state, and that Detroit was home to the nation's largest osteopathic hospital (Citizens Committee on Education for Health Care 1967, 1,11), it was clear that any reconfiguration of primary care delivery in Michigan would need to take account of osteopathy.

As of September 1965, there were 1,904 osteopaths in Michigan, and 914 of these were general practitioners in private practice. In 1966, there were 2,208 allopathic physicians in private general practice in Michigan. As among allopathic physicians, there was a trend toward urbanization among the osteopathic physicians. In 1960, 37 percent of Michigan osteopaths were located in communities with less than 10,000 population. Just five years later, that percentage had dropped to 28 percent. (Citizens Committee on Education for Health Care 1967, 1)

The hard-line allopathic condemnation of osteopathic medicine as "cultist" softened during the 1960s, although some osteopathic physicians saw this attitude change as part of a

planned strategy that would eliminate osteopathy through assimilation of osteopaths into allopathic institutions. Some tentative moves had been made on the part of the American Medical Association toward the eventual merger of osteopaths with allopathic medicine, but any goodwill that the osteopathic community might have attributed to their allopathic colleagues vanished at the beginning of the 1960s when the osteopathic profession in California was swallowed whole by the California Medical Association. (Citizens Committee on Education for Health Care 1967, 33-34)

The California Osteopathic Association (COA), which at that time represented the largest block of osteopathic physicians in the country, had been negotiating for some time with the California Medical Association about a possible merger. Michigan's delegation to the American Osteopathic Association (AOA) was particularly firm in disapproving this negotiation, and during the 1959 national meetings introduced a resolution reaffirming that osteopathy should "maintain its status as a separate and complete school of medicine." The Michigan resolution passed ninety-five to twenty-two, with California providing all of the negative votes (Gevitz 1982, 113).

California's osteopaths persisted in pursuing amalgamation with the American Medical Association. Therefore, on Nov. 21, 1960, under national president Roy J. Harvey, D.O., of Midland, Michigan, the AOA revoked the California group's charter for "acting in a manner detrimental to the entire profession."

The California Medical Association, by a vote of 296 to 63, on May 3, 1961, ratified the merger with the now-disenfranchised California Osteopathic Association, through which it accepted 2,400 osteopaths into its organization. On May 17, the House of Delegates of the California Osteopathic Association approved the merger by a vote of 100 to 10. Soon California legislation was enacted which ended the power of the State Board of Osteopathic Examiners to issue any further osteopathic licenses in California and defined the eventual phase-out of the board's existence.

Carol Monson, D.O., (Personal interview, 1996) notes that the California osteopaths (newly proclaimed as M.D.s) now found themselves in an untenable position. They could not

practice in any state other than California as allopaths, because other states would not recognize their status as M.D.s, and they could not practice outside of California as osteopaths because they had been disenfranchised by the AOA.

The AOA, after the California merger, reiterated that it will resist all efforts to be absorbed, amalgamated or destroyed, be it through overt political maneuvering or through the guise of making its individual members conform to the scientific dictates of the American Medical Association.

In Michigan, during the early 1960s, the allopathic community had opened its door a crack to osteopathic physicians. The University of Michigan and Wayne State University opened some of their post-graduate training programs to osteopaths in 1961. The number of allopathic community hospitals providing staff privileges to osteopaths increased. Osteopathic physicians gained representation on the Board of Directors of Michigan Blue Shield in 1963.

The MSMS House of Delegates in 1964 adopted a policy of working toward the establishment of a single medical practice act in Michigan which would ensure that both D.O.s and M.D.s had received equivalent training. In 1964, a report on relations between the two professions written by a member of MSMS stated,

It is no secret that the medical profession considers eventual amalgamation as the only way to resolve the matter. The science of medicine is one. The osteopathic schools teach the same medical sciences as do medical schools. They use our textbooks. They are licensed to practice medicine in Michigan in the same manner as M.D.'s.

However, this goal of merger is years away. First there must be a single Medical Practice Act as a yardstick to determine that both D.O.'s and M.D.'s have the same scientific qualifications. Second, an honorable means must be sought whereby D.O. candidates may obtain M.D. degrees. Third, and most important of all, adequate numbers of D.O.'s must WANT to merge. It took twenty years to achieve merger in California. Michigan has only been exploring the situation for three years. (Citizens Committee on Education for Health Care 1967, 36)

The osteopathic response to these overtures was summa-

rized by the state osteopathic association's president in an editorial of the *Michigan Osteopathic Journal* of January 1965 when he said, "Members of the Michigan Association of Osteopathic Physicians and Surgeons have indicated their preference for maintaining a separate and distinct profession." The osteopaths, in fact, had just established the private Michigan College of Osteopathic Medicine — the first new osteopathic college in the country in fifty years. (Committee on Osteopathic Unity 1989, 15). When asked in the mid-1960s "Do you believe amalgamation of allopathy and osteopathy would be in the best interests of the state?" 195 Michigan osteopaths were in favor and 1,338 were opposed (Citizens Committee on Education for Health Care 1967, 33-34).

Pushing on without the support of the state's osteopathic community, Michigan allopathic physicians were in the forefront of efforts to alter the status quo within the American Medical Association. In 1968, Francis P. Rhoades, M.D., reported back to Michigan general practitioners that, "The House of Delegates of the A.M.A., in an impressive way, moved to implement bylaw changes that will permit the 13,000 osteopathic physicians . . . to become members." He went on to explain that this was one step

toward the goal of full amalgamation of osteopathy with medicine . . . Those states, including Michigan, in which osteopaths render a significant share of medical services strongly favored the report . . . The vote was 126 to 91 for adoption; now state societies may admit osteopaths to membership.

During the same session, bylaws changes were instituted permitting the nation's 4,000 African-American physicians to become members. Although they already were being admitted to some state societies, there had been no nationwide policy mandating acceptance into the overwhelmingly white organization (Rhoades, December 1968, 5).

By 1968, a move was underway for the Michigan state legislature to authorize that the private Michigan College of Osteopathic Medicine become a component of Michigan State University. To indicate their commitment to the concept, members of the Michigan Association of Osteopathic Physicians and Surgeons assessed themselves approximately \$2,000 each, with

the goal of reaching \$3 million (Jung 1996, 12). They hoped that once they reached the \$3 million mark, the legislature would match the funding for the new college. In 1969, the legislature approved the establishment of the Michigan State University College of Osteopathic Medicine.

During the campaign to establish the osteopathic college at Michigan State University, Charles Sellers, M.D., (Sellers 1968, 6) wrote of a countermove by the MSMS, which opposed the idea,

One of the most sensible plans to emerge for a long time in the field of medical education has been the recent suggestion by the members of the Council of Michigan State Medical Society that the three regular medical schools in Michigan include in their courses something about the principles of osteopathy to the end that medical graduates could be granted according to his choice either an M.D. or D.O. degree.

He then called for a single medical practice act, saying,

When medical education and medical examination for licensure in Michigan become uniform, a single medical practice act would be a logical consequence. There is no rationale for more than one system of medical care in the practice of medicine.

The following year, Michigan Academy of General Practice delegates to the American Academy of General Practice Congress of Delegates (Michigan Academy of General Practice 1970, 5) were mandated to “initiate and/or support a resolution to offer membership in AAGP,” to osteopaths. Lee E. Feldkamp, M.D., reported back to Michigan that he had supported such a motion in the national Congress of Delegates, but that it had been disapproved (Vitu 1971, 7).

Medical access for the poor

At the national political level, attention was being turned toward access to health care by the poor, and with a landslide election of Democrats in 1964, the way was paved for the establishment of Medicare and Medicaid (Mueller 1993, 6-7). These programs established the undeniable precedent that government should facilitate access to health care among those who couldn't obtain it for themselves and it radically altered

the way health care would be financed in the United States.

While the traditional American Medical Association position was to resist any governmental involvement in the doctor-patient relationship and the concept of fee-setting by a third-party payor, some physicians advocated expanded and government-backed health care coverage for the poor. Lionel Swan, M.D., as president of the National Medical Association, travelled to Washington, D.C., with several others from the NMA for a half-hour audience with President Lyndon B. Johnson to advise the president on health care issues. Swan left the meeting impressed by Johnson's understanding of issues of race and class as they related to health care services (Swan 1996 Personal interview).

Others, such as Roy J. Gerard, M.D. (1967, 3), of Saginaw, did not necessarily advocate the new program, but urged physicians to adapt to the new system, saying,

The environment around us has changed and is continuing to change. We have new demands from the health consumers, from prepaid insurance, from social legislation, particularly the Social Security Amendments of 1965 and other federal legislation resulting in Title 18 and 19 of the Medicare and Medicaid Acts, respectively. So out of necessity, we must *adapt*. This is not to say that we must *capitulate* but we must mold ourselves with the changes in medicine, both scientific and social, into such a form that will enable us not only to perpetuate the private practice of medicine but to give even a better form of health care.

According to Paul Starr (1982, 370), the profession soon discovered that Medicare "was a bonanza," though Medicaid continued to carry a stigma attached to it.

Movement toward board certification

It was not until 1965 that the American Academy of General Practice was unified enough on the desirability for a certifying board that its Congress directed the Academy officers to proceed with an application for a certifying board (American Academy of Family Practice 1980, 31-33). Although the idea had been proposed repeatedly during the first half of the decade, members had expressed a number of arguments against board certification. One concern was that the general practitioners' scope of practice would be limited by board cer-

tification. This concern focused especially on whether surgery, and to a lesser extent obstetrics, would fall within the family physician's scope of practice if a board was established. Even though they were finding increased difficulty in obtaining hospital privileges, general practitioners valued their traditional right to practice surgery. Another concern was that general practitioners would become divided into a caste system of those who were certified and those who weren't, thereby weakening rather than strengthening their position and accentuating differentials in professional status already correlated with age and race. A more diffuse concern was simply that establishment of a board would not be the panacea that its advocates hoped it would be.

The turnabout came in the context of an intense national debate about the needs of the American public for comprehensive, family-directed medical care. The national commissions were at work, although their reports had not yet been published. A conference sponsored by the Family Health Foundation and focusing on "What constitutes comprehensive medical care for the American family?" immediately preceded the 1965 American Academy of General Practice convention and called for bold new approaches (American Academy of Family Practice 1980, 31-33).

The conference was chaired by John Walsh, M.D., of California, who was soon to become the first president of the American Board of Family Practice. He later reported several points of essential agreement that emerged from the conference, 1) that more family physicians were "vitally needed and desired by the American public," 2) that a three-year training program was necessary and that a method of certifying competence was desirable, 3) that family practice included internal medicine, pediatrics, obstetrics, psychosomatic medicine, and certain definable aspects of surgery, and 4) that "time is of the essence" to effectively produce results (Walsh 1967, 7-8). In addition to influencing the American Academy of General Practice decision directly, this conference was such a success that it generated a series of regional conferences in early 1966 in Denver, Chicago, and Philadelphia to discuss the future of medical training.

A second national conference on Feb. 14, 1967, in Chicago,

explored how best to train a physician to render comprehensive medical care to the American family. Eight Michigan physicians were in attendance, including three from Saginaw. By this time, the national reports had been issued, and their content was reported, compared, and contrasted during the Chicago presentations.

Conferees heard medical administrator James E. Bryan (1967, 17-18) tell them,

What confronts us today is a societal monstrosity; a profession that is standing on its head. Its management function — its generalist coordinator — lies at the bottom of the heap and is rapidly being ground out of existence. We must somehow right this pyramid and stand it on its base. But to do so, we have to create a new family physician, define his form and function, endow him with authority and status, support his activity economically, and create the literature and research base which will give him substantial legitimacy.

Walter Averill, M.D., attended the Chicago conference. He had taken an internship at St. Luke's Hospital in Saginaw in 1961, and then joined the group general practice established by Drs. Robert Toteff and Clyde Davenport. After attending the conference, he enthusiastically began working to change the department of general practice at St. Luke's into a department of family practice, and soon was instrumental in writing a proposal that would establish a family practice residency program in Saginaw — among the first in the country (Averill 1996 personal interview).

Family practice attains specialty status

It would take two more years of intense negotiations at the national level before family practice was approved as a specialty by the Advisory Board for Medical Specialties, the AMA Council on Medical Education, and the Liaison Committee for Specialty Boards on February 8, 1969. The American Board of Family Practice was then legally established in April of that year (American Academy of Family Practice 1980, 51-52).

To be eligible for examination, a physician must have completed an approved family practice residency program or have been active in family practice for at least six years and have

completed at least 300 hours of acceptable continuing education (Geyman 1980, 16). Practice eligibility was only acceptable until 1978. After that time, all candidates were required to have completed an approved three-year family practice residency program.

Continued reservations

Even as the struggle had finally been won, some Michigan physicians expressed reservations about the wisdom of specialty status. In March, Francis P. Rhoades, M.D., himself long an advocate of specialty status, reported

Many of our AAGP members . . . are deeply concerned that certification may not bring the prestige and commensurate remuneration that is necessary if the requisite numbers are to be attracted to the new specialty. They also fear that certification may narrow their practice and reduce their surgical and obstetrical hospital privileges. They are apprehensive that they may be regarded as something less than the physicians they already are.

But he tried to reassure them,

On the bright side of the picture, the Board may well prove to [be] the salvation of family practice. In 1931, 84 percent of practicing physicians were G.P.'s, the present figure is now less than 30 percent. General practice residencies have had the lowest percentage of takers . . . For the foreseeable future there will be many sections of our country that will need and welcome the services of the family physician. Our present G.P.'s and the new family physician will work in harmony to supply this vital need. (Rhoades 1969, 5).

In the same issue of *The Bulletin*, Michigan Academy of General Practice President Lee E. Feldkamp, M.D., (March 1969, 3) tried to reassure test-shy general practitioners,

While the prospect of taking a Board examination has engendered some apprehension for many who would be practice eligible, those who have submitted to the examination during the planning phase have assured me that it is practice oriented and within the capabilities of the active generalist who has continued his postgraduate education. Board certification will not be a requirement for Academy membership . . .

Unconvinced, a few months later Arthur Goldberg, M.D., (1969, 6) wrote in *The Bulletin*

Specialty status for the family physician, presently the aspiration of the American Academy of General Practice, is . . . not the answer. The inherent tendency of the specialist on the staff of a large hospital to feel and act superior to the generalist will not, in any large measure, be mitigated by this spurious specialty classification.

Nonetheless, the specialty board and the development of an educational system that would prepare young physicians for certification were now a certainty.

Development of an identity

Though in some ways the path now seemed clear, the next few years would be a period of intellectual ferment and political turf battles as the discipline defined itself and fought for positioning among other proposed models of health care delivery. Within the discipline there were considerations of the appropriate scope of practice — especially the role of surgery and obstetrics — and a search for the unifying concept that would define family practice.

In addition to the internal ferment, advocates of family practice continued to nudge a medical educational establishment that had no desire to budge. None of the three medical schools in Michigan would enthusiastically embrace a new department of family practice. Schools such as University of Michigan would offer new configurations such as med-peds programs that provided for dual certification in internal medicine and pediatrics for generalist physicians, counterpoised to the development of family practice.

The 1960s and 1970s brought with them a number of health care innovations in addition to the development of family practice, such as the development of training programs for physician assistants and the emergence of the nurse practitioner. The relationship of family practitioners to the newly emerging physician assistants and nurse practitioners would still need to be negotiated.

Feldkamp (May 1969, 4) reflected this uneasiness about the place of family physicians in the health care system when he warned,

Board recognition was essential to our cause but will not automatically provide family physicians, or even insure the opportunity for the student and young graduate to secure the needed training. We still face the activists who would promote group practice as a substitute for the family physician, others who envision the use of allied health personnel and a lesser trained physician-like technician to assume our role.

Acceptance of family practice as a specialty was soon followed by reorganization of the Michigan chapter of the Academy (Dooley 1970, 3) and a new name, the Michigan Academy of Family Physicians.

Family Practice: Struggles

“When I went to practice medicine in Jackson, one doctor said to me, ‘You probably won’t get anywhere because all of the women who have ever tried it never got anywhere. They’re quitters.’”

— *Hilda Habernicht, M.D.
Berrien Springs*

“I told my high school teachers that I wanted to be a doctor, and they told me that was too hard for a woman and that I should think about being a nurse or a teacher. Even though I was in accelerated science and math classes, I still got that kind of feedback. I graduated in the upper 5 percent of my graduating class. I went to college and said the same thing, that I wanted to pursue a pre-med program, and got the same kind of response.”

— *Carol L. Monson, D.O.
Okemos*

“At Ft. Polk I earned my privileges for upper and lower endoscopy. I brought those privileges with me to Foote Hospital. One of the physicians there was very supportive outwardly that I would be able to present my privileges to the executive committee and obtain those privileges. When it came down to the meeting, there was nothing but animosity and questioning. It didn’t come from him, but from one of the other internists. I was forced to withdraw my request for privileges, even though I had had those privileges in a federal facility. I was the only D.O. doing that, so it could have been a D.O. issue. It could have been a family practice issue. I’m not sure.”

— *James Taylor, D.O.
Jackson*



5 How Should Family Physicians Be Trained?

Community hospitals pioneer in offering residency programs

The year 1968 had been one of uncertain waiting as Essentials of Approved Residencies were drawn up for the anticipated specialty of family practice. Programs which were already offering more than the traditional one-year rotating internship found themselves ready to make the necessary adjustments to their programs, but uncertain about what would soon be required of them. With the approval of family practice as a specialty, several community hospitals were poised to submit their applications to train family practice residents. Midland and Saginaw programs were approved on Dec. 3, 1969, in the third group of programs to be approved nationwide (ACGME, 1996, 1) Sparrow Hospital in Lansing was approved the following summer, and Oakwood Hospital in Dearborn was approved in August 1971.

Midland General Hospital.

In 1967, Midland General Hospital had instituted a 2½ year family practice program, again sponsored by the University of Michigan. Part of the participants' educational experience involved ongoing responsibility for the health care of a specified number of families through the program's Family Clinic. Each young doctor also spent one-half day per week working in the office of an attending physician. Robert E. Bowsher, M.D. (Hoheisel 1967, 1173), the hospital's director of medical education, explained that in this innovative program, "We want the people in our program to recognize the patient as an individual, looking at him not as a case or a disease entity, but as a whole human being, as a member of a family and a community."

In July 1968, the American Medical Association's Department of Graduate Medical Education sent out a memo saying,

Even though "Essentials" for family practice programs are not in existence at this time, hospitals having both approved rotating internships and two-year general practice residency programs are free to organize such programs into a planned continuum, and to develop brochures for local use, describing such programs as preparing candidates for entry into family practice. (Nunemaker 1968, 2)

Bowsher, with a 2½ year general practice residency already in place, had been waiting for the final revisions of the Essentials of Approved Residencies before he submitted an application transforming his program into a full family practice residency. (Bowsher 1968). He was encouraged, however, to submit an application on short notice in November 1968 "for approval of our residency program in family medicine," saying, "I understand that this can be nothing more than provisional approval pending final action of the AMA House of Delegates." He noted in his cover letter to Leland B. Blanchard, M.D., that his application was submitted in narrative form, rather than on the designated application form because the application "actually does not very well fit the description of our program since it is not really set up as an integral part of a large university medical center."

In his 1968 application, Bowsher described the outpatient facilities for the 2½ year program thus,

The "Family Clinic" consultation room is located adjacent to the emergency room and has two examining and treatment rooms across the corridor from it. For additional outpatient experience, we make rather liberal use of selected physicians' offices which are located nearby.

One year later, when submitting formal application for approval as a three-year residency program in family practice, he was able to boast of a 3,600 sq. ft. family practice office that was nearing completion on the hospital grounds (Bowsher 1969, 1). The residency's new outpatient facility would include a waiting room, receptionist and business office, three consultation rooms, six adult examining and treatment rooms, two pediatric examining and treatment rooms, a minor surgery room, laboratory, storage, and work room. Coordinator of the clinic was to be a local physician, Charles Schoff, M.D., who had also coordinated the smaller Family Clinic.

Approved Dec. 3, 1969, as the one of the first two family

practice residency programs in Michigan, the Midland program already had residents enrolled in years two and three because of its ongoing general practice program. Third-year resident David W. Knox later became director of the program. The program continued its affiliation with the University of Michigan.

Bowsher (Anon. 1970, 6) articulated the program's goals and philosophy as the training of residents in

continuing and comprehensive care of patients and families. It is important that these young physicians have the experience of following and caring for a number of families on a continuing basis during the residency. Emphasis is placed on considering the patient in terms of an individual with a problem rather than a disease entity. Effects of the illness of the patient on his family and environment, and vice-versa, are also emphasized along with preventive care.

Soon, according to Schoff, Bowsher had "hoodwinked" Schoff into closing his practice and joining the program full time (Personal interview 1996). Schoff had been in general practice in Midland since 1956. After the family practice residency was approved, Bowsher tried to recruit him to work full time, but Schoff consistently refused. Something of a politician, Bowsher had a talk with Mrs. Schoff during a party. Schoff recalls, "She came down real heavy. 'I needed to do something like that,' and 'it wouldn't be as much work,' and all that sort of stuff." Mrs. Schoff won the day, and her husband became associate director of family practice.

Schoff was satisfied with the arrangement that he and Bowsher had worked out. He would tend to the needs of the residents and Bowsher would handle the program administration. Unfortunately, Bowsher was soon diagnosed with lung cancer and his illness progressed rapidly. Schoff was left in charge of the program. Recognizing that he did not care for program administration, he soon left family practice to handle Midland General's emergency room.

Saginaw.

The family practice residency program in Saginaw received its approval by the Residency Review Committee during the same session in which the Midland program was approved. Walter Averill, M.D., was the son of a Saginaw physician who returned from Wayne State medical school in 1961 to do his

internship at St. Luke's Hospital in Saginaw. Through the 1960s, he became increasingly interested in the concept of family practice and was instrumental in recruiting interns for the St. Luke's program. In 1967, St. Luke's was approved by the American Academy of General Practice to conduct a family medicine program. Averill recalled that he was instrumental in changing the name of the Department of General Practice at St. Luke's to the Department of Family Practice.

At about the same time, the three hospitals in Saginaw, St. Mary's, St. Luke's, and Saginaw General began to work cooperatively. The first joint venture for the three institutions was the development of a common laundry facility. With that proving to be cost effective, they began to consider joint educational programs. On July 1, 1968, they began a cooperative medical education program through Saginaw Cooperative Hospitals, Inc. (SCH) (Fisk 1986, 86).

Once family practice had been designated a specialty, Averill began writing an application for approval of a family practice residency at St. Luke's Hospital. It was approved Dec. 3, 1969, and Curt Keller, M.D., and Stan Johnson, M.D., joined the program as its first residents.

Averill (Personal interview 1996) was director of the program, but soon realized that he could not devote adequate time to the developing program and maintain his full-time practice. Leaving the program was not easy, and he later described it as "kind of like putting a baby up for adoption."

Roy Gerard, M.D., was selected to raise the "baby." Gerard had come to Saginaw from the University of Michigan, where his advisor Harry Towsley, M.D., had told him that if he went into general practice, he "would never amount to anything." Undaunted, Gerard had set up a practice in Saginaw. His office sign read, "Roy J. Gerard, M.D., Family Physician." He later recalled, "this got me in trouble with the medical society because they said it was advertising, and I have been explaining the name 'family physician' ever since." Before his



Figure 2. First four family practice residencies in Michigan.

practice opened, he wrote a pamphlet for his patients explaining what role he had planned for families. At the time he was chosen director of the family practice residency, Gerard was also director of medical education at St. Mary's Hospital. Gerard's office was to become the model Family Practice Unit for the new program.

Averill and Gerard had differing philosophies of family practice. Averill (Personal interview 1996) believed that family physicians should be trained to perform the maximum range of procedures possible, including surgery and obstetrics. He feared that otherwise the family physician risked becoming simply a referral agent for other specialists. Gerard was more oriented toward medicine and toward the psychosocial dynamics of the family than he was toward surgical procedures. The philosophical direction of the residency program shifted, therefore, as the program developed under Gerard's leadership.

The integration of educational programs into SCHI accelerated during the early days of the residency program. Soon, with a little nudging from Peter Ways, M.D., associate dean for the College of Human Medicine's Saginaw campus, Gerard realized that developing the residency program meant leaving private practice to devote full time to the program. He was able to sell his practice to SCHI where it became the residency's practice, thus preserving the jobs of his staff. Ninety-four percent of his private patients elected to move to the residency practice.

The Family Practice Center opened in late January 1971, and the practice soon had 24 residents, serving patients out of 16 exam rooms in the trailers that constituted the Center.

E.W. Sparrow Hospital.

Six months after the approval of family practice residency programs in Midland and Saginaw, E.W. Sparrow Hospital in Lansing received its approval as the third program in Michigan. Growing from informal conversations between Harold "Pat" Crow, M.D., and Andrew D. Hunt, Jr., M.D., dean of the Michigan State University College of Human Medicine in 1965, a committee was formed which worked for five years to develop the program. The proposed family practice residency was to be sponsored by Sparrow Hospital and affiliated with Michigan State University (*Orifice* 1973, 1,4). Crow, the program's first director, closed the Lansing private practice that he had begun

in 1964 and invited his patients to transfer to the group practice that was being set up at Sparrow's family practice clinic.

Crow strongly believed in a nonrotational residency program (*Orifice* 1973, 4). The first year of the program was still operated on the rotational model, with exposure to skills such as could be learned in obstetrics, pediatrics, and internal medicine. First-year students spent two half-days per week in the family practice clinic. In the clinic, residents began to build their own roster of patients, who would be followed for the remainder of the residency program. The second and third years of the program sought educational autonomy from the other specialties. The program, for instance, developed its own obstetrical patient population comprised of private family practice center patients and the Ingham County Health Department Clinic prenatal patients. Residents utilized obstetrical staff as consultants when needed and progressed "with appropriate supervision and privileges at each level." (Crow et al. 1980, 831).

When interviewed by a writer for *The Orifice*, Michigan State University's medical school newsletter, Crow stated,

One of the major decisions that we made in setting up the program was that we felt the family physician was entitled to a personal family life much the same as other people or as some of the specialty physicians. We thought that many people had left general practice because of the demands of the practice in terms of number of hours, effort, and frustration that had led many private physicians to rapidly reach the 'burn out' point... Obviously, one of the ways to do this is to incorporate a group practice in the program... (*Orifice* 1973, 1,4)

Crow arranged the residency into a group practice format based on a four-physician model. Second and third-year residents had one week out of four—or two weeks together out of eight—when they were free from patient care. As part of his philosophy that residents should learn to practice in a group model, Crow emphasized office management skills for his residents, intending that they be well prepared to assume the management of an efficient family practice office.

Crow soon recruited Robert Landick, M.D., as associate director. Landick had been a solo general practitioner in Charlotte, who later specialized in anesthesiology. After a few years in which his work as an anesthesiologist consisted of "hours of

boredom, punctuated by moments of terror,” Landick longed for more patient contact (Personal interview 1996). As a preceptor for the Michigan State University College of Human Medicine, he had discovered that he enjoyed teaching.

Landick brought to the program a strong interest in the behavioral aspects of medicine. He established a system of audiovisual taping, using a one-way mirror, to tape residents as they conducted medical interviews. As faculty and residents reviewed the tape together, Landick especially challenged the residents to identify the feelings that they had brought to the interview with them, and explore how these feelings and reactions might have influenced the course of the contact with that patient.

Oakwood Hospital.

Oakwood Hospital in Dearborn had established a two-year general practice residency in 1958 just five years after the hospital opened. The hospital had a strong general practice presence on its staff, and developed a tradition that a general practitioner would be chief of staff every other year (Battle, personal communication, 1994) In 1969, Everal Wakeman, M.D., assistant director in charge of emergency and outpatient services which included the general practice residency, reported that the program was being redesigned to meet the requirements of the Essentials for Residency Training in Family Practice (Wakeman 1969). The family practice residency program was approved as Michigan’s fourth program on Aug. 30, 1971.

The old general practice residency program was quite unstructured, according to Wakeman (Personal interview 1996). “You got somebody in the hospital, and they stirred around with some of the old boys,” he remembered, while his new family practice program provided more structure and intensive training.

Despite Oakwood’s generalist tradition, Wakeman found himself in a battle with the board for financial support and resources. Adequate space for the program’s clinic was not provided at the hospital.

Sumpter Township in southwestern Wayne County had no active physicians, although the Wayne County Health Department did operate a baby clinic for township residents. Rep-

representatives of the township visited Wakeman at the hospital, exploring ways that the residency program could help serve the area. The hospital board was convinced to purchase a house trailer which was then placed in a township park. Wakeman recalled that the trailer had three bedrooms, a kitchen, and a living room. The kitchen doubled as office and laboratory.

While the residents worked out of the house trailer, a township resident made what Wakeman considered an irresistible offer, but he had not adequately counted on the vagaries of hospital politics. He later recalled,

There was a fellow out there who had 120 acres or more. He said, "I'll give you five acres, your choice, any five acres I own. Get your hospital attorney to come and talk with my attorney." So we came back and told the hospital attorney, who said, "Well, have *his* attorney come and see *me*." Then the old fellow out there who was going to give us the land had a stroke and died, and the hospital attorney had a stroke and died.

And the deal was off.

Finally, the hospital board did agree to purchase land and build a clinic in Sumpter Township. Although his bureaucratic headaches did not end with this decision, Wakeman was pleased with the size and convenience of the new clinic building.

Wakeman recalled that it was difficult convincing medical students to take a chance with the new specialty of family practice. "The all-American boys were taught that they had to go into internal medicine or ob/gyn to be a doctor," he remembered. He also found himself battling with the other specialties at Oakwood to accept his residents and provide them with a meaningful experience on their rotations.

St. Joseph Hospital in Flint, under the directorship of Lewis Simoni, M.D., followed Oakwood, obtaining approval in December, 1971. By the end of 1973, there also were family practice residency programs in Grand Rapids, at St. John Hospital in Detroit, and at Detroit Medical Center. By the end of the decade, 16 programs had been approved in Michigan.

Medical schools ignore appeals

While several community hospitals were intrigued by the possibilities offered by the new specialty status and were

eager to offer approved family practice residency programs, Michigan's three medical schools were much less enthusiastic. Between 1969 and 1974, an intensive campaign was waged on several fronts to encourage Michigan State University, Wayne State University, and University of Michigan to establish departments of family practice within their medical schools. These campaigns were primarily spearheaded by the Michigan Academy of Family Physicians and ranged from the establishment of a family practice club for medical students to playing political hardball through the state legislature's medical school budget appropriations.

University of Michigan.

In the late 1960s, the University of Michigan's response to the state's dearth of primary care physicians was rooted in its specialist tradition. A committee chaired by B.C. Payne, M.D., formulated a Program in Comprehensive Continuing Care. The staff was to be comprised of faculty specialists in internal medicine and pediatrics, plus part-time community physicians. Services at the program's clinic would include personal health, periodic health appraisal, acute and chronic illness, specialist consultation, immunizations, dietary instructions, well baby care, family planning, and psychiatric evaluation. The site would provide training for both internal medicine and pediatrics residents (Rhoades 1969, 5).

With the program's timing coinciding with the birth of family practice as a specialty, some family physicians criticized the university for failing to provide a program that would adequately train a well-rounded family physician. Lee E. Feldkamp, M.D., came to the program's defense, however. He argued,

We must put aside our emotional interpretations and recognize that for the first time a planned attempt is being made within the medical school to provide an exposure to family practice, and to thus stem the precipitous decline in the number of men entering family practice... if experience indicates deficiencies as the program evolves, in the light of practice needs, let us be ready to offer constructive criticism in a cooperative way. (Feldkamp 1969, 3)

Although the University of Michigan was not directly providing training in family practice, interest in the new spe-

cialty was increasing among students. A study of trends in career interests among University of Michigan medical school graduates in 1971 and 1972 showed that interest in general/family practice jumped from a distant fourth place in 1971 to second place in 1972, with internal medicine in first place—an increase of 15.7 percent in the course of one year (Herrmann 1973, 451-2).

Michigan State University.

While Wayne State University and the University of Michigan had a history of encouraging students to become specialists rather than general practitioners, Dean Andrew D. Hunt, Jr., M.D., at Michigan State University's new College of Human Medicine voiced a different concern. The medical school at MSU had been established at least in part to meet the growing need for primary care physicians in Michigan. Hunt was firmly in favor of an interdisciplinary approach to medical training, and he deplored the seemingly inevitable establishment of fiefdoms within medical schools as each specialty guarded its turf against other departments.

Hunt was interested in training medical students for careers in “first contact specialties,” and felt that the principles of family medicine should be integral to all medical training. In June 1969 he wrote,

The individual cannot be understood separately from the understanding of his family, his community, his educational experiences, and the various environmental impingements to which he has been subjected. Thus, if you wish, “family medicine” is fundamental to our educational effort.

In 1969, MSU was still a two-year medical school and Hunt's efforts were focused on obtaining four-year status. He was supportive of the developing family practice residency program at E.W. Sparrow Hospital in Lansing, but did not see increased visibility for family practice or establishment of a department of family practice as a priority within the medical school.

Family Practice Club

In 1969, aware of the inhospitable environment of academic medicine, MAGP president Douglass Haddock, M.D., reported to the Academy membership,

In the continuing quest for more family physicians, we must, by necessity, start at the beginning—the medical schools... Dr. James Dooley and Dr. Bowsheer... are busy formalizing plans to set up family practice clubs in the medical schools of our state. Experience has shown us that working with the medical educators in developing family practice programs in the Schools of Medicine is a tedious job requiring much patience by all parties concerned. (Haddock 1969, 3)

Dooley later recalled that the Academy recognized that the medical schools could be influenced through their students. He said, “I postulated that we should stimulate the medical students themselves to clamor for family physicians. So we established family practice clubs in the three medical schools. That was very effective.”

Under Dooley’s leadership, planning for a Michigan Family Practice Club continued into the fall, with the first meeting in Ann Arbor on Nov. 11, 1969. According to Dooley, Michigan was the sixth state to establish a family practice club. More than 90 students and their guests attended that first meeting, with 34 Academy members and their wives acting as hosts. Carroll Witten, M.D., of Louisville, Kentucky, a past president of the American Academy of General Practice was the inaugural speaker. Witten, in 1965, had been instrumental in the AAGP shift from opposing to supporting the idea of specialty status for family physicians. Dooley explained, “The Ann Arbor campus was chosen simply because it is centrally located, has the largest number of medical students, and affords the greatest challenge to creating this revolutionary environment in the lives of medical students.” (Dooley 1969, 6)

Shirley McCormick, M.D., began medical school at the University of Michigan in 1968. McCormick later attested to the club’s influence in encouraging students to consider family practice

This club met regularly “off campus” and many of us became influenced to enter the new specialty of family practice. As a result of encounters with local family physicians at these meetings, I signed up for my senior circle 10 rotation at the Chelsea Medical Clinic in Chelsea. While there, I became sold on family practice. (McCormick n.d., 2)

At Michigan State University, medical student James Weatherhead became the prime mover in establishing a campus

family practice club. Weatherhead did not recognize the clubs as being part of a political strategy. He later remembered, "The basic objective of the club was to introduce students to the idea of family practice as a means of primary care. At no time was I ever told that one of the purposes of the club was to help establish a department of family practice in the college."

Donald McCorvie, M.D., the faculty advisor for the club, concurred, "We didn't try to get the students to say, 'Let's assault the dean's office!' We just wanted to show the students that family practice is a viable form of medicine." (Gerard and Smith 1979, 9)

Political avenues

While the establishment of family practice clubs for medical students may not have been directly recognized as political pressure, there was no doubt that the carrot and stick technique applied by key advocates within the state legislature would eventually be recognized and responded to by the medical schools.

Michigan's state funded universities were somewhat safeguarded from public pressure by the state constitution, which declared them to be autonomous entities reportable to their own elected boards. That did not make them totally impervious to political pressure, however, and the Michigan Academy of General Practice began to look into the ways in which their concerns could most effectively be made known. Gerard and Smith recorded the events of this era in a report to the W.K. Kellogg Foundation in 1979 and the following summary draws upon their report (Gerard and Smith 1979, 4-8).

In 1970, the Academy created a Committee on Legislation and Public Policy, headed by Robert W. Oakes, M.D., a young physician from Harbor Beach. Several years earlier, Oakes had worked on the successful state senate campaign of Alvin DeGrow, a Republican from the Thumb Area. When Oakes became chair of the MAGP committee, he turned to Sen. DeGrow for assistance. DeGrow recognized that advocacy of family practice could help resolve the lack of medical care in his own and other rural districts in Michigan, and he emerged as the leading proponent of family practice in the state legislature.

One of the first actions of the Academy committee was to purchase 10 tickets, at \$100 each, so that physicians from the

Academy could attend a Sept. 15 Republican legislative dinner in Lansing. Through the Academy's Wayne County Chapter, it also purchased tickets to a Democratic pre-election fundraiser. "The purpose of this is to show that we are there when they need us so that when we need them they will listen," Oakes explained.

In December 1970, Oakes sent the Michigan legislative service bureau the proposed text of a bill that had been approved by the board of directors of the MAGP. The purpose of the bill was to authorize the governing boards of the three medical schools to create departments of family practice.

Academy president James Dooley, M.D., explained to his constituency,

It is not our intention to force the medical schools to establish such departments but rather to attempt to ease the burden faced by the schools each year in their attempt to thoroughly and equitably allocate funds to reach the goals of the institution. The Academy feels secure in its belief that the people of Michigan through their legislative representatives will be given the needed and desired opportunity to direct the medical educators of our state to train more family physicians, who are so direly needed in many areas, and that such legislation will hopefully allocate specific funds for this purpose.

In February 1971, DeGrow and three other legislators met with representatives of the Academy at Dines Restaurant in Lansing to discuss the proposed bill. Jack M. Stack, M.D., of Alma, who kept the minutes, wrote,

a proposed plan of action was that a concurrent resolution be proposed before the Senate and the House with some whereas clauses that mention the problems of shortage of physicians in many areas . . . and a resolve to encourage the development of more family physicians and departments of family practice in the medical schools . . . Later, when the appropriations bill for higher education is being considered, an amendment to request the medical schools to create departments of family practice could be proposed, even with a modest dollar proposal attached.

DeGrow and twelve cosponsors introduced Senate Concurrent Resolution 47 in March 1971. By May, both houses had adopted it.

He had three copies of the resolution framed, and one was

presented to each of the medical school deans by James Dooley, M.D., president of the Michigan Academy of General Practice, during a June 11 evening meeting at Weber's Inn in Ann Arbor. Edward J. Kowaleski, M.D., president of the American Academy of General Practice spoke during the meeting, saying that Michigan was one of only a few states which was not making progress toward establishing academic departments of family practice.

Senate Concurrent Resolution No. 4 of 1973 established a Joint Committee on the General Practice of Medicine, specifying that state senators, representatives, medical students, representatives of the medical school deans, and representatives of professional organizations such as the Michigan Academy of Family Physicians would be represented on the committee. The committee concerned itself with the establishment of departments of family practice in medical schools and the financial support of family practice residencies in Michigan.

According to Gerard and Smith, the clout of the committee was indirect, stemming from the other legislative offices held by its members. Senators DeGrow and Garland Lane also were members of the Senate Committee on Appropriations, and in 1973 Lane chaired the Joint Capital Outlay Subcommittee. Sen. Lane was a Democrat from Flint, and one of the most influential men in the legislature. He had been a major force in increasing appropriations for the Wayne State Medical School and in supporting the development of the MSU College of Human Medicine from a two-year to a four-year medical school.

Explaining his influence with university administrators, Lane said, "I never told them that we wouldn't fund their school if they didn't establish a department of family practice. I just said I might not look so kindly on their requests." He explicitly linked appropriations and family practice on Nov. 1, 1973, during a joint meeting of the special legislative committee and the Joint Capital Outlay Subcommittee. Lane explained to the committee members that the purpose of the special study committee was to find out why family practice programs had not developed in the medical schools and why more medical students did not specialize in family practice and remain in Michigan to practice.

Oakes and several other family physicians campaigned

door-to-door for Lane during his 1974 reelection campaign. However, Lane lost the election, ending a 26-year career in the state senate.

Osteopathic college joins Michigan State University

The movement of Michigan's only osteopathic college from Pontiac to Michigan State University in East Lansing became inextricably intertwined with the College of Human Medicine's desire to expand from a two-year allopathic school to a four-year degree-granting medical college. The osteopathic physicians had engaged Edgar L. Harden as their chief lobbyist with the Michigan State Legislature, seeking to attach their four-year private osteopathic college to a publicly funded university. The University of Michigan spurned the school, but Michigan State University president John A. Hannah seized the opportunity.

When the legislature approved the merger, however, they attached a rider stating that the university which accepted the osteopathic college must, itself, have a four-year allopathic college as well. This rider paved the way for the expansion of the College of Human Medicine to a four-year degree-granting institution. A Department of Family Medicine already existed within the College of Osteopathic Medicine, but it was only with the expansion of its own curriculum into a four-year school that the College of Human Medicine could begin considering the possibility of a department of family practice (Gerard and Smith 1979, 11-12).

Family practice develops at Michigan State University

In January 1971, Dean Andrew D. Hunt, Jr., M.D., wrote to Harold H. Hiscock, M.D., president of the Michigan State Medical Society regarding a recent MSMS resolution that urged the establishment of a department of family practice. Hunt acknowledged Michigan's need for an increasing supply of family physicians and assured Hiscock that this was one of the medical school's priorities, listing several ways in which the College of Human Medicine was contributing to the solution of this problem. He went on to express his reservations about establishing a department of family practice, saying,

Whether or not we establish a separate department of family medicine will remain to be seen...As you well know, the mere establishing of a department in no way assures that it will impact strongly on student career choices...The effect of such a department could well be to absolve the other clinical departments of responsibility to teach primary care and one could well question the wisdom of such an event. (Hunt Jan. 13, 1971)

However, on Feb. 23 Hunt sent a memorandum to members of a newly formed Ad Hoc Committee on Family Medicine charging them with the task of exploring the advisability of establishing a department of family medicine within the College of Human Medicine (Hunt Feb. 13, 1971). The Ad Hoc Committee was under the leadership of Robert Daugherty, M.D., director of the Interdepartmental Curriculum at the College of Human Medicine. Among the committee members were Harold "Pat" Crow, M.D., Roy Gerard, M.D., and Lewis Simoni, M.D., each the director of a family practice residency program. At that time, there were only nine departments of family medicine in United States medical schools (Gerard and Smith 1979, 13).

Hunt had hoped to have the committee's response by June, but it was November when the report was presented. The Ad Hoc Committee suggested that the college establish an Office of Family Practice Education and Research (OFPER). The committee stopped short of recommending establishment of a department for two reasons. They felt that the few existing departments were having problems defining their roles and responsibilities in relationship to other clinical departments, and they were concerned about the shortage of potential full-time family practice faculty. The halfway measure of establishing an Office of Family Practice could provide time to work on these problems (Gerard and Smith 1979, 14). OFPER would "be a freestanding academic unit with a full-time director who has full power to appoint his own faculty." (Ad Hoc Committee on Family Medicine Nov. 18, 1971).

The Ad Hoc Committee declined to propose a curriculum for family medicine saying that the new office should develop the curriculum, but they did propose several activities that would be the responsibility of the new office, including development of preceptors, teaching, development of a family practice clerkship, and responsibilities for the primary clerkship.

Following the release of the report, there was not much progress toward the establishment of OFPER. The college was putting greater priority on the creation of departments of surgery and ob/gyn which were required for accreditation as a four-year medical school, and Hunt remained unconvinced about the need for development of family practice within the college.

When reviewed by the College Advisory Council of the College of Human Medicine, the Council approved the concept, but urged that the report be modified to “include the suggestion that serious emphasis be given to the teaching of issues and processes relating to the family, and that input from other medically related programs, including nursing and social work, be considered for inclusion in the program.” (Kallen June 22, 1972)

Almost two years after the Ad Hoc Committee’s report was issued, in December 1972, Hunt set up an Implementing Task Force for Family Practice, with Daugherty again as chair (Gerard and Smith 1979, 19-20). In setting up the task force, Hunt acknowledged that the report “has not been the beneficiary of action from this office. This inaction is the result of a number of forces, issues, and confusions which need not be repeated in this memorandum. Suffice it to say that the time has now come for implementation.” (Hunt December 14, 1972)

In the same memo, Hunt brought forward a proposal that was later to prove challenging to the developing department. He suggested,

with family medicine being fundamentally a community-based discipline, and given the distributed multi-community arrangements characterizing the development of this college, family medicine in this institution could very logically be our first department whose origins are in fact in the communities. With such an arrangement, family medicine would have multiple foci in the various parts of the state subsuming graduate and undergraduate functions, and with appropriate academic and financial arrangements generated and negotiated according to mutual needs.

The composition of the Implementing Task Force differed from that of the Ad Hoc Committee in the addition of two faculty from the Michigan State University School of Nursing,

Isabella Payne and Dorothea Milbrandt (Gerard and Smith 1979, 21). They were committed to an interdisciplinary approach to medical education and felt that the development of family practice would be an ideal setting for the development of interdisciplinary team health care.

Prospects for implementation were given a boost by the availability of W.K. Kellogg Foundation money for development of a department of family practice. Gerard and Smith (1979, 21-22) note the conceptual development that took place between the first and the fourth draft of the grant proposal that the Task Force prepared in 1973 for the Foundation.

The January draft makes no mention of nursing, and focuses on the new department's relationship to established medical professions. The definition of a family physician in that first draft was exceptionally loose, and was reflective of the apprehension in the existing clinical departments that family practice would pre-empt the entire field of long-term primary care medicine . . .

In subsequent drafts of the proposal, the idea of a family physician is more tightly defined. In the fourth draft, which was the one officially submitted to the W.K. Kellogg Foundation, the concept emerges of a family physician as a specialist concerned with the health of a family. More importantly, the third and fourth drafts come to grips with the potential intellectual content of family medicine. Whereas the proposed department was at first perceived as an intellectual and organizational appendage of the existing clinical departments, it came to be recognized as having the potential of making its own contribution to the theory and practice of medicine. From that more secure academic and professional footing, the department was expected to establish interdisciplinary connections with . . . other units of Michigan State University.

Gerard and Smith (1979, 22) give much of the credit for emphasizing the intellectual potential of family medicine to Ray Helfer, M.D., of the Department of Human Development (pediatrics). As a member of the task force, Helfer argued that the intellectual basis of family medicine should be the study of family interactions as they affect health and disease.

As the proposal was being developed for the Kellogg Foundation, a search committee to select a chair for the family practice unit first met on July 12, 1973. They immediately

agreed that they did not have adequate information about the College's commitment to developing a family practice unit, the financial basis for the position, the unit's eventual status as an office or as a department, and the relationship that would be established with the osteopathic college's Department of Family Medicine, and sought these answers from Acting Dean Donald Weston, M.D. (Kirschbaum July 12, 1973).

At their second meeting, the committee agreed on the importance of board certification in family practice as a qualification for the position. The committee began to actively circulate the job description for chair of a *department* of family practice. On Aug. 10, Thomas S. Kirschbaum, M.D., chair of the search committee, received the official charge from Dean Andrew D. Hunt, Jr., M.D., to recruit a chair for the Department of Family Practice. Hunt's letter (Hunt Aug. 10, 1973) said, "It has been decided . . . that Family Practice would have full departmental status in the College."

Roy Gerard, M.D., was at that time the director of the family practice residency in Saginaw. Gerard had been a member of the Ad Hoc Committee, the Implementation Task Force, and the Search Committee but he resigned from the Search Committee when he decided to apply for the position himself.

As he remembers his decision to apply for the position of chair, Gerard said,

Having invested a lot of my personal philosophy in the Kellogg document in terms of what a family doctor was, I found myself interviewing people who wanted to be chair of this department, who didn't have a prayer of understanding where I thought the department should go. I kept thinking about that, and I think I lost my objectivity in terms of the people who were applying for the position.

So, I talked to Dr. Hunt. I said, "I'm having a hard time with this. What do you think I ought to do?" He said, "If you're interested in the position, you're going to have to throw your hat into the ring," which is what I did. I didn't think they would pick me. I thought they would probably try to pick someone who had experience working in a medical school in some capacity.

In August 1974, the search committee submitted its recommendation to the dean. The committee had interviewed nine candidates, three of them twice and selected Gerard (Gerard

and Smith 1979, 29-30). The June 19 announcement that the W.K. Kellogg Foundation was allocating \$667,931 over a four-year period for the development of the Department of Family Practice provided a fiscal underpinning for the process (Featherstone June 19, 1974).

Wayne State University embroiled in conflict

While development of a department of family practice was sometimes controversial at Michigan State University, the process became contentious at Wayne State University.

In a 1975 report, the Michigan Academy of Family Physicians summarized Wayne State University's path toward a Department of Family Medicine as described below. (Michigan Academy of Family Physicians Feb. 18, 1975, 5).

In 1970, Wayne State had created a Department of Community Medicine. Junior medical students rotated for five weeks through the department, where they attended lectures pertaining to the economics of medicine and the delivery of health care. They spent a four-week preceptorship in the office of a family physician. Based on the success of this preceptorship, the name of the department was expanded to the Department of Community and Family Medicine.

In 1972, Robert Coye, M.D., was named dean of the Wayne State School of Medicine. Family physicians, community physicians, interested legislators, and health planners became clear that it was necessary for family practice to have its own autonomous department and held several meetings with Coye about the possible development of a department of family practice at Wayne State.

The report states

In January of 1973, at a dinner meeting, several members of the administration of Wayne State University School of Medicine and several members of the Michigan Academy of Family Physicians, medical students from Wayne State University, interns and residents of the Detroit area, met together to discuss the possibility of creating a department of family practice. At this meeting, we were told by Dean Coye that at this time, he saw no need for the creation of a department of family practice, and that he could not visualize the creation of a department of family practice for several years. He further declared the only way that a department of family practice would be created would be for family practitioners

to join the faculty in various departments in the university on a full time basis to prove their merit. Then if they proved the worth of family practice, he would then consider creating a department of family practice.

The Michigan State Legislature, concerned that minimal action had been taken by the medical schools to establish departments of family practice as urged by Concurrent Resolution #47 two years earlier, established a legislative committee to study the status of family practice in Michigan. Hearings were held at Wayne State, which the dean and others addressed. The legislative committee determined that there was, indeed, a need for a department of family practice at Wayne State.

About this time, the state legislature was considering funding of a new Wayne State University Clinics Building. Funding authorization became tied overtly to the expectation that Wayne State University dedicate itself to the training of family physicians (Michigan Academy of Family Physicians 1975, 5).

Ruben Meyer, M.D., chair of the Department of Community and Family Medicine resigned, and the department was divided, creating the Department of Family Medicine (Hess 1978, 591). In November 1973, Wayne State University announced the development of a department of family medicine at the School of Medicine. The dean accepted the announcement and appointed a search committee to recommend a chairperson.

According to the MAFP report,

On the search committee, he placed several individuals who were specialty oriented, who did not look favorably upon family practice. There was no consultation with community physicians, or family physicians, or the Michigan Academy of Family Physicians as to the composition of this committee.

In the summer of 1974, Coye announced his choice for professor and chair of the department, Joseph W. Hess, M.D. Hess was an academic internist who, according to the MAFP, had never practiced medicine in a private office and had no exposure to family practice.

At the annual meeting of the Michigan Academy of Family Physicians, the Academy was informed by William E. Rush, M.D., from Wayne State of Hess's appointment. Opposition to Coye's choice was swiftly organized. Representatives of the

Academy met with Coye in September to voice opposition to his choice. He remained firm in his decision and asked that the Academy have faith and give the new chair time to develop the department. He suggested that they meet with Hess to hear his plans.

The group met with Hess at Schweitzer's Restaurant. The Academy reported

Dr. Hess informed us that as far as he was concerned the only interest that the department of family medicine had at this time was in the area of family practice. He stated that he would not begin developing other models of "family health care delivery" for at least three years, and that he would hire only people to develop the family practice model for those next three years. (Michigan Academy of Family Physicians 1975, 6)

Despite Hess' reassurances, within a year the brewing confrontation would explode with the Michigan Academy of Family Physicians calling for Hess's resignation.

University of Michigan develops slowly

By 1969, the University of Michigan School of Medicine was graduating 200 students per year, and was planning to increase its classes to 300 (Hubbard 1969, 475). That planned expansion did not, however, include any consideration of development of a department of family practice. In fact, as late as Dec. 30, 1974, Sen. Alvin DeGrow reported,

A great deal of effort must be expended to convince the University of Michigan that a family practice specialty program would be desirable. The [Joint Committee on Family Medicine] felt that the University of Michigan was completely oriented to the production of specialists, and since they do not regard family practice as a specialty, they will never develop a successful program. (DeGrow Dec. 30, 1974)

Joseph Fisher, M.D., a family physician practicing in Chelsea, a small town 12 miles west of Ann Arbor, later remembered his first attempts to encourage the medical school to consider family practice.

My records show that we first met [with representatives of the medical school] in February 1971...and persuasively articulated our conviction that the time was now propitious, even an educational imperative, for the medical school to open its academic doors for the training of future well trained

family physicians. The response to our position was not one of warm enthusiasm. (Sheets and Davies 1988, 4)

On April 26, Fisher, George DeMuth, M.D., of the University of Michigan Medical School, and Michael Papo, M.D., also a Chelsea area family physician, met to discuss the possible establishment of a family practice residency program. Carl Frye, M.D., an Ann Arbor family physician, had already set up a committee at St. Joseph Mercy Hospital for a similar purpose. A committee representing three Ann Arbor hospitals was set up.

An application for approval of the Washtenaw County Residency in Family Practice was submitted to the American Medical Association Council on Medical Education on Aug. 29, 1972. Shirley McCormick, M.D., later recalled,

Several of us who graduated in 1972 took rotating internships at St. Joseph Mercy hospital hoping to enter the program at the second year. While awaiting approval, Joseph Fisher, M.D., was named chairman of the Family Practice Residency program, and St. Joseph Mercy Hospital approved the program with a rotating internship to be spent the first year at St. Joseph Mercy... One half day each week was spent in a preceptorship at the Chelsea Medical Clinic. (McCormick n.d., 2-3)

The Chelsea Medical Clinic was a new three-building \$1.5 million medical complex established by a group of five family physicians in the small town (population 3,700) of Chelsea several miles west of Ann Arbor. In October 1969, it had a staff of thirty-three, with seven full-time physicians and six part-time staff members. The group was in the process of constructing a 106-bed extended care facility which would connect to the medical complex through a tunnel. The group boasted of service, availability, convenience, a high degree of professional competence, and direct and enduring physician-patient relationships. Papo was one of the owners of the Chelsea Medical Clinic (Anon. 1969, 6).

Even though everything seemed to be falling into place, the Residency Review Committee of the AMA denied the application, citing several deficiencies. First, they determined that the model unit was unsatisfactory because it was located in the offices of private physicians and the director of family practice had no control over either the management of the offices or of

the patients. Second, the relationship of the program to the teaching hospitals and the commitment of their medical staffs to family practice was not documented. Third, the residents' learning experiences appeared to be excessively fragmented and preceptorially oriented (McCormick n.d., 2-3).

The undeniable fact was that the program had not been approved. It was not so clear who was responsible for its denial. Kent J. Sheets, Ph.D., later theorized,

The ultimate rejection of the proposed Washtenaw County Residency in Family Practice... was surely prompted by the apparent aloof indifference displayed by the neighboring University of Michigan Medical School toward any direct involvement in these plans. Then and now, there were many who saw the University of Michigan and the specialty of family practice as oil and water, an intrinsically incompatible combination. (Sheets and Davies 1988, 4)

On the other hand, Dean John A. Gronvall, M.D., of the University of Michigan Medical School, remembered the situation differently, stating,

During 1972-73 the Medical School cooperated with Chelsea Medical Center and St. Joseph Mercy Hospital to propose a family practice residency on a cooperative basis. This proposal was not approved by the Residency Review Committee, primarily because of deficiencies in the proposed model practice unit which was to be located at Chelsea (Gronvall 1975, 4).

In any case, the RRC suggested that any reapplication should come either from St. Joseph Mercy Hospital or from the University of Michigan Hospital. (Sheets and Davies 1988, 4)

Early efforts by the Michigan Academy of Family Physicians to interest the University of Michigan Medical School in establishing a department of family practice had been singularly unrewarding, despite some innovative programs in which the school did participate. George A. Dean, M.D., (1976) president-elect of the MAFP, summarized some of these efforts in early 1976. In addition to the establishment of the Family Practice Club in Ann Arbor, he cited,

The Paeon, which is the monthly publication of the medical students at the University of Michigan School of Medicine, devoted eleven pages to the subject of family practice and posed the appropriate question, "When will we have a de-

partment of family practice at the University of Michigan?"

In the meantime, the Michigan Academy of Family Physicians and the medical school at the University of Michigan through the Postgraduate Medical Education Department has collaborated to provide quality educational experiences for practicing family doctors at the Towsley Center. The highlight of this relationship is the Family Practice Review, a five-day intensive course with subjects pertaining to family practice. This year the program was the most successful since its inception with over 350 family physicians attending.

Dean went on to describe a program called the Media Library developed in conjunction with MAFP to serve the postgraduate medical education needs of physicians in rural areas, and discussed a statewide preceptorship in primary care that provided University of Michigan medical students with exposure to primary care. (Dean March 29, 1976)

On Feb. 20, 1975, Gronvall stated that he had recommended to the Executive Committee and to the faculty that a department of family practice be established. On Oct. 31, he charged a committee headed by J. Robert Willson, M.D., to determine whether the university should establish a family practice residency. He stated to the committee,

My own position is that family practice has now achieved status as a recognized specialty, there is demonstrated public desire that the number of family physicians be increased, and our own students are increasingly seeking such residency training. It is further my belief that for the University of Michigan to establish a quality training program in this discipline this can be most effectively accomplished through the establishment of a Department of Family Practice.

However, he warns that "this is a time of very short resources which would make such a department difficult to establish," asking that they consider the resource question carefully. (Gronvall Oct. 31, 1975)

The committee's final report was submitted March 29, 1976, and in November the Board of Regents gave official approval for establishment of the department. On March 1, 1978, Terence Davies was appointed professor and chair. Davies had been on the faculty with Hiram B. Curry, M.D., at the University of South Carolina when Joseph Fisher joined that faculty after leaving Chelsea. Davies had soon moved to the University of

South Alabama at Mobile as associate chair. While there, he became particularly interested in the behavioral aspects of family medicine (Davies, telephone interview, 1996).

The university leased the teaching and clinical facility at Chelsea. (Sheets and Davies 1988, 5) Papo, whom Davies later described as “a remarkable individual—one of the most entrepreneurial individuals I’ve ever met,” had offered to sell or rent his practice to the medical school (Davies, telephone interview, 1996).

To Davies’ disappointment, the most supportive member of the medical school administration, Charles Votaw, left within a couple of months to take a position at the University of Eastern Tennessee. Davies was soon to discover that the decision to establish a department of family practice had been made “at a political level, rather than at a heartfelt academic level,” and that he would need to struggle to develop and maintain the program.

State funding for community-based residency programs

Despite attainment of specialty status in 1969, the number of family physicians nationwide continued to decline until 1975, when there were 54,557 in the United States (AMA Council on Long Range Planning and Development 1988, 1273). Early in the 1970s, an increasing number of residency programs were quietly turning out board-eligible family physicians, but not at a rate that could yet turn around this trend. The six programs in Michigan had a combined ability to graduate 55 residents per year in family practice, although at their 1973 funding levels and developmental stages they expected to graduate only 15 in 1974 increasing to 35 in 1976. Most of them had loose affiliations with one of the state’s three medical schools, but there were no departments of family practice at these schools with which the residencies could interact (Ad Hoc Committee of the Michigan Academy of Family Physicians for Financing Residency Programs 1973).

The young residency programs, none more than four years old, were facing a funding crisis. Saginaw, which had been approved for eight positions per year, was expecting to reduce its number to four per year because of lack of funds. Ironically, these new programs were being initiated just as national health

care policies were shifting from an emphasis on expanding access to health care to an emphasis on cost-containment in the health care sector (Mueller, 1993).

Family practice residencies in several other states such as Minnesota, Iowa, and Indiana were receiving state funding, either as a total allocation or as a capitation per family practice resident. The residency directors determined that they would collectively approach the state to request a legislative allocation for family practice graduate education. An ad hoc committee was convened through the auspices of the Michigan Academy of Family Physicians, and Robert Toteff, M.D., from the Saginaw program, was selected as chair.

Toteff later remembered the disbelief that greeted their decision to pursue state funding, "They said, 'You guys are crazy. No way are they going to give you money, just no way. First of all, you know, it's going to go to the universities.'"

In a document that informally became known as "the white paper," the group proposed that the legislature provide interim funding to the residency programs of \$200,000 per program.

This was Toteff's (Personal interview 1996) first foray into state politics. He had been active in the Michigan State Medical Society and was able to use this affiliation and his ties to the Michigan Academy of Family Physicians to bolster his requests. He found himself staying overnight three or four times per month in Lansing, visiting legislators, attending meetings, or giving testimony. At home he fielded late evening calls from the floor of the legislature for conversations with an advocate who was negotiating on their behalf.

The lobbying succeeded, and a line item allocation of \$750,000 was made to family practice residency programs through the state Department of Health for fiscal year 1974-75 (American Academy of Family Physicians 1995, 75-76). State funding topped out at \$1 million in the late 1970s, but became increasingly unstable in the early '80s and was discontinued in mid-decade (American Academy of Family Physicians 1992, 44-45).

During this process, Toteff also found himself being challenged to stretch his consciousness in ways that he had not anticipated. As he had negotiated with the state legislators, Sen. David Holmes and Reps. Morris Hood and Raymond Hood

challenged him on the white racial composition of the residency graduates and the fact that there was little emphasis on providing family physicians for urban neighborhoods. They had ample cause for concern. A survey of family practice residency programs nationwide in 1975 would show that of a total of 3,720 residents, only 195 were from racial minorities.

Toteff remembers, “The black legislators said, ‘Where are the black guys?’ We dumped it in their lap and said, ‘You bring them to us. We can’t bring them. If they don’t apply, we can’t take them.’” But he acknowledged that their persistent challenges made him more conscious of his recruiting techniques, saying, “What Hood was doing was making me think about it myself, too. While I said I was ready to take black students if they applied, I maybe wasn’t going out seeking them. So he jogged my social conscience a little bit, too.”

Family Practice: The Joys

“Obstetrics is so demanding. I loved it. It’s fun. It’s interesting. The biggest majority of the people, you gave them something they wanted—a happy thing.”

— Edward Hunt, M.D.
Fairgrove

“When we went to Frankenmuth everybody said, ‘You’ll be an outsider. You won’t be accepted.’ People accepted us with open arms and made us a part of not only the community, but of their families. It’s been just a novel experience.”

— James Shetlar, M.D.
Frankenmuth

“We give our time to the community, my wife and I. It’s our home town. When I talk to residents, when they are moving into other communities, I say, ‘You know, if you don’t get involved with the schools, if you don’t get involved with the church, you’re not going to be involved with your town, and the town people are going to know that.’ And they don’t understand that! They don’t realize that they won’t be able to go in and sit down and practice medicine and leave that community for the weekend or after five o’clock.”

— Charles Zimont, M.D.
Constantine

“The six years that I spent in Escanaba [with the Michigan State University Upper Peninsula Project] were the best six years of my life, no question about it. It was absolutely a peak life experience. I had an opportunity to be on the cutting edge of American medical education.”

— Paul Werner, M.D.
Detroit



6 The Struggle for Equal Reimbursement

While family practice advocates were focused on developing educational opportunities for medical students and residents, family physicians in communities throughout Michigan were becoming aware that there was a hole in their pocket. Blue Shield, a major reimbursor for medical services and fiscal intermediary for the Medicare program, was paying most of them less for many procedures than it paid other physicians for performing the same procedure.

The federal government had become involved in large scale reimbursement for medical services for the aged and disabled when Medicare was instituted in 1966 (Vitu 1981:11). The United States Department of Health and Human Services established a policy of paying general practitioners less than specialists for performing the same procedures. Blue Cross/Blue Shield of Michigan, the fiscal intermediary for Medicare in Michigan, then extended this policy to its private business transactions as well.

For purposes of reimbursement, Health and Human Services had divided physicians into three categories, or screens. The first screen included osteopathic and allopathic family physicians who were not board certified, chiropractors, podiatrists, and dentists. Screen two dealt specifically with in-patient services. Screen three included all osteopathic and allopathic board certified family physicians and all physicians other than family physicians, whether certified or not. The reimbursement limitation for an initial comprehensive office visit in Lansing during 1980 was \$25 for Screen one and \$50 for Screen two—an increase of 100 percent (Gilchrist and Cafferty 1985, 6-7).

According to Saginaw physician Robert Vitu, M.D., “Since neither Medicare or Blue Shield is in the habit of publicizing

this kind of policy decision, it took some time before we became aware that we were the victims of discrimination.”

A committee of the Michigan Academy of Family Physicians, chaired by Joseph Batdorf, M.D., of Grand Blanc, entered into conversation with Blue Shield in an attempt to end this practice. The controversy became public in July 1969 through an exchange of letters between Louis R. Zako, M.D., and Louis F. Hayes, M.D., Blue Shield of Michigan vice president, that was published in *The Bulletin*, the monthly magazine of the Michigan Academy of Family Physicians. Zako stated,

We resent Blue Shield's *de facto* disregard for the time-honored concept of "equal fee for equal service." . . . We strongly question your apparent acceptance of the concept that a thrombosed hemorrhoid enucleated by a "specialist" or a normal obstetrical delivery attended by a "specialist" is inherently worth a greater payment than when these procedures are carried out by a family physician. (Zako 1969, 5)

Hayes (1969, 6) responded, "The tug-of-war between generalist and specialists is a game having a long history. Its resolution is a private matter for organized medicine to resolve. It surely is not appropriate to sandwich Blue Shield between the combatants."

Michigan Academy of Family Physicians sues

Philip Lange, M.D., a Lansing physician, (Personal interview, July 26, 1996) remembered that for several years he would hear other physicians complain about the situation during the Michigan Academy of Family Physicians Congress of Delegates meetings, "I listened to this for a few years. Finally I started planting the idea that we were going to have to sue them. That's the only way you can get attention. They would not accept registered letters. They wouldn't return phone calls. It was like we didn't exist."

In addition to the direct economic impact of Blue Shield's unequal reimbursement, some family physicians feared that a wedge could be driven between general practitioners who had not become board certified and those who had, with George A. Dean, M.D., (Dean 1972, 4) expressing the concern that "the 'Blues' . . . are now attempting to lure board certified family physicians in this ill-intentioned endeavor. This could create potential discord."

On the other hand, the controversy did provide an opening for increased cooperation with osteopathic physicians in the state, as Joseph Fisher, M.D., Michigan Academy of Family Physicians president, noted (Fisher 1972, 3)

Our Medical Economics Committee has held several recent exploratory sessions with the D.O.s. Relationship to insurance carriers, fee schedules, dissatisfaction with the "Blues," etc. have been agenda items... Would [the "Blues"] heed the combined and unified voice of approximately 2,500 family physicians? The answer to the rhetorical questions posed is, I believe, a strongly affirmative one.

In 1973, the Academy began to consider legal action and engaged Gilbert Frimet as its lawyer (Vitu 1981, 11). At the 1973 Michigan Academy of Family Physicians Congress of Delegates, Lange moved that the membership be assessed an extra \$25 for a legal fund. The motion passed overwhelmingly.

In February 1974, Zako, now MAFP president, was able to report,

The response to the \$25 Special Assessment for a legal fund in our efforts to end fee discrimination by Michigan Blue Shield has been overwhelming. Many of you have written or scribbled brief or lengthy words of support on the bill sent to you, on progress notes, on your letterhead and odd scraps. Although a few of you have questioned the propriety of our efforts, the overwhelming majority feel that the action your Congress of Delegates has authorized is both appropriate and timely.

He added that the organization was trying to resolve the matter "short of a long drawn out and costly court battle," but that they were determined to reach a successful conclusion (Zako 1974, 3).

Suit was filed in Federal District Court in Detroit in December 1976 naming both Blue Shield and the Department of Health and Human Services (Vitu 1981, 11). Lange remembers,

It was obvious that we were doing very, very well, and that Blue Cross/Blue Shield was doing badly. Before the judge's decision, Blue Cross/Blue Shield dropped out and said, "Ok, you've got what you want. You'll be screened with the other physicians for fees." Then it was just Health and Human Services. And of course, they lost.

Four years after the suit was filed, on Dec. 31, 1980, the Michigan Academy of Family Physicians received word that

Judge Horace Gilmore had rendered a decision in its favor, finding the United States Department of Health and Human Services in violation of the Medicare statutes in segregating general and family physicians from other allopathic physicians and placing them in a lower reimbursement category (Vitu 1981, 11).

Health and Human Services appealed the decision, but in 1984 the lower court ruling was upheld (Vitu 1984, 3). The agency then appealed its case to the United States Supreme Court, where it was heard in late 1985, but again the original decision stood.



7 Establishing an Academic Presence

After the first flush of excitement that family practice had finally arrived in the halls of academia, a more grim reality set in. Departments of family practice would find themselves facing an uncertain resource base, fighting to maintain departmental integrity of their budgets, and intellectually scorned by some of their colleagues from the more traditional departments. The national policy swing toward cost-containment in health care programs was to impact the fledgling academic departments as well as the residency programs.

At the same time, the faculty in these new departments at Michigan State, Wayne State, and finally the University of Michigan believed that they represented the future of medicine, that the medical establishment's increasing orientation toward fragmented, specialty care had to give way to a new paradigm of health care and that they were in a position to lead the way.

They were experimenting with interdisciplinary models of care, theorizing about the role of the family in family practice, and glancing, however tentatively, at the society-wide changes in health care financing and delivery that would soon place a premium on primary care delivery systems.

Michigan State University

Of the three medical schools in Michigan, all of which established departments of family practice or family medicine in the 1970s, Michigan State University made this transition most easily. However, there were challenges to be overcome.

The College of Human Medicine was often unorthodox and innovative, and in establishing the Department of Family Practice, it remained true to form. Most medical school departments operate from a strong central base firmly entrenched on campus. But by the time the Department of Family Prac-

tice was established on campus there were already four young family practice residency programs with loose affiliation agreements with the College of Human Medicine, and they had just been given a healthy infusion of state monies that would not be channeled through the university.

Gerard and Smith (1979, 25-26) described the decentralized departmental structure,

One of the expectations which had been fostered in the meetings of the Family Practice Task Force, and which was referred to obliquely in their proposal to the Kellogg Foundation, was that the directors of the community family practice residencies affiliated with Michigan State would serve as a governing group for the department. It was expected that departmental faculty would be drawn to a large extent from the residencies, whose personnel would teach part time in family practice courses on campus. In turn, the department was expected to serve as a conduit for channelling the expertise of the College of Human Medicine into the support of the family practice residencies.

Robert Daugherty, M.D. (Gerard and Smith 1979, 25-26), later commented,

As the idea began to evolve, some of us thought that this might be one of the things that would keep the College of Human Medicine from retreating into the standard model of a campus-based medical school. We thought that the Department of Family Practice could become a prototype of how people in the community could become involved in the affairs of the medical school.

When Gerard accepted the position as chair of the new Department of Family Practice and moved to East Lansing, he found himself quite isolated. The other family practice residency directors in the loosely connected network now considered him suspect, although he had just recently been one of them.

As initially conceived, the executive committee for the department would consist of the directors of each residency program, at that time Harold "Pat" Crow, M.D., of Sparrow Hospital in Lansing, Lewis Simoni, M.D., of St. Joseph Hospital in Flint, Roy Gerard, M.D., of Saginaw Cooperative Hospitals, Inc., and John Newton, M.D., of Grand Rapids. An intense rivalry developed among Crow, Simoni, and Gerard which was

based in part upon ego conflicts and in part upon philosophical differences regarding issues such as the role of the family in family practice and the wisdom of interdisciplinary health teams.

Within the College of Human Medicine, Gerard felt equally alone, although he did have some supporters such as Thomas Kirschbaum, M.D., chair of the search committee that had selected him. Not only was he the first chairperson of a department that had ambivalent support, but Gerard had been a family physician, for most of his career practicing outside of the universe of academic medicine. Gerard remembers,

All these people had been in academia for all these years, and suddenly it was like instant coffee. They mixed me into hot water, and I was a chair and a full professor . . . I think it took a long time for me to gain the respect of those other chairs. Because, you know, I'm a family doc, and I followed a different drummer.

Funding problems.

Although the new department had received a generous start-up grant from the W.K. Kellogg Foundation of \$824,000 over five years, and it participated in an interdisciplinary team training grant that provided \$862,000 over three years, the department almost immediately faced financial challenges. Federal funding for the College as a whole was declining, and the department was supported very weakly by university general revenue funds (Gerard and Smith, 1979, 39-40).

Innovative programs.

Despite the concerns about departmental status and funding, the new Department of Family Practice immediately plunged into innovative developments. Almost as soon as he arrived in Lansing, Gerard became involved in interdisciplinary team development for health care delivery. The concept of the primary health team became familiar during the late 1960s, through the Office of Economic Opportunity's Neighborhood Health Center Guidelines. A 1966 document states,

The concept of supporting staff should go beyond traditional roles and might include physicians assistants, family health workers, health visitors, community health aides and others . . . The program should demonstrate new roles in the health-related professions and test realignments of the or-

thodox relationships between primary and supporting personnel.

In 1975, David Kindig, M.D., codirector of the Montifiore Hospital Institute for Health Team Development, wrote

As primary care develops over the coming decades, patient needs will increase in the psychosocial environmental areas that require the collaboration of a large number of health professionals. In curative primary care alone, the growing number of new health professionals on the team leaves no choice about the necessity of mechanisms for role clarification, decision-making, and leadership. (Kindig 1975, 100).

When Michigan State University was invited to send a group to the Institute to learn the techniques of health team development, Gerard became the physician member of the team. Other members included two nurses, a social worker, a psychiatrist, an osteopathic physician, and an anthropologist. Several of these team members received appointments in the Department of Family Practice (Gerard and Smith 1979, 33-34). The interdisciplinary team training at Montifiore led to the development of a course named "An Introduction to Interdisciplinary Health Team Delivery of Primary Care," first offered in spring 1976 and taught numerous times after that.

The health team concept was not universally accepted, even within the department. Robert Landick, M.D., was one faculty member who had reservations. In the late 1970s, he said of the program,

I don't think that the team people have resolved the issue of whether team care is medically effective and cost effective . . . As I understand the concept, it involves shared responsibilities for the patient. I believe that somebody should take final responsibility for the patient. Unless someone does take responsibility, the patient will have no one to rely upon when a crisis arises. (Gerard and Smith 1979, 44)

In other accomplishments during the first years of its existence, the department created or supported the development of several clerkship opportunities in family and rural practice, developed its own family practice residency at St. Lawrence Hospital under the direction of James O'Brien, M.D., and began a yearly Family Practice Research Day at which family practitioners throughout the state could present the results of their own research.

The Upper Peninsula Medical Education Program.

Almost concurrently with the development of the Department of Family Practice, the College of Human Medicine undertook an ambitious experiment in undergraduate medical school education that was intended to augment the number of students who chose to practice primary care and who would remain in a rural environment for their practice. The Upper Peninsula Medical Education Program brought international acclaim to the College of Human Medicine, yet it almost cost the college its accreditation.

The unique Upper Peninsula curriculum involved four years of both classroom and clinical education at Bay de Noc Family Health Center in Escanaba in an ambulatory outpatient setting (Werner, Richards, and Fogle 1978). The Upper Peninsula project had been the inspiration of Donald Weston, M.D., at the College of Human Medicine, then associate dean. Ron Richards, head of the Office of Medical Education, Research, and Development (OMERAD) at the College of Human Medicine became intrigued by Weston's ideas, and agreed to move to the Upper Peninsula to establish the program.

Students spent their first ten weeks on the East Lansing campus participating in an introduction to medicine that was shared with the campus-based medical students. The remainder of their classroom and clinical experience took place in the Upper Peninsula, utilizing a learning technique known as "focal problems." Focal problems were

learning packages based on 14 cardinal symptoms or signs, such as dyspnea, elevated blood urea, chest pain, or mental retardation. Using the problem as a take off point, the student learns all the relevant data from each of ten discipline areas, which include all the basic sciences, behavioral sciences, and clinical correlation." (Werner, Richards, and Fogle 1978, 326)

Two full-time faculty were on site in Escanaba, and other faculty rotated up from East Lansing. Students received their medical degrees through Michigan State University, with the first 10 students graduating in spring 1978.

The first cohort of students was already in Escanaba when Paul Werner, M.D., (personal interview 1996) was hired straight out of residency as preceptor and instructor. Werner had grown up in the northern Lower Peninsula and had hoped

to return to northern Michigan to practice, never dreaming that he would have the opportunity to teach while practicing in a rural area.

Werner remembers,

It was absolutely a peak life experience. I had an opportunity to be on the cutting edge of American medical education. In fact, we were so cutting edge that we were considered radical. That was a very hard political lesson to learn, because from my perspective what we were doing was absolutely the answer to America's needs for primary care, for well-oriented community based physicians. I couldn't understand why the rest of the world didn't see it that way, why we were such a threat, such a concern to everybody.

When Werner first visited the Escanaba site in December of 1974,

All that was there was a secretary, her desk and equipment, a couple of card tables, and some folding chairs and a few books — and that was it. It took a lot of faith that students were coming in a couple of months, and more importantly, it took a lot of faith that patients were going to be cared for in this center in a few months.

Werner did not join the faculty until the following July, and in the meantime the students were taught by faculty rotating up from East Lansing and by local physicians such as Raymond Hockstad, M.D., Escanaba family physician and original head of the Upper Peninsula Health Education Corporation which administered the program.

Werner and others on the staff designed a longitudinal, nonrotational program that involved clinical contact from the time the student arrived in Escanaba. Students each were assigned twenty-five families that students would follow, taking increasing responsibility as they progressed through the curriculum. Students participated in a Comprehensive Care Clerkship rather than the traditional specialty-defined clerkships. The relatively small hospital available to the students could not produce enough cases in a short period of time to accommodate the students' learning needs, but over time provided an adequate mix for a comprehensive experience. To Werner this more closely approximated the realities of primary care, where "what determined what you did next was

what walked in the door, so you might as well learn to practice that way.”

Although Werner found himself hosting visitors from around the world who were intrigued by this innovative program, he found the Upper Peninsula’s program was increasingly a political liability to the College of Human Medicine. The College had received only provisional accreditation, and the LCME had several concerns about this new medical program. The focal problems curriculum employed both by selected students on the main campus and by the Upper Peninsula program, and the fact that Michigan State University medical students were not required to take the national boards were two points of contention. But increasingly, criticism focused upon the Upper Peninsula program. Werner recalls,

These site visits kept happening one after another . . . They would come and spend a ferocious amount of time in the U.P. Their basic attitude was that there was no possible way that we could be running a legitimate medical school in the back office of a family practitioner who’s only a couple years out of medical school himself, 250-300 miles from the main campus, with part-time faculty.

Despite the academic success of its students and the high proportion that went into primary care, Werner remembers the day in 1980 when he, Dan Mazzuchi, M.D., and Jack Van Tassel were called to Dean Donald Weston’s office on the main campus.

We were up for yet another review. I remember meeting in his office in early evening. It was already starting to get dark outside. There weren’t any lights on in the office. It was gloomy enough already. I don’t remember the whole discussion, but the sense of impending doom. The message I got from that meeting was that it appeared the LCME was going to come to town and it was going to hold the entire medical school hostage. Unless the U.P. program disappeared, the whole medical school would be put on probation and essentially closed.

Werner soon left the program for a position at another medical school.

According to Mazzuchi, (personal interview 1996) associate dean for the Upper Peninsula program, over the next few

years the program evolved into a two-year community campus, with the students attending classes at the main campus during their first two years, then moving to the Upper Peninsula for clinical training. As Marquette General Hospital expanded to become the region's tertiary care center, the Upper Peninsula medical students became increasingly drawn into clerkships and other clinical experiences in Marquette. By the mid-1990s, students only spent a total of three or four months at the initial Escanaba site.

Mazzuchi summarized the experience by saying, "When measured against its purposes, the program has been more successful in recent years, increasing in size, producing more primary care physicians, and returning more physicians to northern Michigan."

Wayne State University

The program at Wayne State had been born in controversy, tied legislatively to funding for its new Clinics Building and opposed by the dean of the medical school (Michigan Academy of Family Physicians 1975, 6). The dean's decision to hire an internist, Joseph W. Hess, M.D., as chair, rather than a board certified family practitioner, added to the turmoil. Within seven months, members of the Department of Family Medicine faculty issued a position paper to the Wayne State University Board of Governors expressing their "frank consternation" about the direction of the program (Bedell et al. 1975, 1). The paper was signed by Archie W. Bedell, M.D., Ph.D.; Darwin J. Belden, M.D.; Dwight J. Dutcher, M.D.; Richard J. McAlpine, M.D., Ph. D.; and Sol Leland, M.D. They cited dissatisfaction with Hess' leadership and charged that a recent essay on primary care by William E. Rush, M.D., assistant dean for area medical education, had indicated a disinterest in promoting family practice. While the group stopped short of demanding Hess' resignation or threatening their own resignations, they did say "We, individually, collectively, and at great personal sacrifice, may have made an unwise choice in joining the Wayne State University faculty."

Less than two weeks later, a report was submitted to the Board of Governors by the Michigan Academy of Family Physicians (Michigan Academy of Family Physicians 1975, 7) warning, "For the past seven months, we have seen this depart-

ment flounder, have seen the full and part-time faculty of family practitioners become so disenchanting and so upset that the majority of them are now on the verge of resigning their academic appointments and looking elsewhere." Their concerns included the failure of the department to obtain admitting privileges for faculty at any hospitals other than Grace, and the impact this would have upon recruitment for the new Wayne State University-Grace Hospital Affiliated Family Practice Residency Program. They also charged that Hess was "devoting a good portion of his time to developing a proposal for graduate training in primary care in internal medicine," despite his earlier promise to focus only on family practice as a model of primary care for his first three years.

Additional concerns cited in the report include a charge that internists and pediatricians were being recruited, rather than family physicians, and, finally, that Hess had appointed a nurse clinician to co-administer the family practice clinic when it should have been run by a physician. This last action was seen by some as the final straw. The report (Michigan Academy of Family Physicians 1975, 8) charged,

In a practitioner's office, the person who directs the care of patients is the family physician. The nurse clinician whom Dr. Hess appointed, set policy and attempted to hire and fire employees without consultation with practicing physicians, the medical director of the model or the administrator of that clinical service. This was an impossible situation and was intolerable.

The Michigan Academy of Family Physicians requested a freestanding and independent department of family practice, with a reordering of priorities. It also requested that the search committee be reconvened and restructured to recruit a chairperson who was board certified in family practice and who had clinical family practice experience.

Hess weathered the storm, and in November 1978 (Hess 1978, 591) he wrote,

The four years from 1974 to 1978 were tumultuous, to say the least. Physicians accustomed to the speed and simplicity of management decisions in private practice had great difficulty understanding why the wheels of a university bureaucracy turn so slowly and why resolution of problems takes so long.

But he believed, “persistence is paying off, the storm is subsiding and we are beginning to see some of the results we have been working for.”

Among the results that he cited were a department with nine full-time and sixty-six clinical faculty members, twenty-two residents, ongoing CME programs and other educational activities, plans for a second Family Practice Center, an affiliation with the Beaumont Hospital system which would establish another unit of the department’s residency program, and preliminary discussions with several other hospitals.

After the Wayne State program had been in place for two years, those medical seniors who had chosen family practice residencies were surveyed about their choice. The investigators discovered that 14.8 percent of the seniors had selected family practice, with no significant difference between the percent of men and the percent of women entering family practice. The students’ home town physicians and their clinical preceptors in medical school were found to be significant influences in their selection of family practice as a specialty, but they considered the medical school curriculum to be slightly detrimental to their choice (Eagleson and Tobolic 1978).

University of Michigan

The University of Michigan had lagged several years behind Michigan’s two other medical schools in fielding a department of family practice. While the other schools at least had a viable program in place when an economic downturn in the 1970s threatened their financial stability, Terence Davies, M.D., faced financial challenges almost from the day he was hired as chair of the University of Michigan’s Department of Family Practice.

Davies had a solid background in academic departments of family practice in the South, but found himself facing an inhospitable and sometimes unrealistic medical school administration. He remembers,

A lot of people were very outspoken in saying that they didn’t think family practice belonged at the University of Michigan, so there was considerable resistance to the introduction of family practice in Ann Arbor. In fact, there had been a very serious attempt to start a primary care internal medicine [program] as an alternative to family practice. (Davies personal interview 1996)

Davies recalled,

The first year or two it was pretty hard going, but it became easier and easier. One of the things that sustained me from the beginning was the attitude of the medical students. They were incredibly supportive. I always remember when I was interviewing for the job the medical students put on a dinner for me, and the family practice club gave me a big reception. It was heartwarming.

Some of the financial surprises that he encountered were not so heartwarming, though. Due to Michigan's overall financial situation, one-third of promised state start-up funding was cut.

He also discovered that from its perspective as a tertiary care center, the university had miscalculated its projections of income from the Family Practice Center in Chelsea. It had accepted estimates on the facility's profit record as a private group practice, rather than factoring in either the additional expenses or the different medical philosophy that would be appropriate for a family practice teaching facility.

For instance, the referral income that University Hospitals was anticipating from the Family Practice Center's patients was much higher than any self-respecting family practice clinic would generate, according to Davies.

He said,

They were anticipating a great deal more inpatient revenue than I could possibly justify with a well-run family practice. The truth is, the first year we doubled the number of outpatient visits, but halved the number of inpatient admissions. It was precisely what I thought we should have done, but for the hospital — and it was all hospital administrators who had worked up the financial figures for the program — that was just terrible.

Another financial surprise was the discovery that the medical school and the University Hospitals had made no provisions for supporting stipends to the family practice residents. "I remember one memorable meeting where the hospital director turned to the dean and said, 'Well, who's going to pay for these residents?' It was a major insight for me," Davies recollects.

In July 1978, Davies (Davies, 1978, 55) warned in a report to the medical school that the Family Practice Center in

Chelsea would “require much further attention as it undergoes an evolutionary transition from its previous status as a private facility supplying largely episodic patient care, to a planned, modern-day, learning center for students of family medicine,” noting that, “the physical facilities . . . are notably inadequate for our future needs.”

Despite these financial challenges, much was accomplished during the first couple of years (Sheets and Davies, 1987). Within the department’s first three months, an elective clerkship was instituted at the Family Practice Center. By July 24, 1978, five full-time faculty had been appointed.

A cadre of faculty clinicians from other departments was developed who worked with the family practice faculty to develop the residency at Chelsea, which received Residency Review Committee approval in February 1979. In July, four residents entered the program. A federal training grant for graduate training in family medicine provided funding for major renovations of the Family Practice Center by the end of 1979.

During the 1978-79 academic year, a new Family Practice Clinical Service was implemented at University Hospital and family practice residents and faculty began to deliver obstetrical patients at Women’s Hospital.



8 The Maturing of Family Practice

As the 1980s began, family physicians took stock of their first decade as a specialty and enumerated the challenges facing them. George Dean, M.D., alternate delegate from Michigan to the American Academy of Family Physicians, and a past president of the Michigan Academy of Family Physicians, foresaw that in the 1980s,

- 1) “The development of a vigorous research program in family practice is absolutely essential to the future of our specialty, and the quality of its teaching and patient care.”
- 2) “Hospital privileges for family physicians, commensurate with their training, experience, and proven ability, is a necessary prerequisite for a satisfactory practice.”
- 3) “Family physicians should be encouraged to include obstetrical services in their practice.”
- 4) “Reimbursement of family physicians regarding equal pay for equal service is another problem that challenges family practice.” (Dean 1980, 2-3)

Also looking ahead to the coming decade, Harry Schneiter, M.D., of the University of Michigan’s Department of Family Practice, noted that in its second decade family practice was entering adolescence, and like all adolescents it had its problems to face. Among the many challenges he enumerated were the need to develop a cadre of “our own teachers who are not only trained in family medicine as we view it, but also in teaching techniques and communication so that they can train our future family practitioners.” He goes on to mention the need to teach “family” and to explore the value of the team approach (Schneiter 1980, 8).

Neither Dean nor Schneiter directly mentioned the growth

of HMOs and other prepaid health plans that would soon irrevocably impact family physicians in Michigan, a move toward managed care that was already becoming controversial as the decade opened. Nor did they mention the ongoing struggle of family practitioners to define themselves in relationship to the new “physician extenders,” as well as to the other medical specialties. Those challenges that they did mention — intellectual credibility, competence-based hospital privileges, and an equitable financial base — would all be foci of concern during the decade.

Defining the boundaries of family practice

While defining the relationship of family physicians to other medical specialists consumed much of the attention and energy of organized family practice and its academic departments, some attention was also being paid to maintaining its professional position vis-a-vis the newly developing “mid-level” health providers. Physician assistants and nurse practitioners were being trained to perform much of the patient care traditionally offered only by physicians, and some family practitioners saw their increasing assertiveness as a threat to the specialty of family practice, especially when advocates suggested that nurse practitioners might practice without a physician’s supervision.

In 1980, the Michigan Academy of Family Physicians (Thoms 1980, 11) reiterated the official policy of its national body, initially stated in 1974 and 1978. It stated,

The AAFP must emphasize — to the public, the Congress, other medical disciplines and educators — the importance of health care delivery by the fully trained physician, with all types of physician extenders under supervision of, rather than practicing independent of, the physician (1974),

and,

Because of the present physician shortage and maldistribution, and the goal of the AAFP to provide excellence in health care to all people of America, the adequately trained assistant to the physician is welcome in some situations as a means of assisting in overcoming the current defects in health care delivery. (1978)

While attempting to hold the line on the perceived en-

croachment of mid-level providers, family physicians began exploring the possibility of developing subspecialties within family practice. The American Board of Family Practice, in conjunction with the American Board of Internal Medicine, developed the concept of Certificates of Added Qualifications.

In 1987, the first exam was offered for family physicians and general internists in the field of geriatrics. This move was not without controversy, though, and the 1988 AAFP Congress of Delegates voted overwhelmingly to oppose future development of CAQs. The concept was revisited one year later, when a roll call vote resulted in 55 yeas and 55 nays, with a deciding yea vote cast by the Academy's speaker. The new policy called for support of CAQs, recognizing that they would primarily strengthen academic family medicine (Kelly 1989, 2) by promoting the image and credentials of family practice educators. However, those opposed to the concept worried about the fragmentation of the specialty, and the possibility that CAQs could actually end up placing limitations on the activities of family physicians who had not received the advanced certificate.

Michigan Academy of Family Physicians: organizational maturity

Whatever problems family physicians would face in the 1980s, there was no question that family practice was developing the institutions that accompany a maturing discipline. The decade opened with MAFP members being offered a discount subscription rate to *Family Practice Research Journal*, a new nationally refereed journal whose founding editor was Jack M. Stack, M.D., of Alma. The journal, with an initial publication date of Spring 1981, was designed to encourage research in family practice and to educate family physicians in research philosophy, methodology, and writing (Michigan Family Practice 1980, 23).

In a sense, Stack's involvement had evolved with the specialty. In the early 1970s, he had been MAFP's liaison with the state legislature during the early attempt to pressure medical schools to initiate departments of family practice. A few years later, as a Michigan State University trustee, he quietly encouraged the department's development and showed

special interest in maintaining the separate departmental identity of the College of Osteopathic Medicine's Department of Family Medicine and the College of Human Medicine's new Department of Family Practice (Gerard and Smith 1979).

Rita Lewis Feldkamp had replaced E. Clarkson Long, M.D., as the Michigan Academy of General Practice executive secretary in 1968, and continued until the organization decided to move to the state capitol (Michigan Family Practice 1979, 10). The Michigan Academy of Family Physicians found itself outgrowing each of several offices, first having moved to Lansing in 1979 and hiring its first full-time executive director.

Its first Lansing location turned out to be less than satisfactory when the group's new IBM Selectric typewriters were stolen. Philip Lange, M.D., (Personal interview, 1996) recalls that night. "One night I got a call from a patient of mine. He said, 'Doc, I saw your name in the office of the family physicians. It's been broken into, and all your typewriters are gone.'" The typewriters were eventually recovered, but not until after the police department had "borrowed" them for use in an undercover sting operation. The group then purchased a house on "association row" near the capitol in Lansing.

As the '80s opened, Michigan's family physicians continued to figure prominently on the national scene. Douglass Haddock, M.D., of Kalamazoo was elected board chairperson of the American Academy of Family Physicians for 1981-82. Haddock was a past MAFP president and served as associate director of the Southwestern Michigan Area Health Education Family Practice Residency (Michigan Family Practice 1981, 8).

MAFP activist Robert Vitu, M.D., of Saginaw received national publicity the following year when he was cited as a finalist for the 1982 *Good Housekeeping* "Family Doctor of the Year" award. The award was cosponsored annually by the American Academy of Family Physicians and *Good Housekeeping* magazine (Michigan Family Practice 1982, 11).

In 1982, the Academy (Dean 1984, 13) established a philanthropic arm, the Family Health Institute, funded primarily through donations, with four goals:

“1) to further programs that will encourage medical students to enter family practice as a meaningful career in medicine; 2) to help sustain existing family practice residency programs with supplementary funds, 3) to enhance continuing medical education programs for practicing family physicians and thereby improve patient care in Michigan, 4) to stimulate research in family practice.”

The Academy launched MIRNET in 1984, using the research network to prospectively study the significance of incidentally raised blood pressure in the office setting among patients from associated practices (Trembath 1988, 4).

In the mid-1980s, 12.9 percent of the family practitioners nationwide were women, compared to 4.3 percent in 1970 (AMA Council on Long Range Planning and Development 1995, 173). To address the concerns of women in the field, a Committee on the Concerns of Women Physicians was established under the leadership of Diane Culik, M.D., in autumn 1984, with goals of encouraging the interaction of women in medicine and encouraging women to become involved in MAFP committees and decision making (Culik 1985, 9). There had only been one woman as president of MAFP — Cecelia Hissong, M.D., of Dearborn, who had served 1974-75.

Hospital privileges

As the 1980s began, family practice was still struggling to define its identity on several fronts. Within the specialty-dominated hospitals there was still controversy about what privileges could be accorded to family practitioners. Perhaps even more important was the debate about *who* should be able to grant privileges to family physicians — the various specialty departments such as obstetrics and surgery, or the hospital’s own family practice department.

At the Michigan Academy of Family Physicians 45th birthday party in 1993, Bruce Deschere, M.D., reflected on the situation that had faced young residency-trained family physicians (Ohl 1993, 5).

[The specialists] had gotten all the then-general practitioners out of the intensive care unit and were pushing them out of the delivery room and out of the operating room, and now all of a sudden there’s these fresh young faces coming along saying, “Well, gee whiz, we have all these years of

training [and] think that we should be able to do all of these things." Those battles had to be fought all over again.

The Health Services Commission of the Michigan Academy of Family Physicians had surveyed the Academy's members in December 1979 about the hospital privileges they carried and any problems connected with obtaining privileges (*The Bulletin* 1980, 22-23). The Commission discovered that while the majority of family physicians were satisfied with their privileges, a significant minority of slightly more than 20 percent of the residency-trained physicians was dissatisfied. Problems tended to occur more often in the larger hospitals, and unexpectedly, a great percentage of the problems occurred within hospitals where family practice departments were in existence. After comparing the survey results with those of a 1969 national survey, the Commission concluded that problems were actually increasing, primarily for the younger, residency-trained physicians.

The Commission urged the development of strong departments of family practice within the hospitals, encouraged family practice residents to carefully document their training experiences, and suggested that older physicians who have adequate privileges must stand ready to assist their younger colleagues in obtaining privileges.

In 1984, Avery Aten, M.D., chairperson of the Michigan Academy of Family Physicians Hospital Privileges Committee, wrote a series of three articles advising family physicians on how to negotiate successfully when applying for hospital privileges. Aten noted that even though the majority of family physicians were satisfied with their hospital privileges, "new political and economic forces may bring radical changes and restrictions for new family practice residency graduates." (Aten 1984c, 9) Among his concerns was that the specialty competition already seen in the larger hospitals would spread to the smaller and rural hospitals as the total number of physicians increased relative to the general population (Aten 1984a, 6). He also urged the establishment of a strong department of family practice within each hospital.

In 1985, Wadland, Eustis, and Bollin (1985, 505) described the three-year process through which one community hospital in southeastern Michigan developed an effective family/

general practice department. Among the challenges faced at the 68-bed River District Hospital in St. Clair were 1) successfully integrating non-board certified general practitioners, osteopathic internship-trained family physicians, and board-certified, residency-trained allopathic family physicians into one department; 2) developing departmental bylaws; 3) reorganizing the entire medical staff into a departmental structure; and 4) categorizing privileges.

They noted that even after all of this preparation,

The real test of the Department of Family/General Practice was whether it could actually recommend privileges for new staff applicants. In 1982, two residency-trained family physicians applied, and the executive committee did not accept the family practice department's recommendation of approval. Other departments wanted to review the applicants in their own areas. The Department of Family/General Practice was ineffectual as a department.

They concluded that it was necessary to have a general agreement throughout the hospital on the base-line privileges for family practice. That was developed, but only after nine months of dispute.

Obstetrics

A 1981 report showing the hospital privileges of American Academy of Family Physicians diplomates in a five-state region which included Michigan indicated that 46.3 percent were allowed to do routine obstetrics; 34.5 percent, high risk obstetrics; 40.9 percent, complicated deliveries; and 18.4 percent, Cesarean sections (Avery 1984a, 6).

In a 1986 mail survey of Michigan Academy of Family Physicians members who were listed as doing obstetrics, Mindy Smith, M.D., of the University of Michigan Department of Family Practice, discovered that those who practiced obstetrics were less likely to be in solo practice than was the membership at large and were more likely to have some affiliation with a residency or academic program. Of the 235 physicians who responded to her questionnaire, 9.4 percent were planning to discontinue obstetrics within the following few months. The greatest number gave malpractice liability risk or the cost of malpractice insurance as their reason for dis-

continuing obstetrical care (Smith, Green, and Schwenk 1988).

An earlier study by Smith (1985, 12-13) noted that more extensive integration of obstetrics into the residency program may have been correlated with the number of graduates who incorporated obstetrics into their family practice. She noted that the E.W. Sparrow Hospital residency program in Lansing, which followed one formal month of obstetrical training with a residency-long nonrotational experience in one of two community prenatal clinics, was able to report that 100 percent of its graduates had continued to practice obstetrics.

Managed care/HMOs

By the summer of 1980, Michigan's family physicians were becoming aware of a growing trend toward prepaid health care. Armen Shekerjian, M.D., described "a new cost-conscious health care concept" that was developing in Detroit. Blue Cross/Blue Shield - Michigan was about to begin pilot operation of the Primary Care Network (PCN) (Shekerjian 1980, 13). Three hundred primary care physicians in the Detroit area had formed 20 Physician Incentive Pools. The typical pool consisted of 8 to 26 members. Once a year, Blue Cross/Blue Shield would pay each pool an amount based upon the number of subscribers that had selected that pool. At the end of the year, Blue Cross/Blue Shield and the Pool would split any surplus or deficit. The Pool's liability for excess medical costs for any one subscriber would be limited to \$15,000.

Shekerjian was enthusiastic about the new project, saying, "PCN will allow the continued personal relationships you and your patients now enjoy. Equally important, I think, is what PCN will demonstrate to the public-at-large: that we in the health-care field are perfectly capable of controlling our own costs."

Gary Ruoff, M.D., of Kalamazoo, was president of Michigan Academy of Family Physicians in 1980-81. Although he, too, was concerned about spiralling medical costs, he was less than enthusiastic about capitation plans.

He wrote,

I have been intrigued by the proliferation of Health Maintenance Organizations and Independent Practice Associations which claim that per capita reimbursement limits the num-

ber of tests performed and drastically reduces hospitalized care in favor of ambulatory care. Isn't ambulatory care what family practice is all about? Aren't we already limiting admissions to the hospital and performing fewer tests? Will we be forced to limit hospitalization and testing to the detriment of the patient because the per capita amount is insufficient to cover even reasonable health maintenance to keep the person well? God forbid! (Ruoff 1980, 3)

In *The Social Transformation of American Medicine*, published in 1982, Paul Starr warned,

Medical care in America now appears to be in the early stages of a major transformation in its institutional structure . . . Corporations have begun to integrate a hitherto decentralized hospital system, enter a variety of other health care businesses, and consolidate ownership and control in what may eventually become an industry dominated by huge health care conglomerates (Starr 1982, 428).

By 1984, the changing health care delivery system was being widely discussed by Academy members. There were a few advocates of prepaid plans, but many were concerned about the accelerating trend. MAFP president William Allen, M.D., announced the seeming inevitability of the new trends in health care delivery, and explored the options family physicians faced. He expressed concern that some would attempt to practice medicine as they always had, and would face diminishing numbers of patients, diminishing income, and an ensuing major life crisis. Others might retire or leave medicine for other careers.

The only viable option Allen could find was to adapt to the inevitable (Allen 1984, 2-3). He said,

We must become knowledgeable about the various forms of health care payment. We must become good negotiators and in many respects, we must become entrepreneurs and businessmen. We must be able to select the program that best serves our patients and our own needs.

John W. MacKenzie, M.D., of Flint strongly advocated the HMO model of health care delivery (MacKenzie 1984, 16-17). MacKenzie had been in private practice in Swartz Creek for 25 years before he became a cofounder of Genesee Health Care, an IPA-type of HMO in the early '80s. In May 1982, he left

Genesee Health Care to become medical director of a Blue Cross/Blue Shield subsidiary staff-model HMO called Greater Flint HMO. He said of his involvement in managed care, "This decision caused great consternation and anger among many of my colleagues."

In 1970, there had been thirty-three HMOs nationwide, serving three million enrollees. The 1973 HMO Act made \$364 million in federal funding available over a ten-year period for HMO plan development. By 1980, there were 236 HMOs serving 9.1 million members.

MacKenzie took issue with the idea that such prepaid systems might compromise physician independence or quality of care, stating that physicians in his group "could continue to practice family medicine as we had previously but with some added bonuses." Primary among these added bonuses was the establishment of formal patient education programs, an in-house psychology unit, and a dietitian. He reported rapid patient growth and the need to continually add physicians to the staff.

Physician recruitment was difficult at first, MacKenzie acknowledged, but it was becoming easier after two years. He had begun to notice that "many of today's younger physicians increasingly prefer an organized practice setting where they can use medical skills and be free from administrative duties."

Facing challenges within academia

By 1980, all of the medical schools in Michigan had developed family practice or family medicine departments, the newest being that of the University of Michigan established just two years earlier. Despite their differing contexts and histories, all three programs faced some common challenges. Among them was the need to prove family medicine was a viable intellectual discipline, on a par with the other medical school specialties. Faculty were encouraged to develop their research skills and publications record. Some explored the possible development of subspecialties within the purview of family practice. Another challenge was to develop a solid financial base, making the department less vulnerable in a cost-conscious decade.

Michigan State University.

Already, in 1977, the Michigan State University Department of Family Practice, in collaboration with the Michigan Academy of Family Physicians, had initiated what may have been the nation's first Family Practice Research Day (McKeag and Smith 1980, 325-27). The first competition attracted 62 attenders, and 15 papers were presented. Original research papers were presented during the morning in a competitive forum. The afternoon consisted of a research symposium for participants. The day concluded with a keynote speech and awards banquet. Residents, students, and practicing family physicians were all encouraged to present papers, as were faculty members. It became an annual event by the turn of the decade.

When the department undertook an internal review in the mid-80s, it emerged that the Department of Family Practice had published more articles in national journals than had any other department in the College of Human Medicine. "We were blessed with some very gifted faculty members," Roy J. Gerard, M.D., then chair of the department, has recalled. He especially remembers Howard Brody, M.D., Ph.D., as contributing strongly to developing the intellectual reputation of the department with his work on medical ethics.

By the early 1980s, a conversation had also begun on both the national and local level about the appropriateness of subspecialty development within family practice. An infectious disease fellowship had been instituted in Saginaw, where the residency was affiliated with Michigan State University, and in a published description of the program, Haddy et al. (1982, 601) argued, "Subspecialty training brings to academic family medicine a basic science base that is well complimented [sic] by the unique assets of the family and individual approach to medical care."

At Michigan State University, Douglas McKeag, M.D., and David Hough, M.D., were instrumental in developing a strong sports medicine program, and James O'Brien, M.D., encouraged an emphasis on geriatric care within family practice.

While the department was making strides in developing academic legitimacy, the economic environment was difficult in the early '80s. Significant federal start-up funding had

ended, as had the W.K. Kellogg Foundation grant that had underwritten much of the department's expenses in its early years.

In the mid-80s, Gerard took a step that his faculty was not yet prepared for — he signed a contract between the Department of Family Practice and Health Central, a Lansing-based HMO. Gerard remembers,

Nobody in the department wanted [it], and I really forced it down their throats whether they wanted to or not . . . I think that's one of the few times as chair I did something without the agreement of the faculty. I just felt we needed to do it . . . Suddenly, financially, we were fat again at a time when we needed it. It gave us an opportunity to develop leadership in that area, and we continue to be the leader.

When the department became involved in the development of health teams during the 1970s, Gerard had faced criticism from some colleagues in the field who charged that he was “selling out to nurses, and to social workers, and nutritionists, and so on.” By the mid-80s, he felt vindicated in choosing this path for the department. Not only was family practice the first department in the College of Human Medicine to sign a contract with an HMO, but they already had developed the skills for delivering health care by teams, and Gerard found that to be a prerequisite for making a managed care contract work.

University of Michigan.

The Department of Family Practice at the University of Michigan was initiated four years after Michigan State University's. Because of this late start, the department was still in its infancy when it had to confront the tighter economic situation that characterized the late '70s and early '80s.

The department soon began to receive criticism for its financial situation. The University Hospitals had expected a greater number of referrals than the Family Practice Center in Chelsea would generate, and the Center did not produce the economic profits that it had when it was a privately owned group practice rather than an educational institution (Davies, Telephone interview 1996).

The central administration of the medical school and hos-

pital became increasingly concerned about the department's financial situation, and in 1982 a Family Practice Management Council was created to explore the problem. The Council was suspended after two years, without having resolved key financial issues (Sheets and Davies 1989a, 7).

The medical school's dean, John Gronvall, M.D., resigned in 1982, and Peter Ward, M.D., chair of the pathology department, was named interim dean. Ward expressed concerns about the financial status of the department, and initiated an internal and external review of its functioning.

According to Terence Davies, M.D., chair of the department of family practice, (Telephone interview, 1996), a majority and minority opinion were submitted as a result of the external review. The minority opinion, which called for abolishment of the department, was accepted by Ward, rather than the majority opinion.

The majority opinion (Sheets and Davies 1989b) had actually called the medical school to accountability for its lack of support of the young department, saying,

This recommendation [that the department be maintained] is made with the proviso that the institution be willing to commit itself to encouraging the Department of Family Practice to become the best possible academically-oriented department of its type. This commitment must include a willingness to integrate the department into the mainstream of institutional life, and reflect an understanding that the department (and indeed the discipline) is still in a developmental stage and requires special attention and assistance from the parent institution. The Committee firmly believes that the status quo is unacceptable and should not be perpetuated. If the institution wants Family Practice it should not settle for less than an academically sound program.

The department may have been saved by the concurrent development of plans to initiate M-Care, a University of Michigan prepaid health care plan which would rely heavily on primary care physicians. George D. Zuidema, M.D., was the newly appointed vice-provost for health affairs, and he soon became an advocate for the Department of Family Practice. He believed that family practice would prove its worth to the newly envisioned clinical operation (Sheets and Davies 1989a, 7-8).

Although the department would survive, Davies resigned

as chair on March 1, 1986. Thomas L. Schwenk, M.D., was appointed interim chair and led the department in the expansion of clinical services that accompanied the development of M-Care. In December 1986, the department opened the M-Care Health Center in Briarwood, initially staffed by four full-time family practice faculty members. The site was one of four new satellite clinics established by the university as a part of the M-Care HMO (Sheets and Davies 1989a, 9).

Sheets and Davies cite the early need to focus on developing a patient care base and a residency program, along with a rapid turnover of faculty members in the early years as contributing to a delay in developing the department's research productivity. Davies appointed a Research Task Force in January 1981, which conducted a study of the department's resources and options. Based on their report, the department designated a portion of its budget as seed support for individual faculty research initiatives. In 1984 it established a Unit for Research Support, which in 1986 became the Research Development Group which met monthly to discuss issues related to research activities in the department. The development of this Group responded to one of the recommendations made by the department's External Review.

Osteopathy faces a crisis of identity

By the mid-1980s, the osteopathic community was facing a crisis of identity. Its very growth and its success in gaining access to, and acceptance by, allopathic institutions led it to a concern that the philosophical and clinical core of osteopathy was becoming diffuse.

The profession was growing rapidly, with the number of graduates more than doubling nationwide between 1970 and 1980 (Gevitz 1982, 150), but the osteopathic manipulation techniques that had been its early trademark were now practiced much less frequently than they had once been (Gevitz 1982, 142). With the training of osteopaths becoming more similar to that of allopaths, and many osteopathic medical students opting for graduate training in allopathic residency programs, tensions developed among osteopaths in private practice, the osteopathic hospitals, and the Michigan State University College of Osteopathic Medicine.

Tension also had developed between osteopathic graduate training programs and allopathic programs. Allopathic programs had finally opened their admissions to osteopathic medical graduates, and now the osteopathic graduate programs found themselves competing for residents with allopathic programs that could provide better financial stipends and a wider range of training experiences than could the comparatively underfinanced osteopathic programs (Committee on Osteopathic Unity 1989).

When the College of Osteopathic Medicine began to explore the possibility of developing intern and residency programs with Henry Ford Hospital in Detroit, many osteopathic physicians interpreted this as a threat to existing osteopathic graduate medical programs.

In November 1987, a task force was created by the Michigan Association of Osteopathic Physicians and Surgeons' House of Delegates to bring together leaders from that organization, the osteopathic hospitals, and the MSU College of Osteopathic Medicine with the hope of strengthening unity within the profession. Members were charged with developing a statement that encompassed their understanding of osteopathic identity. After much consideration, the group agreed that the statement would not include reference to the technique of osteopathic manipulative treatment (OMT) on the grounds that while OMT was a valuable tool, it was one of many treatments used by osteopaths and was not solely in the domain of the osteopathic profession.

Instead, they created a statement which they hoped would provide a basis for the possibility of growth and change within the profession:

The foundation of osteopathic medicine is its philosophy of care which combines the particular needs of the patient with medical science and an appreciation of the underlying cause of illness. Osteopathic physicians provide complete, comprehensive, and continuous health care services. These services encompass a recognition that the body is a unit which has self-regulating mechanisms that interrelate body structure and function. This recognition also identifies a rational approach of osteopathic diagnosis and therapy. (Committee on Osteopathic Unity 1989, 1)

The task force encouraged a higher degree of intentional communication and collaboration among the osteopathic institutions in the state, including the development of consortium arrangements among osteopathic hospitals and greater support for the College of Osteopathic Medicine, which was facing financial constraints similar to that of the university-based allopathic medical schools.

“Who are we, and are we happy?”

At the 1988 annual meeting of the Michigan Academy of Family Physicians in Traverse City, 250 family physicians were asked to complete a questionnaire. Louis Constan, M.D., a Saginaw family physician and editor of *Michigan Family Practice*, summarized the findings in two articles.

His first article, “Family Doctors: Who Are We, and Are We Happy?” indicates that

most consider ourselves very smart and consider family practice the most intellectually stimulating and challenging specialty. This is one of the main reasons we chose to go into the field. Further, most of us found that family practice is even more stimulating and challenging than we thought when we first chose it as a career.

When asked if they were to choose a medical specialty again, how likely they would be to go into family practice, the overwhelming majority answered “very likely.” Constan noted, “That is surprising in light of the respondents candid acknowledgment of the many problems that our specialty is facing, including low pay, long hours, and lack of respect from other specialists.”

He found that the three motivators of family physicians most often indicated were the “intense personal involvement with people on a long-term basis,” the opportunity to use that relationship to improve a person’s health, and “helping families and growing with the families we care for.” He went on to note that “not one, no, not one” of the respondents picked as being of major importance “making money,” “being an authority figure,” or “the intellectual challenge of understanding the pathology of the patient’s disease.”

He summarized,

It is pretty rare to see all doctors agree on anything. The

fact that no one checked these items indicated fairly strongly that family doctors are NOT interested in money or power. Therefore, the lack of these benefits, alone, is unlikely to make a family doctor dissatisfied with his specialty.

When asked their perceptions of what made them unique compared to other specialists, the MAFP respondents most often mentioned that they

- 1) provide cost-effective, comprehensive care, early diagnosis, and more effective case management,
- 2) treat a wider variety of medical conditions,
- 3) have a greater involvement in family issues,
- 4) have a stronger patient/doctor relationship, and
- 5) care for the patient's total wellbeing.

Constan noted, "We've heard these things before, no doubt. They constitute the 'party line,' as it were. It is interesting to note, however, that these notions are really subscribed to by the majority of family doctors. They are not just advertising propaganda."

Family Practice: Its Future

“I think a lot goes back to the way the public perception of physicians and their role has changed — the loss of trust in physicians has really closely paralleled the specialization. More and more patients that I meet can explicitly say how important it is to have a family physician, that the physician they need is a family physician. They don’t need to have specialists unless the family physician thinks they need one. They understand that emergency rooms and specialists’ offices are dangerous places to go if they’re not being carefully guided there. Some of my patients have learned these things the hard way. They’re telling their friends, so there’s patient demand for what we’re doing.”

— Paul Lazar, M.D.
Flint

“I think the family physician is going to show the government, without a doubt, that we are the keystone to medical care in America, and they will get off this fix of having the specialists be in charge. I think the specialists will realize that the family doctor is going to be the keystone.”

— Charles Zimont, M.D.
Constantine

“I think when the responsibility for paying for the patient’s illness and his treatment lands on the shoulders of the family physician, as it’s going to through HMOs, it’s going to be to his advantage to do some of those minor procedures on his own, rather than to refer them out and have them done in a surgical care center or something. It’s also going to be to his advantage to do excellent preventive care”

— Walter Averill, M.D.
Saginaw



9

Approaching 2000

By 1990, family practice had overcome many of the hurdles it faced in becoming recognized as a medical specialty and had gone through a long process of self-definition. In many ways, family practice could be said to have “arrived” as a respected medical specialty delivering quality medical care to Michigan’s population. Each of Michigan’s medical schools had a strong department of family practice, with a thriving research program.

At the beginning of the new decade, George Dean, M.D., of Southfield again explored the problems of, and prospects for, family practice as he had in 1980. While he had not discussed managed care directly in his 1980 essay, it was prominent in his 1990 article. In *The Pharos* he wrote,

During the past ten years, there has been a dramatic increase in the size of the managed care industry in the United States . . . Administrators and chief executive officers of alternative health care plans quickly came to the conclusion that family physicians were the most aptly trained and talented physicians to provide managed care in the country.

He suggested that the managed care industry could be a potential source of funding for family practice residency programs, given the direct benefit to them of an increased number of graduates.

He saw as a major concern for the discipline the stagnant number of medical students entering family practice, and gave six reasons for this stagnation:

- 1) lack of resources to start new programs,
- 2) increased educational costs for medical students,
- 3) inadequate reimbursement for nonprocedural care,
- 4) a hostile environment in medical schools,
- 5) inadequate curricular time and poor quality of family practice education in schools, and

- 6) medical schools that did not address the social needs of the country.

Dean argued against either the promotion of a joint internal medicine-pediatrics residency or the development of a “generic primary care physician” through the merger of family practice, general internal medicine, and general pediatrics. However, he urged that, “A welcome should be extended to those interested general internists and pediatricians who wish to become family physicians. An avenue should be provided to convert general internists and pediatricians to family doctors.”

Others also voiced their concerns, newly defining the boundaries of family practice and the appropriate role of various providers. Some, such as Lionel Swan, M.D., (personal interview 1996) of Detroit, warned that the family physician’s role is in danger of being undermined by what he saw as a potentially dangerous trend toward utilizing physician assistants and nurse practitioners as primary care providers.

Some, such as John Battle, M.D. (1994:6), of Oakwood Hospital in Dearborn rebelled against the implication that family physicians might become simply “gatekeepers” in a managed care system, emphasizing that the role of the family physician is to

provide definitive care to our patients and assure them of the best subspecialty care available when the need is identified. We and our subspecialist colleagues must be sensitive to the financial consequences of our decisions, however, that must remain a secondary issue.

Not only did questions of professional identity arise anew as the health care environment changed, but so did concerns about the limits of appropriate practice for the family physician. In the early days of the discipline, there were philosophical differences about how procedurally oriented family practice should, or could, be. As the locus of health care finally began to shift from the hospital to the physician’s office, questions have focused on what procedures could and should be performed in the family physician’s office. Mindy A. Smith, M.D., and Michael S. Klinkman, M.D. (Smith and Klinkman, 1995), both of the University of Michigan, warned that none of the national organizations involved in establishing criteria for training of family practice residents have provided core content guidelines

in the area of office procedures. They suggested that this lack of guidance had created "marked regional variation in procedures training and physician competency, and a significant mismatch between procedures taught during residency and those needed or desired in practice." They noted that the growth of managed care plans would "undoubtedly result in increased pressure to perform more diagnostic and therapeutic procedures in the primary care setting," and called for an extended dialogue on the many questions associated with the increased performance of procedures by family physicians in an office setting.

Managed care

Despite the apparent success of family practice, these new societal stresses and challenges indicated that old models of primary health care delivery might no longer be adequate in the 1990s. As Paul Starr (1982) predicted in the early 1980s, health care services had indeed become increasingly controlled by large corporations and health maintenance organizations. In 1994, Sheldon Freilich, former president and chief executive officer of DMC Care, estimated that 20 percent of the population of southeast Michigan was enrolled in HMOs, with another 28-30 percent enrolled in PPOs (Michael 1994, 1). He projected that in 10 years 75 percent of the population would be covered by managed care.

Statewide, HMO enrollment grew steadily from just over 1 million in 1985 to 1,725,000 (20 percent of Michigan's population) in 1993 (Carlson 1995, 29). Sixty-nine percent of Michigan physicians had a contract with an HMO, and 74 percent had a contract with a PPO in 1994. By mid-decade, Michigan Medicaid was moving quickly toward managed care for the 1.2 million people for whom it provided health care coverage.

While concerns about the impact of managed care both on the practicing family physician and on patient quality of care continued, an ever-increasing percent of graduating residents found salaried positions, with very few anticipating a solo practice.

The concerns voiced by white physicians about tightening profit margins in managed care contracts, arbitrary termination of contracts, rejection of less healthy patients by HMOs, and the imposition of practice protocols were felt even more strongly by African-American physicians. In a survey conducted at the

1994 annual convention of the National Medical Association (Lavizzo-Mourey et al. 1996), 350 physicians responded to the question, "Do you feel African-American doctors have contracts terminated more often by managed care organizations than white doctors." Ninety-two percent answered "yes." Seventy-one percent said that they had at least one contract with a managed care organization.

Of those who had applied for a contract, 88 percent had been denied at some point. Eighteen percent of the primary care physicians who responded had had a contract terminated (compared to 30 percent of the subspecialist respondents). Respondents were taking a variety of measures to make their practices more attractive to managed care organizations, including forming independent practice organizations, changing their referral patterns, and changing the hospitals to which they admitted patients.

Lavizzo-Mourey hypothesized that one reason African-American physicians might be less desirable to managed care is that they "have historically attended to the health care needs of vulnerable populations including urban and rural poor and minority populations," adding that for managed care organizations, "a principal strategy for keeping costs down and maximizing profits is to limit the enrollment of a large number of chronically ill patients."

She continued,

Because the consumption of medical resources often is tracked as part of the managed care physician evaluation process, one possible explanation for differential treatment is that African-American physicians are less attractive to managed care organizations due to their patient populations.

Michigan Academy of Family Physicians grows into a new building

James Shetlar was MAFP president when the organization decided that it was time to move again. After his term as the state Academy's president was up, he chaired the building fund drive at the turn of the decade to construct a building in Okemos. Shetlar (Personal interview, 1996) recalls that the fundraising group assigned a certain monetary value to each of the rooms of the proposed office building, as well as putting a price on the entire building. If someone donated the requested

amount for a certain room, that person could dedicate the room. The person who would donate \$25,000 to the building fund would be entitled to have the building named after someone of his or her choice. He remembers, "Everybody said you will never get \$25,000. Nobody will do that."

They had not counted on Nell Rhoades' dedication to the Academy or to the memory of her recently deceased husband, Francis "Dusty" Rhoades. Nell Rhoades had been as heavily involved in the Academy as had her husband, and continues to attend the MAFP Annual Meeting each summer.

Shetlar remembers,

Janice Klos, our executive director, called and asked if I could come down to Lansing. Mrs. Rhoades sat down, just like you and I are talking. She said, "How much money do you want in order to have the building named after my husband?" I said, "\$25,000." She never batted an eye. She just looked me straight in the eye and said, "Can I have that commitment today?" Then she contributed a lot more after that for the museum. She's been a very strong supporter.

Nell Rhoades also contributed her husband's personal library and memorabilia covering his career as a family physician. The Francis P. Rhoades Center, which had opened in 1991, was dedicated in his name on Sept. 16, 1992 (*Detroit Medical News* 1992, 1).

In 1991, Shetlar became the first Michigan family physician to sit on the American Board of Family Practice, after being selected to a five-year term by the American Academy of Family Physicians.

Women and people of color in family practice

A previously active Committee on Minority Affairs was reestablished in 1990 with Martin Kabongo, M.D., as chair, in response to concerns that minority physicians were not being adequately addressed (Michigan Academy of Family Practice 1990, 12). Leonides Leach, M.D., of Flint had been the only person of color to head MAFP, and that had been in 1967. During the 1993 birthday party for MAFP, Kabongo noted that he was gratified by "some genuine efforts" that had been made by the Academy during those three years, but said that the small number of minority medical students going into family practice was still "ridiculous." He urged strong support and mentoring

of young people of color, and commented that he had recently treated a child who said he had never seen a black physician before.

In 1991, Karen B. Mitchell, M.D., vice chair of the MAFP Committee on Women in Family Practice (1991, 5), reported that 30 percent of family practice residents were women, and that 73 percent of all women practice physicians were less than 45 years old and were a rapidly-growing part of the Academy's membership. Twenty percent of all AAFP members were women, and this was expected to rise to 30 percent by 2010.

However, in the AAFP's history, only three women had ever served as a board member, and none have been officers. Michigan, with women constituting 16 percent of the active Michigan Academy of Family Physicians members, had no women chapter officers in 1991. There still had been only one woman as president of MAFP, and that had been seventeen years earlier.

The second woman to be chosen as president, Mary Elizabeth Roth, M.D., of Southfield, was installed in July 1997, and Mitchell was named first vice president of the Michigan Academy of Family Physicians at the same time.

Osteopaths accepted by American Academy of Family Physicians

In 1989, the American Academy of Family Physicians tightened its membership requirements, requiring completion of a three-year AGME-approved family practice residency, according to Janice Klos, executive director of the Michigan Academy of Family Physicians (Klos, Personal interview 1996). This most directly impacted osteopathic physicians who might seek AAFP membership. While some had graduated from allopathic residency programs, many had trained in American Osteopathic Association-approved programs and would no longer be eligible for membership. According to Klos, the Michigan Chapter made an intensive effort to enroll osteopathic physicians before the more restrictive regulations went into effect. Then the chapter began advocacy of its AOA-trained colleagues.

MAFP president Bruce Deschere, M.D., (1993, 1) reported that in 1991 the Michigan Academy had passed, and referred on to the national level, a resolution supportive of active membership for osteopathic physicians who went through three

years of general practice training approved by the American Osteopathic Association. The resolution was approved by the 1991 AAFP Congress, but required a bylaws change prior to implementation. Although the bylaws change received majority support from the delegates in 1992, it did not receive the required two-thirds majority.

Deschere said,

The debate... was quite vigorous. Proponents noted that the physicians in question had clearly dedicated themselves to the concept of family medicine by virtue of continuing their training two years beyond the usual year of internship required for licensure. Opponents argued that the training was not equivalent to the training provided by the 400 programs nationwide that are currently approved by the ACGME and are essentially allopathic programs (although some DOs train at them).

The MAFP reintroduced the measure in 1993, when it was approved, allowing active membership for osteopathic physicians who were residency trained in an AOA-approved program (Tobolic 1993, 1). Four years later, Larry Carr, D.O., of Bay City was selected president-elect of the Michigan Academy of Family Physicians, in line to become president in July 1998.

Michigan's twentieth family practice residency was accredited in 1996, when Munson Medical Center in Traverse City was approved (Michigan Family Practice 1996, 10). Munson was Michigan's first program to be jointly accredited as both an osteopathic and allopathic family practice residency program, another indication of increasing cooperation between the osteopathic and allopathic professions.

Relationship to other health care providers

As the century neared its end, the relationship of family practitioners to other health care providers continued to be held in some tension. In late 1997, MAFP president Mary Elizabeth Roth (Roth, 1997, 1) alerted members that Michigan Senate Bill 104 had reported out of committee, and would allow independent practice and prescriptive powers for "licensed registered nurses with special certification."

A look at the numbers

In the mid-1990s, 1,923 nonfederal family physicians provided direct patient care in Michigan, 11.3 percent of all phy-

sicians in the state (American Academy of Family Physicians 1995, 12). As the specialty of family practice neared its 30th birthday, fewer and fewer general practitioners remained in medical practice. In 1995, only 430 of Michigan's 1,923 family physicians were general practitioners, more than half of whom were above the age of 60 (American Academy of Family Physicians 1995, 16) and nearing retirement.

Statewide, there was one family physician for every 4,903 civilians in Michigan (American Academy of Family Physicians 1995, 12), just slightly better than it had been in 1985 when it stood at 1 to 5,012 and Michigan was among the twelve states with the least desirable ratio of family physicians to civilians (American Academy of Family Physicians 1987, 8). Among members of the Michigan Academy of Family Physicians, 30.5 percent were in solo practice, 12.8 in a two-person practice, 44.3 percent in a family practice group, and 12.2 in a multispecialty group (American Academy of Family Physicians 1995, 32).

As a percentage of the total number of physicians in the country, family physicians and general practitioners combined have continued to decline slightly from 1965 through 1993. Nevertheless, family practice is the second largest specialty (American Medical Association 1994, 20), following only internal medicine, and the actual number of family physicians has increased as the percentage has declined. More important is that the physician/population ratio in family and general practice, which dropped to a low of 24.9 in 1975, has gradually risen slightly to 27.7 in 1994 (American Medical Association 1994, 1983).

The Michigan Academy of Family Physicians served 1,317 active members as of January 1995 (AAFP 1998). In 1998, Michigan family practice residency programs offered 133 openings for first-year residents and filled 85 percent of the positions (American Academy of Family Physicians).

Family Practice: Managed Care

“When I went into practice, I desperately wanted to practice fifty years. It will never happen. I just know that I’m not going to practice seven more years. It’s too disturbing to have all the interventions of government and third party payors dictate one way or another what decisions ought to be made. I try to divorce myself from that, and I don’t make decisions based on these things. I make decisions on what’s best for people...I suppose in a few more years I’ll quit.”

— Richard Howell, M.D.
Midland

“I think managed care has affected D.O.s the same way that it’s affected M.D.s. There is a lot of competition. I’m not so sure that it’s always healthy competition. I think that the government and a lot of people who look in on our profession recognize that the way to keep us from being more together is to divide and conquer. If they can fragment people, they have a better chance of being successful and getting people to participate with their programs and cut their prices. Physicians tend to be a pretty independent group of people, and it isn’t always easy for them to interact and form unions to prevent themselves from being victimized in some cases.”

— Carol Monson, D.O.
Okemos

“I haven’t personally been impacted by managed care yet in a rural area, but I’m kind of scared of it. They talk about how it used to be how full your parking lot was that showed you were a busy practitioner. Now, it’s how empty your parking lot is. That scares me. Patients are going to suffer. Until I can figure out some way that isn’t going to happen, I just want to stay away from managed care.”

— William Stewart, M.D.
Union City



10 Epilogue

In 1974, Alberta Parker, M.D., wrote, “Searching, dissatisfied patients; tired, dissatisfied providers—these are the ingredients of primary care for many, and the reason why it is essential to explore this country’s needs for primary health care and to consider how these needs can be met in this changing world.”

When Parker wrote these words, the specialty of family practice was only five years old. The supply of primary care physicians, especially general practitioners, had been declining for several decades. The health care paradigm focused on hospital-based care and a biomedical model had facilitated major technological advances in medical care; but the general public found access to primary or preventive health care increasingly difficult, and medical care was fragmented among the burgeoning number of specialists.

The new family practice movement of the 1960s “symbolized a generation’s passion for equity in medical care, its desire to open up the stern rigidities of medical education to a broader, more humanistic curriculum and to decentralize the power of the medical schools,” according to G. Gayle Stephens, M.D (1986, 4). It successfully raised the standards of graduate education for family physicians, introduced training in ambulatory care, and emphasized the importance of social and familial context as factors vital to the health of patients.

Yet, the wearying persistence of concerns about geographical and financial access to health care, coupled with increasing health care costs and complicated by the looming dominance of managed care plans, leads us back to Parker’s concern of more than two decades ago. Patients are still dissatisfied—with fragmented care, long waits, spiraling costs, and now with a perceived restriction of physician choice and/or treatment options. Primary care physicians are dissatisfied—with increased paperwork and practice costs, and with decreased autonomy

and income.

Attempts to control the rising cost of medical care have indeed been accompanied by constraints in the way that family physicians, as well as other specialists, will be able to practice in the future. Solo private practice will become increasingly difficult to maintain, as the number of fee-for-service patients continues to decline. The autonomy to which family physicians are accustomed in determining treatment plans has also become more restricted, as managed care seeks to develop protocols which will provide cost-effective care for the greatest number of patients.

Whether managed care represents an unique opportunity for family physicians to function as the coordinator of care for their patients, or whether management directives from the parent corporation represent a grave threat to the ideals of family practice is arguable. Some physicians suggest that family practice can finally come into its own as a specialty in the managed care context, while others feel affronted by challenges to their professional autonomy. Medical protocols that limit a physician's choice of treatment can be seen as a floor that ensures each patient will receive appropriate and cost-effective treatment, or they can be seen as unprecedented interference in a physician's decision-making autonomy. A concern that mid-level providers might squeeze family physicians out of their position in the health care field is counterpoised to the possibility of increased opportunities for collegial team delivery of primary care.

A summary of current trends in health care delivery and education (MacLeod 1996, 17) includes several shifts. (See Table 1.)

However these issues are viewed, it is clear that the practice of medicine has been altered by economic, social, and technological forces beyond the control of the individual physician. Daugird and Spencer (1996) have discussed the losses that many physicians have experienced as managed care becomes increasingly dominant. While they do not deny that managed care can also afford some benefits, they feel that many physicians will need to go through a period of grieving their perceived losses before they will be able to embrace a new health care system.

**Table 1. The Changing Health Care Scene:
Prominent Trends in Health Care and Health Professional Education**

From:

- Homogeneity in medical education
- A primarily biomedical sciences orientation
- Focus on individuals and their diseases
- Biomedical- and curiosity-oriented research
- Heuristic medical and health care
- Intuitive decision-making
- Insecure funding regarding essential research
- Independent decision-making
- Disciplinary isolation in education
- Physician-driven health care
- Physician independence
- Consumer passivity
- Unbalanced lifestyle
- Autonomous growth
- Government monitoring
- Public acceptance of government role in health

To:

- Diversity of preparations for a medical career
- Increasing balance with population health sciences
- Awareness of population health
- Balance with health services and applied research
- Research-based interventions
- Evidence-based policies and practice
- More secure funding for research
- Group decision-making
- Interdisciplinary (multi-professional) educational initiatives
- Multi-professional balance
- Cooperation and collaboration with multi-disciplinary and multi-sectoral groups
- Specialist teams, multi-technological approach
- Revitalized role for generalist (holistic) practice
- Blended primary, secondary and tertiary care team approach
- Community-based (ambulatory care) balance
- Rationalized, interdependent hospital system
- More even service distribution
- Health promotion, disease prevention
- Gender equality
- User involvement in decisions
- Balanced lifestyle
- Accountable choice/selective growth
- Government direction with accountability
- Public skepticism regarding government's right to choose.

Among the losses they have seen physicians experience are

- financial security and high income
- social status and prestige
- independent clinical decision making
- independent clinical resource utilization and care management decision making
- independent private solo or small group practice as an option
- authority and power in governance of hospitals and other health care organizations
- freedom of choice and security in geographic practice location
- freedom of choice in specialty selection
- physician collegiality
- physician-patient relationship continuity
- autonomy.

But along with these losses comes new opportunity. The demise of the hospital model of health care delivery provides an opening for the development of a new primary care- and community-oriented paradigm of health care. Family physicians can play a vital role in the development of such a new paradigm, but the transition will challenge and stretch all members of the profession. It will be necessary to recognize and confront the weaknesses, and even the failures of family practice, as the discipline moves ahead.

Can family practice meet the challenge?

Stevens (1986, 17) suggests that the enduring contribution of family practice has been that “it deflected the trajectory of mainstream medicine towards humanism and personalism to a degree that would not have occurred otherwise,” although it has not been able to single-handedly turn the increasingly fragmented health care system around. And he adds that to have achieved that much “would be no mean accomplishment.”

Perhaps it is too much to expect that any one discipline alone can provide a full corrective to social dynamics taking place on not only a national, but an international, scale. However, it is important to explore how family physicians can collectively act most effectively to impact the larger medical system.

As family practice has come of age, it has seemed that the desire to establish itself as a respectable member of the medical family sometimes has been at odds with the advocacy of its unique goals and values. Christianson (1987, 207-208) has argued that family practice relied heavily in its self-definition on traditional, conservative values which actually may have constrained its ability to attain some of the reforms that it espoused. He noted that,

Family practice is one of the most conservative of the challenges to the establishment... Much of the success of family practice with the general public has been due to its association with conservative and nostalgic themes of rural life and the old family doctor.

He suggested that “family physicians have chosen to have a family quarrel [with the medical establishment] without moving out of the big house.”

Christianson urged,

The family physician, particularly in urban areas, is a natural advocate for the poor, who will face increasing problems in receiving adequate health care. Concern for patients can lead to greater attention within our specialty to the workplace, community, health care delivery system and other elements of the environment in which our patients live which we have neglected in the past. Resisting the lure of acceptance of the traditional medical approach, while maintaining and strengthening our position as critics of the status quo in medicine, may indeed be the best path to survival and growth in the future.

A new paradigm for health care

As family physicians find their comfort zone pushed by the changing economic and social environment in which they practice, new opportunities are arising that can help them attain the very goals they aspired to as young physicians. It is clear that this is a time of challenge in which the goals and values of family practice must be re-examined. Those values which are still found to be sound must be reaffirmed, and new strategies to accomplish these goals must be explored.

As articulated by leading proponents over the past thirty years, some major goals of family physicians have been to:

- 1) provide personal, continuing, and comprehensive

- care, regardless of sex, age, or type of problem
- 2) serve as the patient or family advocate in all health-related matters
 - 3) be available to care for the entire family, with its interlocking problems and dynamics
 - 4) consider the biopsychosocial environment of the patient and family
 - 5) provide health care to medically underserved groups and locations.

While some have called for a re-examination of goals and values within the structural context of the specialty of family practice, others suggest that a new type of generalist now is needed in the delivery of health care. The old models of health care delivery separate family physicians from others who deliver primary health care. This unique and separate identity was hard won, but rigid adherence to specialty differentiation may now stand in the way of close and effective cooperation.

In 1994, the World Health Organization outlined the characteristics of the "Five Star Doctor." They included:

- *Care provider*, who considers the patient as an integral part of a family and the community and provides high standard clinical care (excluding or diagnosing serious illness and injury, manages chronic disease and disability) and personalizes preventive care within a long-term trusting relationship.
- *Decision maker*, who chooses which technologies to apply ethically and cost-effectively while enhancing the care that he or she provides.
- *Communicator*, who is able to promote healthy life styles by emphatic explanation, thereby empowering individuals and groups to enhance and protect their health.
- *Community leader*, who having won the trust of the people among whom he or she works can reconcile individual and community health requirements and initiate action on behalf of the community.
- *Team member*, who can work harmoniously with individuals and organizations, within and without the health care system to meet his or her patients' and communities (sic) needs.

Some current discussions focus on the feasibility of retraining specialists so that they can become proficient in providing

primary care. Others suggest the merger of family practice, general pediatrics, and general internal medicine into one primary care discipline. New integrative technologies in health care (for instance the computer, which can provide access to both patient data and health care literature and enhanced telecommunications systems), can facilitate consultation among geographically separate physicians and provide an unprecedented ability for the generalist to integrate medical information in the service of a patient (Reiser 1995, 11).

Relationship-centered care

A related conversation is reconsidering the vision of quality health care — what is needed today and how it can be attained in a social and economic environment that substantially differs from that of the late 1960s. A recent Pew-Fetzer report (Tresolini and Pew-Fetzer Task Force 1994) on the state of health care in America emphasizes that the “foundation of care given by practitioners is the relationship between the practitioner and the patient, a relationship vitally important to both. This relationship is a medium for the success of therapeutic regimens, and an essential ingredient in the satisfaction of both patient and practitioner.”

The report concludes, “We feel that a primary focus on ways to enhance and enrich the relationships that are relevant to health care through both education and practice is of critical importance.” From this statement came the development of the phrase, “relationship-centered care.”

Perhaps we need to take as our starting point a discussion of how our health care system can ensure relationship-centered care throughout. This concept would require an unprecedented level of cooperation among health care disciplines, with attention paid to the development of collaborative models of care. Such models must account not only for working relationships among primary care specialists and with subspecialists, but with the growing numbers of nurse practitioners, nurse midwives, and physician assistants.

It is estimated that, nationwide, there is one of these professionals in practice for every four primary care physicians (Public Sector Consultants 1996, 2). Studies indicate that nurse practitioners can manage 80 percent of adult care and 90 percent of pediatric care now provided by primary care phy-

sicians, while physician assistants can provide an estimated 80 percent of the routine functions of a primary care practice. It is interesting to note that even as some family physicians fear the loss of positions to less expensive mid-level providers, some in the nursing profession are also concerned that they may be "squeezed out" of their more advanced responsibilities by a projected oversupply of physicians (Hadley 1996, 6).

McWhinney (1997) states that home health care is the fastest growing segment of the health care system. He notes that home visits by health care professionals have doubled from 31 million in 1985 to 63.6 million in 1991. Visits by nurses increased from 15.4 million to 36.5 million.

However, home visits by physicians had not changed significantly during this period, dropping slightly from 8 million in 1985 to 6.7 million in 1991. Family physicians made an average of 21.2 home visits per year in 1991, and 35 percent did not make any home visits.

He stated further,

We have a long tradition of home care in family medicine, and it is still kept alive by those family physicians who understand its importance, but that is not enough. I believe the time has come for our discipline as a whole to reaffirm its commitment to home care. Of course, we cannot put the clock back to the 1950s, nor would we wish to. The world has moved on. Even the question, "Do you make house calls?" has little meaning now. Making one or two home visits a month is neither here nor there. The question is, "Can you work as a member of an integrated team caring for your patients at home?"

Home care offers a great opportunity for family medicine, but it requires a new level of collaboration with nursing and the other home care occupations. With changing demographics and the aging of the United States population, if family practitioners do not seize this opportunity to meet the needs of an important segment of the population, there are others ready to do it.

How can medical education adapt?

As more and more health care professionals move from autonomous private practice to positions within larger health care organizations, an ability to work collaboratively should provide benefits in professional satisfaction and intellectual crossfertilization as well as in enhanced patient care. But for

professionals to begin moving easily in such a collaborative environment may require a refocusing of training resources. Traditionally, medical schools focus on differentiation and specialization, often to the exclusion of inclusivity and collaboration. Perhaps we need to revisit and revise the way that our health care professionals are trained, to ensure their success in a collaborative environment.

The educational model most familiar to the senior author is that of Michigan State University's College of Human Medicine. When this medical school was first envisioned, proponents (Hunt 1974, 171) "emphasized unofficial and obstructive barriers between the various branches of medicine and suggested that a comparative approach to teaching and learning should be effective and that it might begin to break down some of these barriers." While the initial structural arrangements of the college did not survive, and departmental autonomy grew over the years, the precedent is worth noting and re-examining.

Hopefully, the model of community medical education at Michigan State will continue to evolve to meet the needs of 21st century society. Brody et. al. (1993) in discussing ways that the academic medical center can adapt in a changing environment, express hope that new knowledge will be discovered at the level of community practice.

It may be that current trends in health care delivery call for a level of integration in training programs on an unprecedented level. For example, at Michigan State University, reorganization of the allopathic and osteopathic medical schools and the nursing school into one combined College of Health could reflect relationship-centered care and professional collaboration. The new college could be an interdisciplinary model of health education, emphasizing relationship-centered care for providers, patients, and communities. Nursing of all types could be represented: home-care nursing, nurse-practitioners, nurse administrators, and nurse managers. A physician assistant program could also be integrated into the new College of Health. There could be social workers, nutritionists, and medical students whose focus is primary care in a collaborative model that would mirror the new health care system for the 21st century. In this context, we could develop a new definition of primary care that would empower patients and families to participate in the delivery of primary care.

Today's emphasis on cost-containment could actually facilitate such a focus. As practice-based research begins to provide empirical data on how health care can be most effectively delivered, the value of a cross-disciplinary, community-oriented approach to training and practice will be documented.

For instance, home visits are often seen as an ineffective and expensive use of a trained professional's time. But a recent study by a large health maintenance organization has indicated that the single most effective strategy to reduce hypertension among patients was to send a nurse practitioner into the home regularly to explain medications and assist patients in complying with their regimens. The HMO documented a substantial cost savings resulting from improved compliance (Hadley 1996, 9).

The practicing physician

What does this mean for the practicing family physician? How can physicians in solo or small group practice maintain or rekindle the joy and enthusiasm with which they opened the doors of their practices five, fifteen, or twenty-five years ago?

It will be the rare individual who can maintain a successful and joyful practice in professional isolation. By developing and maintaining networks with other family physicians, by working closely with allied professionals to meet the prevention and referral needs of their patients, by utilizing computer technology to link and enhance rather than to insulate, the family physician can find stimulation and companionship in an often challenging medical environment.

Managed care plans may require physicians to hone their financial management skills beyond what they might desire, but they also often provide patient resources for health education and preventive care that the solo practitioner has neither the time nor the skill to offer to patients, for example, prenatal or smoking cessation courses.

Family physicians will need to become increasingly comfortable with computerized patient and information systems. Computerized medical records systems make it easier for a patient's family physician to keep close tabs on the patient's progress when referred to subspecialists or allied health professionals. The same managed care financial incentives which nudge family physicians to develop such monitoring systems

can also benefit patients who are seeking continuity of care and a responsible personal physician.

Physicians can access medical information easily and quickly on-line with their computers, as well as consult and network with professional colleagues. This technological development promises to make the professional isolation of rural communities much less problematic, but again it requires the family physician to learn, to become comfortable with new ways of interacting with colleagues. UPRNet in the Upper Peninsula provides an example of a networking system that not only provides academicians with practice-based research data but provides rural practitioners with intellectual stimulation and companionship.

Those physicians in solo or small-group practice who have shied away from working closely with allied health personnel may now find a strong financial incentive to explore ways in which they can work productively together for the patient's benefit. As prevention and early intervention become the responsibility of family physicians, they will increasingly be assessing practice-based research results to help guide their patient management decisions.

Just as individual general practitioners were not able to transform general practice in the 1950s and 1960s, individual family physicians, in isolation, should not expect that they can, in isolation, impact the current health care environment— an environment that in many ways seems moving toward less personal care and less compassion. To develop a new paradigm of health care will require a commitment to collaboration and unified action. Thirty years ago, such unified action brought family practice to birth. And just as it was necessary thirty years ago, transformation of today's health care system will require the strong leadership of professional organizations. As corporate health care becomes increasingly well organized, so must those who will accept nothing less than quality health care, who have a vision for what health care can become and a willingness to stand firmly in support of this vision.

The changes in the ailing health care system should not discourage family medicine, but should be looked on as opportunities to heal the sick system of health care in the United States. The foundation of family medicine/family practice has

been the doctor-patient relationship and we need to restore this relationship for all of medicine. In particular, we need to change managed care so that this relationship is not lost. Our responsibility is to the patient, not to the managed care organization. As we share patients with other providers such as nurses and physician assistants, we need to redefine primary care, not to give away our patient care responsibilities but to assume a different role. Family medicine in the next century should play a greater role in general medicine than at the present time. After all, family medicine is the conscience of medicine.

Medical care has become extremely complex and technical. It requires a provider who has broad vision. If we look at medical care in a metaphorical sense, medical care is a musical score, a symphony. Family medicine should be the conductor of the symphony of health care and orchestrate who plays the bassoons, the drums, the oboes; whether the players are specialists or mid-level providers. By assuming this broader role, the score could be better understood by the patient.

This is a great time for family medicine if we are proactive. We need new Essentials for family practice education in the next century. We need a new definition of primary care. We should seize the opportunity to work with the federal government to create a system of universal health care, to create a compassionate system of health care that is available to all.

The beginning!



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Appendix

The Michigan Academy of Family Physicians The First Fifty Years

An address by Douglass A. Haddock, M.D., past president of the MAFP, during its 50th Anniversary Celebration in Lansing, Michigan, May 20, 1998.

We appreciate your joining us in the celebration of the fiftieth anniversary of the Michigan Academy of Family Physicians, and sharing this unforgettable trip with us. When “Sometimes I summon up remembrance of things past,” and peer down yesterday’s road with memories drifting past my senses, there lives the hope that all the nostalgia is woven from threads of truth.

Fortunately, it is unnecessary to rely entirely upon my recollections, for “Dusty” Rhoades saved every scrap of information pertaining to our academy which passed through his hands and Nell thoughtfully delivered it all to the Academy’s archives. With this in mind, I shall attempt to reshape the past in whole cloth, wishing for forgiveness in case errors exist.

Historically, the creation of a society for general practitioners grew from the frustration of these physicians for their deserved recognition. They were losing numbers, hospital privileges, and respect in the headlong rush to specialization following World War II. In order to preserve their integrity and existence, they marshaled their forces to create an organization with strict educational requirements for membership, which would represent the GP in the years ahead on all fronts, and eventually would gain the ultimate recognition of the specialty of family practice. Shortly after the birth of the AAGP during June 1947 at Atlantic City, a group of Michigan physi-

cians organized "The American Academy of General Practice of Wayne County." This organization held its "First Annual Postgraduate Lectures for General Practice," November 19-20, 1947, at Henry Ford Hospital in Detroit.

These pioneers continued to pursue their vision and on June 25, 1948, received the State Charter of the Michigan Academy of General Practice from Mac. F. Cahal, the executive director of the AAGP in Kansas City, as verified by the following members: Arch Walls, M.D.; E. Clarkston Long, M.D.; Jack DeTar, M.D.; A.C. Stander, M.D.; Luther Day, M.D.; and E.C. Texter, M.D.

Our early history from then until 1955 is sketchy, at best. We do know, however, that we had excellent representation on the Board of the AAGP at that time: Elmer Texter, from Grosse Pointe, was vice president of the AAGP 1947-48, and its second president 1949-50; Arch Walls, from Detroit, was elected director in 1947 and served as chairman 1950-51; Jack DeTar, of Milan, was speaker 1951-55, and president 1956-57. Incidentally, according to national records, Arch Walls was apparently the first president of the MAGP, serving in that capacity for only a few months in 1948.

The first Congress of Delegates was planned during 1956 in the basement of Carl Stander's home in Saginaw by the board of directors composed of Russell Fenton, president; E.C. Long, secretary; Dusty Rhoades; and Carl Stander. The Congress was convened later that summer at the Book Cadillac Hotel in downtown Detroit. How officers and national delegates were chosen prior to that date is unsure, but I suspect the choices were made by the Board itself.

The timing of the division of the state into chapters for the purpose of electing directors to the Board and assigning delegates to the Congress is unclear. Even though the names and boundaries of the chapters have varied, and the numbers decreasing from a high of sixteen in 1969, to a low of twelve due to consolidation, the present count of thirteen occurred with the creation of the Monroe chapter in 1997. At times it was impossible to represent a chapter with a director because of the lack of a willing candidate.

During the early years of the Academy it was traditional to alternate presidents from the Southeast chapter and the

outlying chapters. After 1970, this historical precedent was discarded in favor of the more practical and fairer procedure of choosing the best person available for the venerated position, regardless of point of origin.

It is of interest that the annual scientific assemblies of the MAGP are illegally numbered, for they include as the first, the program held in 1947 seven months before the Michigan chapter was officially chartered. There is no one living who is certain of the location of the meetings during the years 1948 through 1952, though I suspect that they were held in Wayne County, and probably at the Book Cadillac Hotel. The seventh annual postgraduate clinic was held on the Michigan State University campus, but, probably because of inadequate facilities, was returned to the Book Cadillac Hotel the following year. Dusty Rhoades stands out as one who had the propensity to create and direct postgraduate meetings, and he did so during most of the fifties and throughout the sixties.

The wives of the officers and Board members entered enthusiastically into promotion of the annual banquet, always dressed imaginatively in costumes representing the motif of the annual banquet. In my memory, Phyllis Royer, Doreen Robinson, Dorothy Long, and Nell Rhoades especially stand out as the most imaginative. Since the themes varied and included "The Pioneer West," "South Seas," "Night on the Nile," and "The Big Top," to mention only a few; the ladies of the auxiliary always beautified the meeting.

The banquets were always an enchanting social event, featuring live entertainment, dancing, and induction of new officers by a national officer. There was an enthusiasm and spontaneity to those banquets which, unfortunately, diminished over the years until they finally disappeared.

The meetings remained at the Sheraton Cadillac (name change during the sixties) through 1969, in as much as the physician numbers in Detroit would guarantee the greatest recorded attendance. Even though attendance on paper was superb, it was obvious from the meager participation at the lectures that most of the attendees signed in for postgraduate hours and immediately returned to their offices. I had long believed that the annual meeting could be more productive, and have more meaningful attendance, if held in a location

attractive to families. Consequently, during my tenure as president, I contacted Boyne Highlands resort in early June 1969 and, after making tentative reservations for the following June-July, received the approval of the Board to move the annual meeting there. This move in 1970 proved to be truly successful and brought families and many younger members to the meetings. Since the physicians were, for the most part, some distance from their offices, they attended the lectures in record numbers. After several years the meeting moved from Boyne to the Traverse City area, where it remains to this time.

I joined the Academy in early 1956, and became first involved with its political affairs in the early sixties while attending the Congress of Delegates as a delegate from the Southwest Michigan Chapter. After being elected to the Board of Directors and serving my three years, I had returned home relaxed until Ed Cochrane, then president, phoned and dropped a bombshell in my lap. He stated that they wanted me to run for president-elect in 1968, and asked whether I was interested. After considerable reflection as to the potential complications this would pose for both my professional and personal life, and after a long discussion with Pattie, I returned his call two days later and agreed to the proposal.

Per plan, I became treasurer of MAGP in 1966 and president-elect two years later. Thus was initiated a whirlwind of activity which finally ended in 1992. Many of you in this room have been similarly involved, and none, I am sure, like myself, have regretted one moment of it. As many of you do or don't realize, I, and others who followed, were the Ed Cochranes of your political lives, and were justly proud of our minor roles in your accomplishments. Each person has one whom he or she looks to for guidance and attempts to emulate. Lee Feldkamp, who preceded me as MAGP president, was my mentor and close friend during those formative years, and I am forever appreciative of his counsel and generosity.

It is difficult, at best, not to skip about a bit with this narrative. The identity of the executive secretary from 1948-1953 is unknown, but the position was held by Mary Halstead 1953-55, when Jean Conklin assumed the duties for one year. The office of secretary and executive secretary was a dual function performed by Dr. Long from 1956 until early 1969. Clarkston's

actual recordkeeping left much to be desired, but his interest in the Academy and its members was above reproach. When Rita Lewis was first assigned to aid Clarkston with the Academy's work in his office on James Couzen's Highway in 1968, we discovered that all the records were housed in a few cardboard boxes. It was said that Clarkston kept the files in his head.

The Board separated the positions early in 1969, naming Rita the executive, and soon thereafter moved the offices to new quarters in Plymouth. Cecelia Hissong was elected secretary in 1969, thus completing the transition. Later, following Jean Feldkamp's untimely death, Rita married Lee Feldkamp. The offices remained in Plymouth until Rita retired in December 1978, at which time Loretta Joyce assumed the position and relocated the offices to Lansing.

In 1981 the Academy purchased a building at 109 East Oakland in Lansing where the headquarters remained until September 1991, when it resettled into new accommodations on Commerce Parkway in Okemos. Incidentally, the \$323,000 mortgage on this building was cleared in May 1996. Loretta Joyce was discharged in 1982. Considerable credit must be given to Harold Kendrick, president 1982-83, Ted Eary, treasurer, and the remainder of the Board, who brought our organization so splendidly through this crisis. Loretta was replaced by Dru Love, who remained until December 1986, when she retired to Florida. Janice Klos, a long-term, very qualified employee of the AAFP, then assumed the helm and remains faithfully and effectively to this day.

In order to develop student interest, during the sixties, the board of directors staged an open meeting yearly at the University of Michigan Medical School to which all of the medical students were invited. Surprisingly, such gatherings were usually well attended. In addition, also yearly, C. Howard Ross, president in 1960-61, would entertain the Board and senior medical students at an open house in his home on Barton Pond. Despite these overtures, the numbers of graduates entering general practice wasn't increasing.

Consequently, in 1969-70, the University of Michigan Family Practice Club was initiated, with three very successful meetings being held at the Sheraton Motor Inn and the Michigan

Union that year. We picked the U. of M. simply because of the challenge of attacking the most resistant site first. Later, clubs were initiated at Wayne. Michigan State University, whose philosophy was more favorably oriented to ours, was tougher to effectively approach because of its multiple campuses.

With the creation of the American Board of Family Practice on Feb. 8, 1969, the specialty of family practice came into being, residencies quickly multiplied, and student interest increased measurably. The first family practice residency in Michigan was developed in Saginaw under the talented guidance of Roy Gerard. In 1971, the MAGP, following the lead of its parent organization, officially changed its name to the Michigan Academy of Family Physicians.

During the seventies, departments of family practice evolved at the three state medical schools. The first was at Wayne State University under Joseph Hess, in 1973, and this was followed by Michigan State, in 1974, which was shepherded by Roy Gerard, and then the University of Michigan, whose departments first leader was Terence Davies in 1978. Success at the latter school was achieved only after many months of hard work by George Dean and his committee. Over the years, close liaison has been maintained with all the medical school departments and residency programs via the academy committee structure.

In 1972 the problem of "equal fee for equal service" was brought before the Academy's Board. Blue Shield, Medicare, and Medicaid were all guilty of paying the specialist more for performing the same procedure than a general practitioner. Bob Vitu was president then, and from that moment forward this became his crusade. Blue Shield acquiesced prior to trial, and the suit eventually only involved Medicare. Eventually a special assessment was levied upon all our members to fund the law suit.

The first decision was rendered by the Circuit Court in Detroit in 1980 which concluded that "there was no reason for specialists to be paid more for the same service than GPs." Medicare appealed the decision to the 6th Circuit Court in Cincinnati and the original decision was upheld. Thereupon the case was appealed to the Supreme Court. By this time the MAFP had exhausted its \$50,000, and when they requested

assistance from the AAFP, that organization assumed liability for the remainder of the expenses. Medicare lost this last appeal, which was a great victory, even though it took many years before equal fees actually became a reality.

In 1981 the Family Health Institute of Michigan was created as the Academy's philanthropic arm. George Dean, who was its guiding force and president for many years, was ably succeeded by Jim Shetlar and Larry Kelly. Its name was changed to the MAFP Foundation in the late eighties after the national foundation became the AAFP Foundation.

During this period, Michigan's presence was increasing locally as well as nationally. Bob Oakes and Louis Zako, who developed a political presence for MAFP in the Michigan Legislature, were responsible for passage of legislation beneficial for family practice.

Lee Feldkamp was elected national delegate in 1969 and I followed him the next year. Lee, then, after much encouragement, was elected to the AAFP Board in 1975 where he served very effectively until 1978, when he lost a close election for the vice presidency.

In the meantime, I was preparing for a future campaign by assuming memberships on one commission and two committees, as well as several committees of the Congress of Delegates. With the Michigan Academy's superb support, I was elected to the AAFP's Board in 1979, and served as its chairman during my third year. Following a year as vice president, I lost my battle for president-elect, and was disappointed for the Michigan chapter, as it had been thirty-six years since Jack DeTar had represented our Academy as the national president.

Michigan was not dismayed, and in 1987, George Dean was elected to the Board, where he served for three years, followed by one year as vice president. Again Michigan lost the fight for the president-elect. On several other occasions during the eighties and nineties, we presented highly qualified candidates to the Congress, Robert Vitu and Charles Zimont, who had worked diligently and effectively for both the AAFP and MAFP. We know there is another president's spot awaiting our chapter, and, hopefully, one of you listening today will successfully answer the call.

Our first president of the feminine gender was Cecelia Hissong in 1974-1975. I am delighted that Mary Elizabeth Roth is here as the second, but anticipate that another twenty plus years will not pass before another appears.

Looking back, I feel deep sorrow that two relatively young past presidents, Gordon Willoughby and Louis Sanford, were lost to their families and the Academy long before their true potentials could be attained.

There are so many other deserving people who should have been lauded today, but it is only because time did not permit. In no way am I adequately able to express my appreciation, and that of the Academy, to all of those past and present, who have unselfishly worked over the past fifty years to make this organization what it is today.

Past Presidents of the Michigan Academy of Family Physicians

Milner S. Ballard, MD	1948-49	Cecelia F. Hissong, MD	1974-75
Leslie T. Henderson, MD	1949-50	Robert W. Oakes, MD	1975-76
John R. Failing, MD	1950-51	George A. Dean, MD	1976-77
E. Clarkson Long, MD	1951-52	Carles R. Zimont, MD	1977-78
Frederick E. Luger, MD	1952-53	Gordon W. Willoughby, MD	1978-79
Karl L. Swift, MD	1953-54	Donald E. DeWitt, MD	1979-80
Kenneth Toothaker, MD	1954-55	Gary E. Ruoff, MD	1980-81
Russell F. Fenton, MD	1955-56	John W. MacKenzie, MD	1981-82
John W. Rice, MD	1956-57	Harold F. Kendrick, MD	1982-83
F.P. Rhoades, MD	1957-58	William W. Allen, MD	1983-84
Clark W. Royer, MD	1958-59	C. Edward Cotton, MD	1984-85
Howard C. Rees, MD	1959-60	B.J. Woodley, MD	1985-86
C. Howard Ross, MD	1960-61	L. Edmond Eary, MD	1986-87
Howard Robinson, MD	1961-62	Gary R. Gazella, MD	1987-88
Leighton Shantz, MD	1962-63	James F. Shetlar, MD	1988-89
Lyle Korum, MD	1963-64	Larry S. Kelly, MD	1989-90
Fred Brace, MD	1964-66	Louis E. Sanford, MD	1990-91
Edgar Cochrane, MD	1966-67	John M. Battle, MD	1991-92
Leonides Leach, MD	1967-68	Bruce R. Deschere, MD	1992-93
Lee E. Feldkamp, MD	1968-69	Timothy Tobolic, MD	1993-94
Douglas A. Haddock, Jr., MD	1969-70	Michael Szymanski, MD	1994-95
James F Dooley, MD	1970-71	William Gifford, MD	1995-96
Joseph V. Fischer, MD	1971-72	Archie Bedell, MD, PHD	1996-97
Robert L. Vitu, MD	1972-73	Mary Elizabeth Roth, MD	1997-98
Louis R. Zako, MD	1973-74		

Family Practice Residency Programs in Michigan

Program	Location	Year Approved
University of Michigan Medical School	Ann Arbor	1979
Oakwood Hospital and Medical Center--Dearborn	Dearborn	1971
Henry Ford Hospital Family Practice Residency Program	Detroit	1988
McLaren Family Practice Residency Program	Flint	1995
Genesys Regional Medical Center/MSU	Grand Blanc	1972
Grand Rapids Family Practice	Grand Rapids	1972
Bon Secours Family Practice	Grosse Pointe	1974
Kalamazoo Family Practice	Kalamazoo	1977
Sparrow Family Practice Residency Program	Lansing	1970
MSU/St. Lawrence Family Practice Residency	Lansing	1977
Marquette Family Practice Residency	Marquette	1978
MidMichigan Regional Medical Center	Midland	1970
North Oakland Medical Centers	Pontiac	1977
Wayne State University/Detroit Medical Center	Royal Oak	1973
Saginaw Family Practice Program	Saginaw	1970
Providence Family Practice	Southfield	1976
St. John Hospital Family Practice	St. Clair Shores	1973
Munson Medical Center	Traverse City	1996
William Beaumont Hospital Family Practice	Troy	1979

**From American Academy of Family Physicians
web page, "1998 AAFP Directory of Family
Practice Residency Programs" May 27, 1998.**

MICHIGAN STATE
UNIVERSITY



Michigan State University Department
of Family Practice
B100 Clinical Center
Michigan State University
East Lansing, MI 48824
fax: 517/355-7700

ISBN 0-9626903-1-7