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Valuing Family Medicine: Historical Journey, Institutional Hostility, and Individual Narratives

Abstract

For over 80 years, concern has persisted in the United States about medicine's trajectory toward specialization and the resulting shortage of generalist physicians, who have long been considered the cornerstone of the health care system. This perpetual problem is investigated at three levels: historical, institutional, and individual. I find that the profession of medicine fails to embrace Family Medicine as an equal--a reality even when Family Medicine first became a specialty in 1969. I show that the struggle for workers is closely joined to a struggle for prestige, which points to a deeper conflict between the values of Family Medicine's holistic philosophy and the medical profession's dominant biomedical model. I argue that the medical profession withholds prestige because Family Medicine's holistic approach enlarges the boundaries of medicine in directions that threaten to undermine the purity and control of the profession's domain of expertise. I argue that this broad devaluing is an underappreciated factor in the generalist shortage, and that this disparagement operates at an institutional level through obstacles embedded in the content, culture, and structure of medical education. Of particular importance, analysis of oral histories reveals an inherent mismatch between the reported rewards of primary care, such as building relationships with patients over time, and the structure of medical training itself. Analysis of medical school mission statements examine the relationship between medical schools' unhidden curriculum and primary care, which yields a moderate correlation between the inclusion of primary care and related words and the production of primary care physicians. However, few schools (14%) of the 141 schools examined publicly value primary care in their mission statements. In light of pervasive disparagement, analysis of Family Medicine resident biosketches asks (1) why individuals commit to a specialty with such low status and (2) how these individuals construct value and appeal in their work. The presence of a social justice schema emerges, that, when embraced, renders Family Medicine as a desirable specialty and diminishes the power of the dominant narratives of disparagement.

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VALUING FAMILY MEDICINE: HISTORICAL JOURNEY,
INSTITUTIONAL HOSTILITY, AND INDIVIDUAL NARRATIVES

Joanna V. Brooks

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Sociology

Presented to the Faculties of the University of Pennsylvania

in

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DEDICATION

To my father and grandfather,
who have shown me that
when medicine fails to cure or explain,
the greatest gift a physician gives a patient is
often that of friendship.

ACKNOWLEDGMENTS

There is no doubt: it truly takes a community.

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ABSTRACT

VALUING FAMILY MEDICINE: HISTORICAL JOURNEY, INSTITUTIONAL HOSTILITY, AND INDIVIDUAL NARRATIVES

Joanna V. Brooks

Charles L. Bosk

For over 80 years, concern has persisted in the United States about medicine's trajectory toward specialization and the resulting shortage of generalist physicians, who have long been considered the cornerstone of the health care system. This perpetual problem is investigated at three levels: historical, institutional, and individual. I find that the profession of medicine fails to embrace Family Medicine as an equal—a reality even when Family Medicine first became a specialty in 1969. I show that the struggle for workers is closely joined to a struggle for prestige, which points to a deeper conflict between the values of Family Medicine's holistic philosophy and the medical profession's dominant biomedical model. I argue that the medical profession withholds prestige because Family Medicine's holistic approach enlarges the boundaries of medicine in directions that threaten to undermine the purity and control of the profession's domain of expertise. I argue that this broad devaluing is an underappreciated factor in the generalist shortage, and that this disparagement operates at an institutional level through obstacles embedded in the content, culture, and structure of medical education. Of particular importance, analysis of oral histories reveals an inherent mismatch between the reported rewards of primary care, such as building relationships with patients over time, and the structure of medical training itself. Analysis of medical school mission statements examine the relationship between medical schools' unhidden curriculum and primary care, which yields a moderate correlation between the inclusion of primary care and related words and the production of primary care physicians. However, few

schools (14%) of the 141 schools examined publicly value primary care in their mission statements. In light of pervasive disparagement, analysis of Family Medicine resident biosketches asks (1) why individuals commit to a specialty with such low status and (2) how these individuals construct value and appeal in their work. The presence of a social justice schema emerges, that, when embraced, renders Family Medicine as a desirable specialty and diminishes the power of the dominant narratives of disparagement.

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PREFACE

The Puzzle of Primary Care: Benefits and Crisis

The benefits of primary health care at a population level are well documented. Primary care has been identified as “the key” to the social target of “attainment by all peoples of the world...a level of health that will permit them to lead a socially and economically productive life” (World Health Organization 1978). Primary care has been shown to “lower the costs of care, improve health through access to more appropriate services, and reduce the inequities in the population’s health” (Starfield, Shi and Macinko 2005:458-459; Starfield 1998). Starfield et al. (2005) have identified positive health outcomes of primary care measured any of three ways: by the supply of primary care physicians, by relationship with primary care providers or facilities as source of care, or in connection with the presence of key characteristics of primary care (459).

A generally agreed upon definition is that “primary care is first-contact, continuous, comprehensive, and coordinated care provided to populations undifferentiated by gender, disease, or organ system” (Starfield 1994; see also Kimball and Young 1994; Starfield 1998; Starfield et al. 2005; Millis 1966).

Bynum and Fisher (2010), in their assessment of the literature, write that in studies and trials, “enhanced continuity of care is strongly related to better quality and lower costs” (62). In addition, patients report better access to care when they have a primary care provider as their regular source of care (Stewart et al. 1997). Finally, research shows that where there are more primary care physicians, there are lower overall costs and lower rates of preventable hospitalizations (Welch et al. 1993, Parchman and Culler 1994; Fisher et al. 2003; Starfield et al. 2005). In fact, the Organization for Economic Cooperation and Development (OECD) (2011) attributes the United States high health expenditures to the fact that “the primary care sector is

still underdeveloped, adding financial burden to the health system” and goes on to say that “the shortage of family doctors contributes to the poor primary care performance” (6). In 2011, the United States spent 17.9% of its GDP on health (see World Health Organization National Health Account Database); it is important to note that the United States spends “two-and-a-half times more than the OECD average health expenditure per person” (OECD 2011:1). The evidence is convincing that our health care system is functioning poorly, and that primary care can and does play a vital role in improving overall health, increasing access to care, and keeping costs low.

However, it is also widely acknowledged that primary care in the United States is in a state of crisis (Lee et al. 2008; Baron 2009). One scholar writes bluntly that “primary care in the United States is on death row” (Reuben 2007:99). Even in popular press, recent articles about primary care physicians portray a grim situation. One *New York Times* article reports the drastic decrease in solo practitioners in primary care, their decrease in income, and increasing pressure to stay financially afloat while guarding time to invest in patient relationships (Harris 2011b). Another article calls attention to the desire of recent graduates to have more reasonable work hours than the typical primary care physician and the desire to prioritize family in addition to work (Harris 2011a).

In the United States, the rising shortage of primary care physicians is alarming and the future of primary care is “precarious” (Boulis and Jacobs 2008:196). Dill and Salsberg (2008), in an Association of American Medical Colleges Report, projected the greatest shortage of physicians will be for primary care as compared to other specialties and write that, “in fact, the projected shortage in primary care accounts for more than a third of the total projected shortage in 2025” (26). Fewer medical students are choosing primary care residencies in favor of surgical specialties and procedural specialties. Population aging, rising patient expectations, increased value placed on technology, and high levels of medical student debt are some of the forces that

fuel this crisis (Mechanic and Rochefort 1996). Additionally, the Patient Protection and Affordable Care Act (PPACA) will exacerbate the shortage problem by adding an estimated 32 million new patients to the system.

This evidence presents a puzzle: the U.S. health care system is in desperate need of reorganization. Primary care has been shown to minimize disparities and lower costs while increasing overall quality of care—in other words, primary care on all accounts appears to be part of the answer for improving our health care system. Yet, there is a shortage of primary care physicians, a problem that we will soon learn is not new. How do we explain this puzzling paradox? If primary care is central to a healthy and functioning system of health care, why is it struggling to survive? This is the context and the puzzle that *Valuing Family Medicine* begins to answer.

CHAPTER ONE. THE MOST GENERAL OF THE SPECIALTIES: THE HISTORY, BIRTH, & DEVELOPMENT OF FAMILY MEDICINE

Introduction

My dissertation shows that Family Medicine's struggle for prestige and workers is not new; its perpetual "crisis" points to deeper conflict between the philosophy of Family Medicine and the dominant biomedical model. This tension existed in 1969 when Family Medicine became a specialty, and it continues to exist today. I argue that the medical profession withholds prestige from Family Medicine because Family Medicine's holistic approach expands the boundaries of medicine in directions that threaten to undermine the purity and control of the profession's domain of expertise. While it could be imagined that professional domain expansion would be viewed positively, Family Medicine enlarges boundaries in directions that bring unwelcome uncertainty and disorder.

Next, I argue that this devaluing is transmitted at the institutional level, embedded in the content, culture, and structure of medical education. Of particular importance, analysis of oral histories reveals an inherent mismatch between the reported rewards of primary care (such as building relationships with patients over time) and the organization of medical training itself. Analysis of medical school mission statements examine the relationship between medical schools' unhidden curriculum and primary care, which shows that few schools (14%) of the 141 schools examined publicly value primary care in their mission statements. In addition to the disparagement embedded in medical education, medical schools as organizations are largely rewarded for ground-breaking research, not for educating physicians to meet the health needs of communities. The obstacles embedded in medical education, the incentives for medical schools,

and the disdain by the medical profession all coalesce to undermine the value and appeal of Family Medicine and primary care more generally.

With a better understanding of *why* Family Medicine is devalued (it presents a messy and impure threat) and *how* the disparagement operates at the institutional level, analysis of Family Medicine resident biosketches asks (1) why individuals commit to a specialty with such low status and (2) how these individuals construct value and appeal in their work. The presence of a social justice schema emerges, that, when embraced, both renders Family Medicine as an appealing specialty and minimizes the power of the dominant narratives of disparagement.

I argue that institutional hostility is an underappreciated factor in the shortage of primary care physicians. Individual analysis is important, but a focus on individual factors ignores and obscures the embedded, long-standing, institutional issues (perhaps that is the point). We must first understand the organizational environment of medical education, and how these training institutions embody values about what “pure” medicine is and what it is not (which will be explored in Chapters 3 and 4). In Chapters 5 and 6, I will turn to the individual level to understand how physicians do in fact talk about their decision to practice Family Medicine, but only *after* a thorough examination of the institutional and organizational dynamics of medical education. Drawing from Marx, I contend that “men make their own history, but they do not make it just as they please; they do not make it under circumstances chosen by themselves, but under circumstances directly encountered, given and transmitted from the past” (Marx 1852). What these individuals do, the decisions they make, and how they make sense of their decisions is consequential and important, but must be examined within the context of the “circumstances” they encounter from academic medicine and medical education, along with the particular past that has been transmitted.

Furthermore, I argue that while economics certainly plays a role in the shortage, my research indicates that its contributory power operates more at the institutional level, through the incentives of medical schools which leads to a hostile structure (as shown in Chapters 3 and 4), rather than at the individual level, where attention on salary and debt is frequently placed, despite the lack of research to support such a claim (Rosenblatt & Andrilla 2005; AAFP “Study of Factors;” Siwek 1993).

Each level of this analysis—historical, institutional, and individual—provides a crucial contribution and perspective to understanding this problem. From the historical analysis, we are able to recognize and correctly define the problem as long-standing and entrenched, which directly affects our ability to create change; a perpetual problem necessitates different solutions—and different questions rather than a repackaging of the approaches that have repeatedly failed. As I have already noted, the institutional level illuminates an environment that is hostile to Family Medicine, and an incentive structure that rewards research over patient care. This failure to value Family Medicine (and primary care more generally), due to a deficit in institutional incentives and professional disdain, are fundamental components of the problem. Finally, at the individual level, oral histories help us better understand the experience of individuals navigating through an educational structure that disparages careers in primary care and discourages recruits from pursuing them. Family Medicine biosketches show us how individuals attach value to the very specialty that is devalued. Because changing a structure with embodied hostility and embedded obstacles is extremely difficult, and without question a slow process, understanding how these individuals withstand the negativity opens up another avenue for increasing the supply of Family Medicine residents.

Outline of Chapters

Peter Berger (1963) writes of the importance and complementary nature of history and sociology that “the sociological journey will be much impoverished unless punctuated frequently by conversation” with historians (20). In understanding the shortage of primary care physicians, ignoring history impoverishes our understanding of the problem and impedes our ability to solve it. A thorough understanding of the history and formation of the field of Family Medicine, as well as its current state of development and persisting struggles throughout decades is vital if we wish to grasp why, despite so many efforts to do so, we have failed to enlarge the supply of primary care physicians.

In Chapter 1, I examine the history of Family Medicine, paying specific attention to the time surrounding specialty’s birth in 1969, when Family Medicine became the twentieth specialty in American medicine. I consider the factors leading up to its board certification and briefly consider the field’s development since 1969.

In Chapter 2, I examine how the perpetual nature of Family Medicine’s struggle for prestige is a consequence of the conflict existing between the values of Family Medicine and the values of the more dominant biomedical model favored by the medical profession. I first consider how there has been much “reform without change” (Bloom 1989) in medical education and the curious re-framing of the specialization problem as “new” (Whitehead, Hodges, and Austin 2012). I argue that Family Medicine’s holistic philosophy introduces unwelcome “impurity” to medicine, resulting in dismissal and disparagement from the medical profession (Abbott 1981).

After considering *why* the field has low status, Chapters 3 and 4 explore *how* the disparagement of Family Medicine and primary care happens. In Chapter 3, I analyze oral histories and find institutional hostility toward primary care medicine embedded in the content,

culture, and structure of medical education. This chapter also documents the inherent mismatch between the reported rewards of primary care, such as building relationships with patients over time, and the organization of medical training itself.

In Chapter 4, I continue to examine institutional values by examining the “unhidden curriculum” of medical schools. I analyze medical school mission statements for inclusion of primary care as a value and the relationship between the inclusion of primary care and related words and the production of primary care physicians.

In Chapters 5 and 6, I turn to resident biosketches to understand how individuals, in light of disparagement, construct value and appeal in their work as well as why individuals commit to a specialty with such low status. In Chapter 5, I examine how Family Medicine residents make their work glorious, focusing on two dimensions of care: patient relationships and variety of patients and problems. I consider how Family Medicine biosketches compare to three other specialties: Emergency Medicine, Obstetrics and Gynecology, and Neurosurgery.

In Chapter 6, I examine the presence of service in biosketches and identify three pathways of relationship between service and specialty choice that residents describe. The presence of a social justice schema emerges, that, when embraced, renders Family Medicine a desirable specialty and diminishes the power of the dominant narratives of disparagement.

A Note on Terminology

Family Medicine versus primary care.

Primary care is a broader term, which usually refers to the three specialties of Family Medicine, general Internal Medicine, and general Pediatrics, (and sometimes includes Obstetrics and Gynecology). I focus on Family Medicine in my analysis of history and residents because

there is a moderate to high rate of subspecialization in Internal Medicine and Pediatrics but not in Family Medicine. Practically, this means that almost all of Family Medicine residents, unlike Internal Medicine and Pediatrics, will actually go on to have generalist careers as opposed to specialist careers. For example, Martini et al. (1994) project only a 35% retention rate for Internal Medicine and a 60% rate for Pediatrics, but a 95% retention rate for Family Medicine. I focus on Family Medicine as a way to examine primary care because this is the best way to isolate who is actually going to practice comprehensive, first contact, primary care-type medicine.

Family Medicine versus family practice.

Additionally, it is helpful to note that family practice refers to “a form of medical service” and Family Medicine refers to the academic discipline (McPhee 1986: 36).

Family practice versus general practice.

"Family practice refers to the *function* of the practitioner, while general practice refers to the *content* of his practice" (Willard 1966).

Generalist medicine.

Generalism, or generalist medicine is still used at a big-picture level as a contrast to specialism or specialist medicine. However, in Chapter 1 we will see that efforts were made to distinguish the new specialty from “generalists” who had low status.

Historical Background

Trend Toward Specialization

The overall trend toward specialization and the shift of medicine from the home to the hospital reaches back many decades (Starr 1982; Stevens ([1971]1998). In 1935, for example, 85% of practicing physicians were general practitioners but by the 1960s, that number had dropped to only 30 percent (Stephens 1982). Concern over this trajectory surfaced as early as 1933, when an editorial in the *Journal of the American Medical Association* talked about the “overgrowth of specialism” (“Diversity or uniformity in medical training,” 1993). Three decades later, Alvey (1961) wrote: “there is a shortage of general practitioners, family doctors, generalists, call them what you may... I do not mean that there is a shortage of physicians, but there is a need for physicians who are interested in the total and continuing care of the patient.”

Much of the shift toward specialization as well as the change in medical education accelerated with World War II. In the military, specialists were given higher ranks and avoided front-line duty. Additionally, the Servicemen’s Readjustment Act of 1944 (GI Bill) subsidized residency training, which encouraged many physicians to pursue further training. Hospitals, as well, were given subsidies when they trained residents, clearly incentivizing hospitals to train increasing numbers of specialists. Arroyo (1986) writes that “the impact of government financing cannot be overstated. In 1940, there were 5,233 resident positions; by 1946, there were over 12,000; by 1957, over 30,000; and by 1970, over 45,000” (83; also Stevens 1971]1998).

Despite the growing number of residency positions and residents, there were not any generalist residencies. Interestingly, as early as the mid-1940s, an emerging intraprofessional status gradient was apparent. Those who had completed residency training looked down upon those who had merely completed an internship year (American Association of Family Physicians

(AAFP) 1980). Training was closely connected to hospital privileges, as well, a factor that began to disadvantage generalists. Whether intentional or not, the government's activities accelerated specialization and "unwittingly discriminated against nonspecialists" (Arroyo 1986: 81). In addition, medical research also became an increasing national priority, and "stimulated by government financing of biomedical research, medical schools were transformed into great scientific research centers" (Arroyo 1986:85; Pescosolido, Tuch, and Martin 2001).

With the onset of these changes, general practitioners, feeling uneasy about their future, privileges to care for their patients who required hospitalization, and the scope of their practice, began to mobilize. The American Medical Association Section on General Practice first met in June of 1946 and a separate professional organization, The American Academy of General Practice¹ was organized in June of 1947. The Academy's numbers grew very quickly; one physician writing about this development attributes the Academy's growing strength to the fact that generalists "were being threatened all over the country" (AAFP 1980:10). Generalists united to protect their way of life and their way of practicing medicine.

As generalist physicians started mobilizing, the effects of specialization on the generalist physician supply began to cause concern. In fact, in 1947, the President of the American Medical Association called attention to General Practitioners' availability and referred to this as the profession's "most urgent need." The subsequently formed committee to study the conditions of general practice presented their report in June 1948 and recommended that General Practitioners have protected privileges and two-year training programs. Despite the committee's recommendation, nothing changed. This would be the first of many appointed committees and many sets of recommendations that were made.

¹ This name of this national association changed in October 1971 to its current name: The American Academy of Family Physicians.

Internal Divisions

While the fight for external and official recognition had only just begun, an important challenge for the development of Family Medicine was brewing from *within* the group of general practitioners as well. First of all, many general practitioners were not in favor of certification and specialty boards. Generalist medicine, after all, was by its very definition *general*. This segment of the field argued that boarding was not, and should not be a goal: “the attitude of physicians in not wanting a specialty was because they were fighting specialties.” AAFP 1980:14). Arroyo (1986) reiterates that “they did not want to be co-opted by the prevailing specialist domination (164).

Second, there was a precarious dance occurring between scope of practice and privileges for general practitioners. On one side, some generalists thought that getting boarded was the way to gain status, increase the standardization of training, and enlarge their presence as faculty in medical schools. But other General Practitioners were skeptical that, even with board certification, this would happen. Furthermore, the process of becoming boarded included the task of defining the field’s specific function and scope. In the late 1940s when this debate was ongoing, obstetrics and surgery comprised a significant part of everyday practice for many generalists. Because of this, there was a fear among generalists of defining the scope of generalism in a way that excluded surgery and/or obstetrics. It should be noted that organizations like the American College of Surgeons (founded in 1913) gave teeth to that fear, as they had a very strong interest in protecting their domain and excluding surgery from every other field’s scope. This concern kept some general practitioners from joining the American Academy of General Practice, as well.

I think most people realized in the back of their minds that no way was the general practitioner going to get a certifying board that would qualify GPs for major surgery... Those groups felt they would be giving up something if they advocated a certifying board in general practice. And there was the other group that felt we'd all go down the drain if we don't get one and we'd better give up some things and get a certifying board before the whole discipline becomes history. (Dr. Cahal in AAFP 1980:20).

Hospital privileges were a connected point of contention in this internal division. One generalist contingent feared that if some General Practitioners started getting boarded, then the ones that did not might lose hospital privileges. However, the other side argued that General Practitioners were already having trouble in some places with having their hospital privileges threatened, a trend that only increases: “as specialty board certification increasingly became a prerequisite to hospital privileges, general practitioners were being squeezed out particularly in areas of obstetrics and surgery” (Arroyo 1986:98).

Committees, Committees, and More Committees²

A second committee reported to American Medical Association (AMA) in 1950, two years after the previous report. This report concluded that there were not enough general practitioners, and also marked “the first official recognition by official bodies that the graduate who was going to do general or family practice should take residency training, like everyone else” (Dr. Ruhe in AAFP 1980:13). Again, prior to this, there were no general practice residencies. When students graduated from medical school, they directly entered practice, while their peers continued with residency training (largely subsidized by GI Bill funding). By 1952, there were 200 General Practice Residency Positions, compared to a staggering 19,000 specialty residency positions (AAFP 1980).

In 1954, the Special Committee on General Practice Prior to Specialization was created by the AMA in response to a call for an “exhaustive study on the problems of general practice.”

² See Appendix A for a detailed chart from the AAFP about the timeline and events. Even a brief look shows the long and complex journey of FM to board certification.

Despite the AMA's many committees and reports, general practitioners were unhappy with the lack of progress and advocacy in protecting their privileges. Discontent with the AMA's efforts, generalists turned to their own organization—the Academy of General Practitioners—to focus on next steps. They decided to form their own committee in 1957: the Minimum Uniform Standards of Education for General Practice (MUSE). MUSE focused on establishing educational standards and training standards that would be required for membership in the Academy (AAFP 1980:15). MUSE was similar to another of AMA's Committees: the Committee on Preparation for General Practice. MUSE recommended, in a 1959 report, to “proceed with all deliberate speed toward creation of a Board of General Medicine” (17); and two months later, the AMA Section on General Practice suggested with strikingly similar language to “proceed with all deliberate speed toward the creation of a Board of general practice for family physicians” (17). The 1959 MUSE committee report also stated the following, that “if board certification is the standard that so many in and out of the medical profession use as a norm of competence, it behooves us to consider an examining board as a possible means of helping general practice—and its potential future practitioners—meet that standard” (18).

Language Change, Identity Change

In the midst of all of these organizational interactions, committee reports, and internal divisions, a significant change transformation began to occur. In order to move the field forward, practitioners have to neutralize or reverse unfavorable conceptions surrounding generalism. They needed a new image: “family physicians needed to clearly distinguish themselves from general practitioners” (Arroyo 1986:172). An important way to create a new identity is to develop a new

name. As we will see, several reports in the mid to late 1960s were also important in changing the title of this practitioner fulfilling the generalist's role and offered different suggestions on the appropriate name. The MUSE committee, along with the Committee on Preparation for General Practice—advocated for care through relationships and, referred to a rebranded *family physician* who would provide this care.

Conflict Remains, Support for Board Certification Grows

Yet, widespread disagreement remained within the field about board certification. In fact, there was a sub-group of the American Academy of General Practice that created an “American Board of General Practice” in 1959, which evoked strong resistance from the Academy, who recommended, through an official statement, that its members refrain from affiliation with this unsanctioned group. Trying to maintain its authority and control the potential changes, the Academy presented arguments for and against board certification in their GP magazine in June of 1962, inviting family physicians to respond.

At this point, about twenty pilot general practice residencies were started, but they offered little appeal to students because they did not receive any certification upon completion. In 1959, the first pilot family practice program was started at the Indiana University Medical Center (AAFP 1980). Overall, the residencies were extremely variable: some required surgery, some did not; some required obstetrics, and some did not. Many of the general practice residency positions that did exist remained unfilled.

Overall, through 1964, the Academy remained anti-certification, believing that board certification would do more to threaten than support its general practitioner members. This

majority view would begin to change, however. Part of the reason for the shift is that the fate of general practitioners was not improving. As one physician reflects on the history of that time, “everything had been tried and not worked—why not a certifying mechanism?” (Dr. Witten in AAFP 1980:36). Members of the AAGP argued persuasively that the time for certification had arrived, or else:

The Academy will then become perhaps the largest organized 'Last Man's Club' known to man, whose sole purpose would be, near the end of its existence, to point out to another group of board family physicians the glories of the good old days of the AAGP, whose Congress had failed to recognize the inevitable change that progress brings to all of mankind. (AAFP 1980: 35)

So, having exhausted other efforts, the AAGP Congress of Delegates finally approved movement toward establishing a certification board in 1965. The physician below explains his thinking at the time:

When those of us who were intimately involved realized that the idea of fighting for general practice [...] as a specialty would also fail, we retrenched and picked up family practice. It was not a dream, it was a necessity if we were going to go forward.” (Dr. Shapiro in AAFP 1980:36)

To consider certification as specialty, the American Academy of General Practice established the Committee on Requirements for Certification (CORC) to begin the process. This committee worked on defining the parameters of the field and also produced a “Core Content of Family Medicine,” which included surgery. Also of note, this Core Content of Family Medicine document was the “first document which specifically mentioned behavioral sciences as part of any medical training program” (Dr. Burket in AAFP 1980:38).

The next difficulty was a logistical one—how exactly is a specialty established? It had been about twenty years since the last specialty had been boarded, and it took some time to confirm the official channels that needed to be traversed for board certification. There was apparently even some confusion about what was required, and Family Practice posed unique issues in defining the

scope of the specialty. The specialty's contribution was framed as based on "a function instead of a body of knowledge;" and "By proclaiming rights as the physician of first contact, the family physician would secure his position in the complex web of specialist care" (Dr. Wilson in AAFP 1980:37; Arroyo 1986:170).

The first step in board certification, a preliminary application was sent to the Liaison Committee for Specialty Boards in February 1966. This committee deferred it, deeming it "premature." The Liaison Committee suggested that the application be resubmitted only after the reports from two ongoing committees were completed. These committees, the Citizens Commission on Graduate Medical Education and the AMA Ad Hoc Committee on Education for Family Practice, finished their reports in the fall of 1966. Throughout the literature, these two reports, along with a third, are frequently grouped together and seen as a critical piece of Family Medicine's journey to and eventual success achieving board certification. Each of the three reports, frequently referred to by the last names of their chairmen, is examined in more detail below.

The "Folsom Report"

The Folsom Report, published in 1966, was titled: "Health is a Community Affair." It was a Report of the National Commission on Community Health Services. The Commission was made up of 33 individuals from medicine, business, health advocacy, and government and was chaired by Marion Folsom, who was a previous U.S. Secretary of Health, Education, and Welfare (Robert Graham Center 2010; Folsom 1966). It advocated, as the title suggests, for community participation to improve health. It also acknowledged importance of considering many factors in care, including "religion, social, economic, cultural, personal" etc. (Arroyo 1986:137). One recommendation of the report in particular had implications for family medicine: that individuals

needed a “personal physician” to care for them. The report described this personal physician as providing “comprehensive, continuing and preventive care” and having “training, status, remuneration, and professional privileges comparable to other medical specialists” (134).

The “Millis Report”

The Millis report, entitled “The Graduate Education of Physicians,” was actually predicted to have the impact on graduate education that the infamous Flexner Report had for the restructuring of undergraduate medical education (AAFP 1980:39). This AMA-appointed group published their report in August of 1966. In addition to John Millis, who was president of Case Western Reserve University School of Medicine, the committee included a sociologist: Everett Hughes. The report highlighted the specialization in medical education and the fragmentation of health care. It emphasized the need for “continuing and comprehensive care of high quality” and called on medical education to produce competent and broadly trained physicians to give that care (Millis 1966:41).

The Millis Report addressed a number of different possible names for these “broadly trained physicians,” even writing the choice is an “annoying semantic problem” (36). They dismiss a number of other suggestions: general practitioner (low status); personal physician (all physician relationships should be personal); first-contact physician (but this is not always the case); family physician (care for the family is not necessarily present); and comprehensive-care physician (too awkward) before arriving on their chosen name: *primary physician* (Millis 1966:36-37).

The “Willard Report”

With a name as long as the “Report of the Ad Hoc Committee on Education for Family Practice of the Council of Medical Education of the American Medical Association,” it is no

wonder this report is referred to by the last name of its chairman, as well: William Willard, who was dean of the University of Kentucky. This committee was charged with examining general practice more specifically and met thirteen times between November 1964 and August 1966 before issuing their “Meeting the Challenge of Family Practice” report in November of 1966.

As Willard describes it, the committee was “set up with representatives from the Academy, the Council and from the Association of American Medical Colleges. I think it was probably the first time that those three different groups were brought together (AAFP 1980:43; Willard 1966). Over time, mutual suspicion of each other gave way to working together, even among members of different groups (43-44). This report called for a “new kind of specialist in family medicine, educated to provide comprehensive personal health care, because of the complexity of modern medicine and the health care system” (40). The report was also pro-board certification, writing that:

The Ad Hoc Committee is convinced that the opportunity for specialty board certification is essential for those properly prepared for family practice. Board certification is the only appropriate recognition for physicians who have invested the time and effort necessary to complete prescribed training programs and who have demonstrated their competence in this important field of medicine. Certification is necessary to provide status to the field and to reward those who have prepared themselves in a suitable manner. Both status for the field and reward for the individual are essential to attract young physicians to careers in family practice. The provision of board certification is not the only requirement to be satisfied if an adequate number of family physicians is to be prepared in the future, but it is an important one (AAFP 1980:40).

Significance of the Reports

As mentioned earlier, these three reports had great importance for the future of family medicine because they essentially all documented—independently—the need for a comprehensive, “personal,” “primary,” and “family” physician. Together, these reports have been

said to have “served as a foundation for the genesis of family practice in the United States” (Geyman 1978).

Another effect of these reports was their ability to communicate to the public about the problem of the shortage of general practitioners:

Those of us in the profession of general practice noticed the drop in numbers and its implications for the health care system. But when these reports came out, and the public, the consumer, the patient became involved, and they began to notice it. This I think was a turning point, when the consumer and patient got behind this change, then it moved. (Dr. Burket in AAFP 1980:38)

Those within the field who had been pushing for board certification were very encouraged by the conclusions of these committees and were happy to recognize their crucial importance in the eventual board certification success. As one former AAGP president said: “In other words, we were really not responsible in ourselves for what happened. Broad sociological changes really did this (Dr. Burket in AAFP 1980:43).

Board Certification

The second preliminary application was submitted in December of 1966, after waiting for these reports to come out, as requested. This second preliminary application included a few changes from the first application—among these was a requirement of recertification every six years and the exclusion of a grandfather clause.

These two points were departures from policy in any of the 19 specialty boards existing at that time, and have since been cited as major factors in the eventual decision to grant approval for the American Board of Family Practice (AAFP 1980:45).

The Advisory Board for Medical Specialties approved this preliminary report the second time around, in February of 1967. After approval of this preliminary application, a final application was submitted in October of 1967, which was both considered and deferred in February of 1968

by the American Board for Medical Specialties, who recommended that they first consult with other specialties in order to more clearly define the content of the field and increase cooperation from other closely connected specialties.

This was a challenging request, considering the fact that these other specialties were not exactly overjoyed about a new specialty infringing on their territory. The AMA Council on Medical Education found specialty representatives from five specialties (internal medicine, pediatrics, surgery, obstetrics/gynecology, and psychiatry), however, to join members of the Academy, members from the AMA Section on General Practice, and the AMA Committee on Family Practice for the Liaison Conferences on Family Practice, which occurred in April of 1968 (AAFP 1980:48). In December 1968, yet another application was submitted, including a change to allow five nonvoting advisory directors from the five different specialties listed above. The application was not considered until February of 1969, at which point the Liaison Committee for Specialty Boards requested even more changes. For example, the Committee wanted the five members from other specialty certifying boards to be *voting* members and they required some changes in the actual examination.

Between February 6 and February 8, there was much discussion among AAGP members on whether or not to make the requested changes: "In those two days, intermediate modifications were drafted and changed after a host of meetings and informal consultations-both within the petitioning group and with various members of the groups which held the options of approval or disapproval (AAFP 1980:50).

In the end, on February 8, the application needed approval from three groups: the Advisory Board for Medical Specialties, the AMA Council on Medical Education, and the Liaison Committee for Specialty Boards (which was made up of people from first 2 groups) (AAFP 1980:50). With the requested changes made, unofficial approval was communicated at 6:20 pm

(51) and official written notice followed the next day, February 9, 1969, at noon. Family Medicine became the twentieth specialty in American Medicine.

After the long journey and multiple applications, family practice was finally a new specialty with a certification board. The new specialty brought along with it a new physician and a new type of care:

The family physician was to be a new type of physician, a medical revolutionary, if you will. He was person-oriented rather than disease-oriented. He was going to connect health care in a different way, a humanistic way (Arroyo 1986:196)

The field had come through a number of struggles and the struggles were not over. In this next section, we will consider the challenges for Family Medicine's development post-1969.

The Birth of Family Medicine—A high point?

We have traced the mobilization of general practitioners and their journey toward board certification as Family Practice physicians. We have seen how a number of other factors—including the reports of three committees who all independently called attention to the need for a new type of physician—played an important role in the final success of gaining approval for a certification board. Even though Family Medicine struggles for prestige now, surely the specialty enjoyed high esteem in 1969 once it was boarded, right?

There are at least two answers to this question. On the one hand, it could be argued that Family Practice was valued because incredible hope was placed in it: "Primary care was viewed as a form of medical care delivery that would right the wrongs of the American health care system" (Arroyo 1986:138). The Robert Wood Johnson Foundation Generalist Physician Initiative Report (2003), which we will examine shortly, even writes: "A shortage of generalist physicians has been a national concern since the 1950s. In response to these concerns, family practice developed as a

new specialty in the 1960s” (3). Family Medicine was held up as the answer to many of health care’s problems.

The medical profession likely had hope in Family Medicine for an entirely different reason, however. Family Medicine became useful for the medical profession in the 1960s, a time when their authority was increasingly challenged and questioned (see Arroyo 1986 for a more thorough argument about Family Medicine being a product of the “spirit of the times” of the 1960s). To add to the growing suspicion of the medical profession and the calls for a comprehensive personal physician, concerns about health care costs were also escalating. President Nixon declared an official health care crisis in July of 1969 (Arroyo 1986:4). All of these factors coalesced, making it difficult for the medical profession to continue to say no to Family Medicine. Instead of supporting the new specialty as a needed and valuable addition to their ranks, it is likely that the medical profession essentially used Family Medicine as a convenient appeasement to the public, with the hope that this “gesture” would protect them from external regulation or encroachment on their expert domain. “In many ways, by our success, we have “taken the heat off’ the medical profession from the public; therefore, the status quo [was] being preserved” (Stephens 1989:103). While it is unclear if the medical profession ever welcomed or considered Family Medicine a valuable peer specialty, it is evident that they preferred it to other potential attacks on their domain.

On the issue of prestige and status within the medical profession, it is also important to consider the ways that Family Medicine, even at its “birth,” received differential treatment. First, as noted earlier, Family Practice introduced a required recertification every six years and they excluded a grandfather clause from their certification process. Some argue that this “one-upped,” helped to establish a “separate identity,” for Family Medicine (Arroyo 1986). However, I would argue that these unique aspects do not necessarily create a more competitive identity for Family

Medicine; higher or stricter standards can also be interpreted as the medical profession keeping a tighter reign on a group that causes them the greatest concern. Finally, the requirement of having five other *voting* members on their board clearly diminishes their power and autonomy from the rest of the medical profession. Even when Family Medicine was boarded in 1969, there is not evidence that it was well respected by the medical profession.

Family Medicine Departments

After becoming a specialty, how would Family Medicine be integrated into medical training? This integration presented a number of challenges, most of which have still not been resolved, over 40 years later. The AMA Committee on Medical Practice had recommended a directive in 1956 to “utilize all possible means to stimulate the formation of a department of general practice in each medical school” (AAFP 1980:54). Despite this recommendation, there has been uneven development of Family Medicine Departments. The American Academy of Family Physicians produces a report “Reprint 164: Activity in Family Medicine in U.S. Medical Schools” which was accessed in roughly 5 year increments since 1969. Using this data, I trace the development of Family Medicine departments in different medical schools across the country. The maps show the geographic presence of Family Medicine departments.³ Each map indicates the location of new Family Medicine Departments, developed since the prior map, in order to clearly indicate the time periods with the most development.

³ To enhance visual clarity, these maps indicate the development of active Family Medicine *Departments* exclusively. It does not include schools with centers, sections, or departments in planning stages. This more nuanced data is available upon request.

Figure 1.1 Family Medicine Departments: 1969

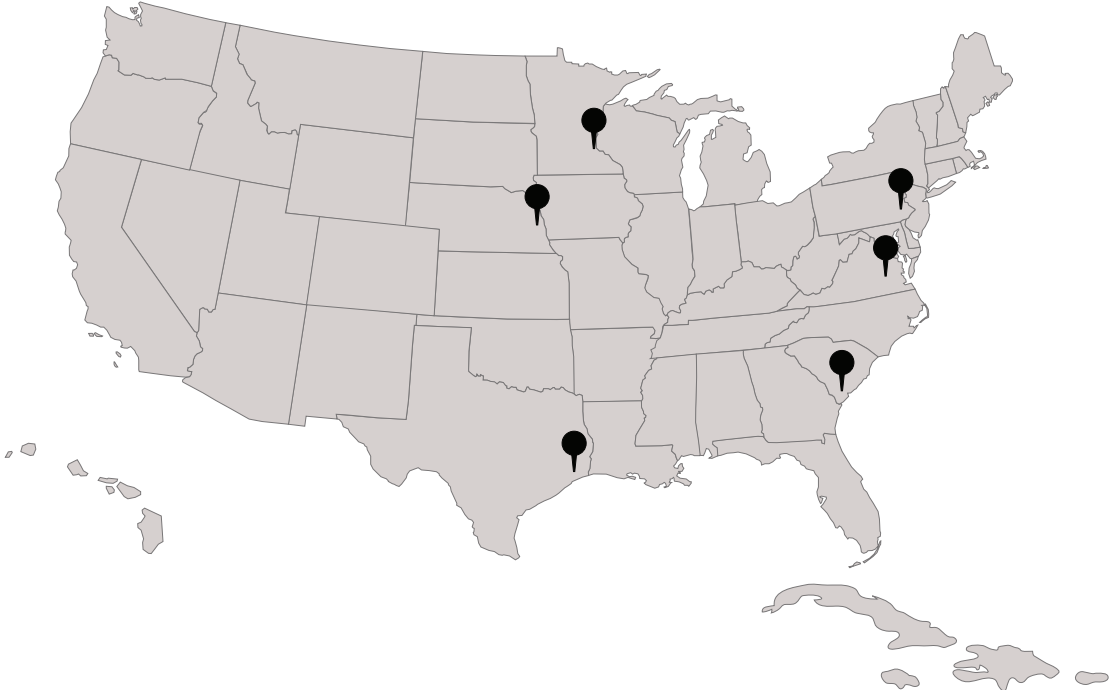


Figure 1.2 Family Medicine Departments: 1970-1974

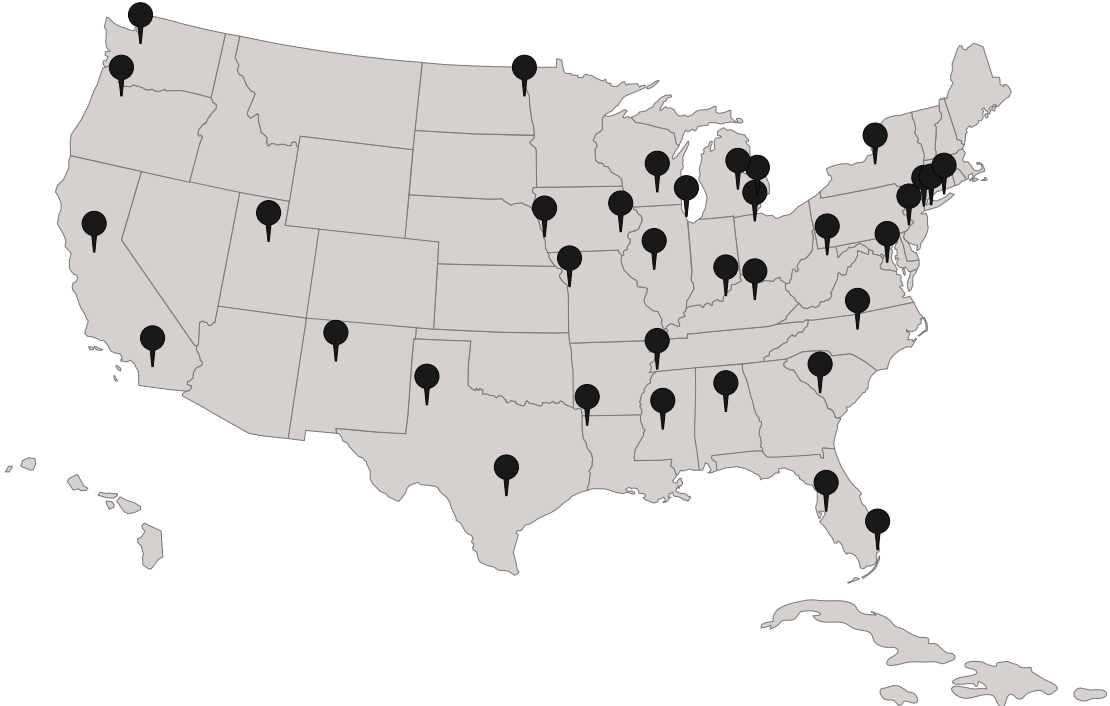


Figure 1.3 Family Medicine Departments: 1975-1979

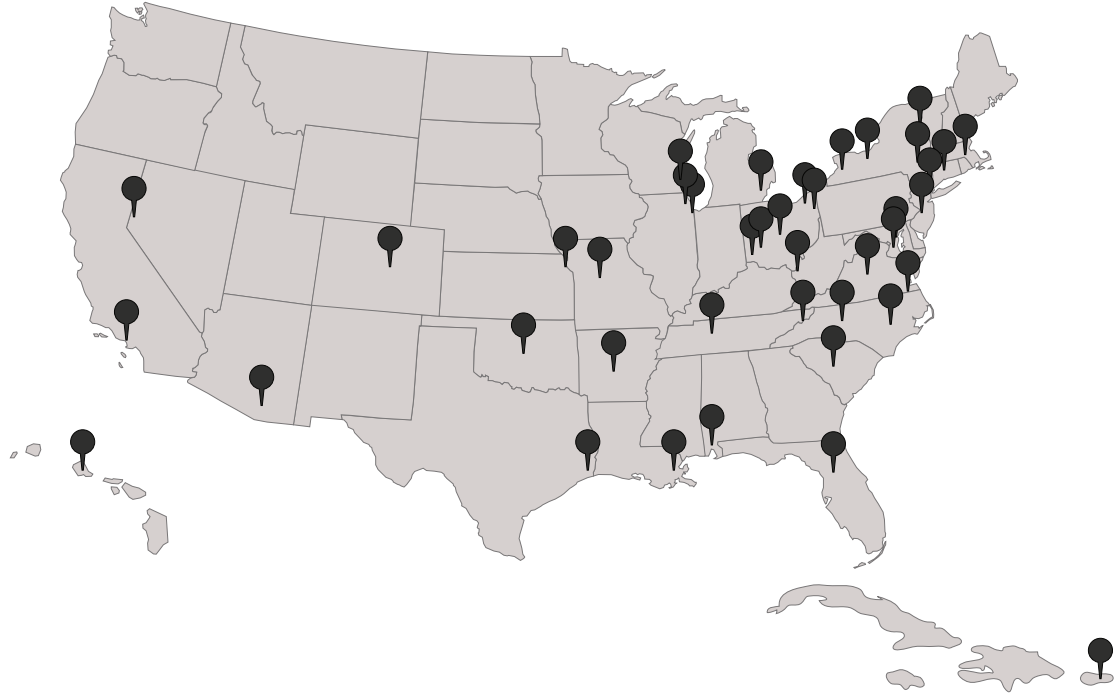


Figure 1.4 Family Medicine Departments: 1980-1984

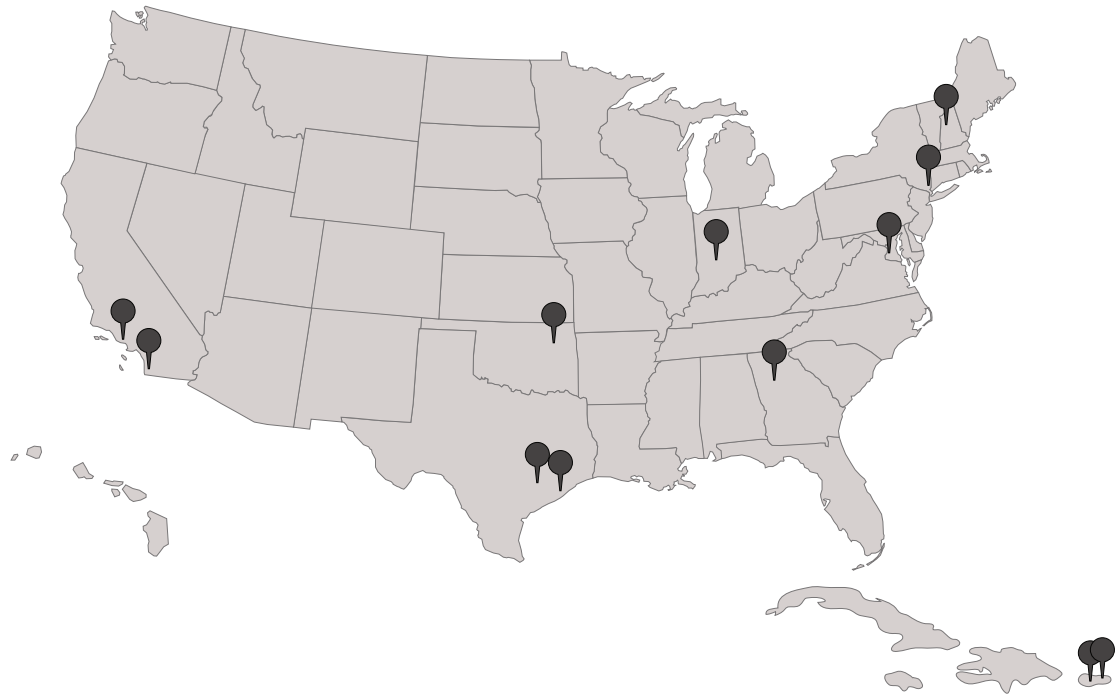


Figure 1.5 Family Medicine Departments: 1985-1989

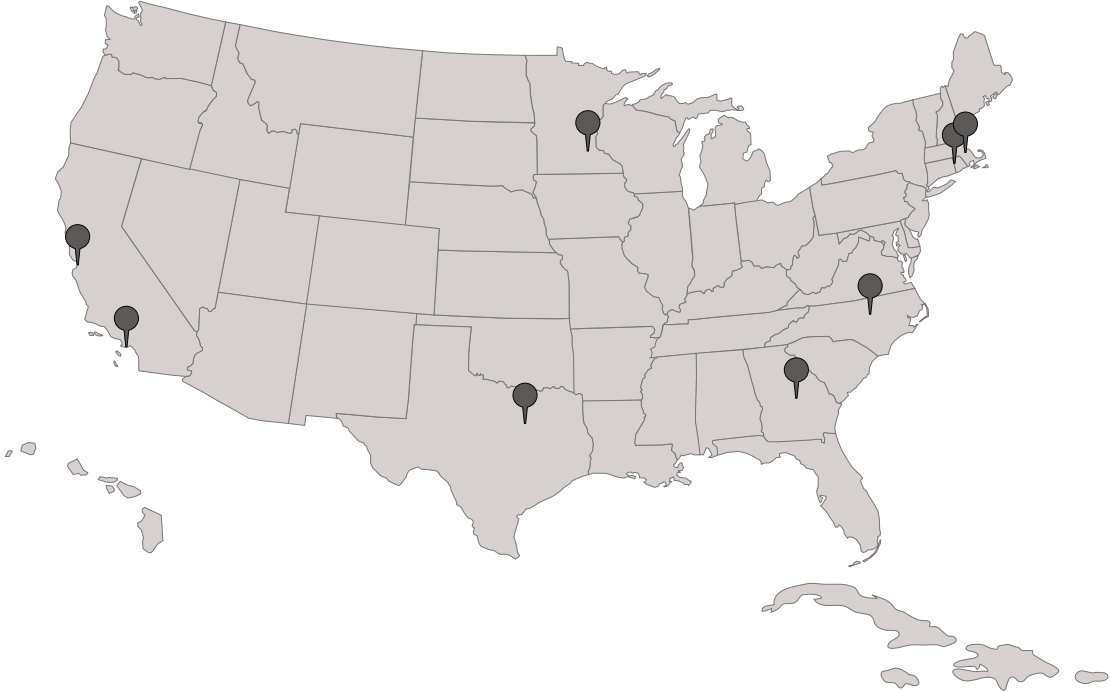


Figure 1.6 Family Medicine Departments: 1990-1994

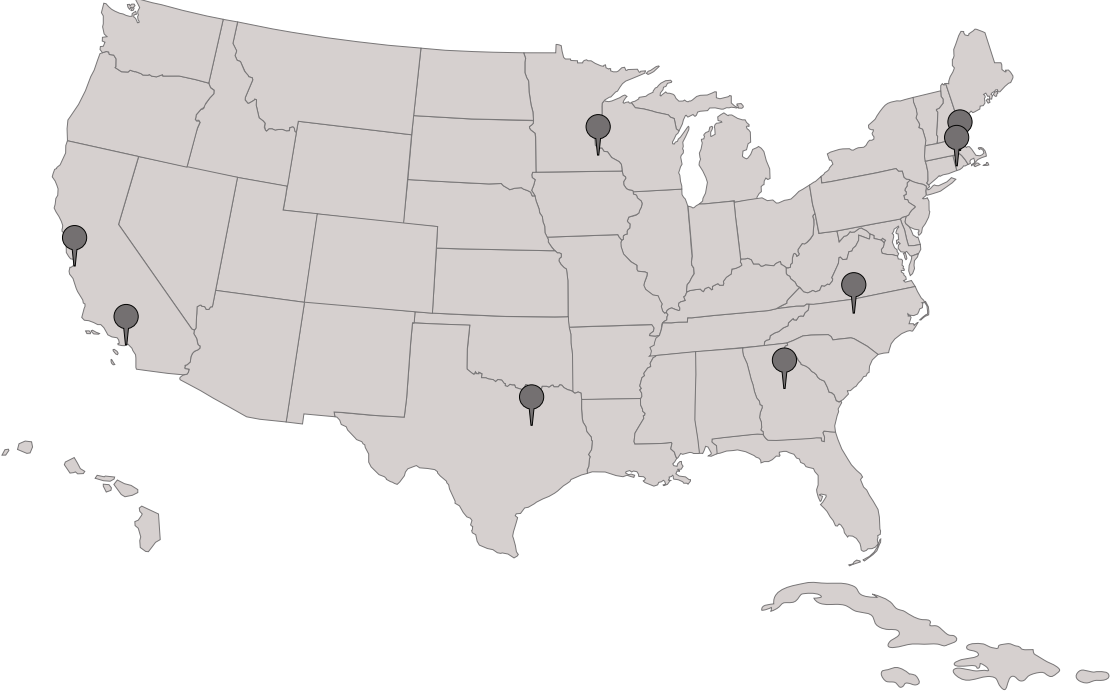


Figure 1.7 Family Medicine Departments: 1995-1999

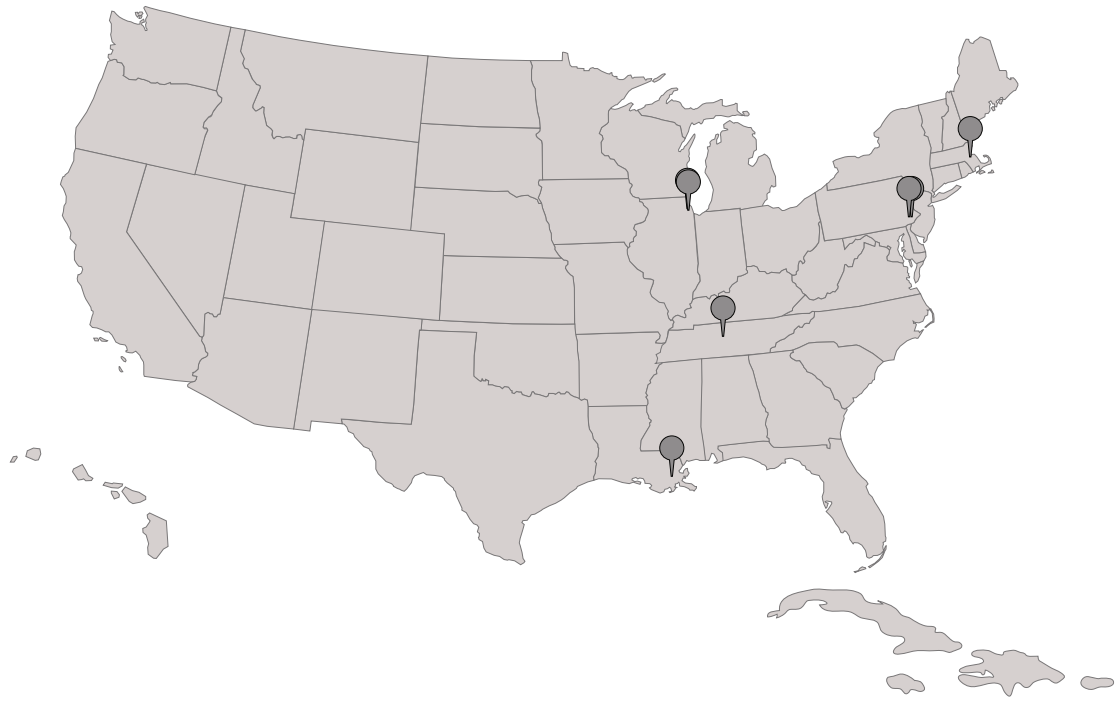


Figure 1.8 Family Medicine Departments: 2000-2005



Figure 1.9 Family Medicine Departments: 2006-2008

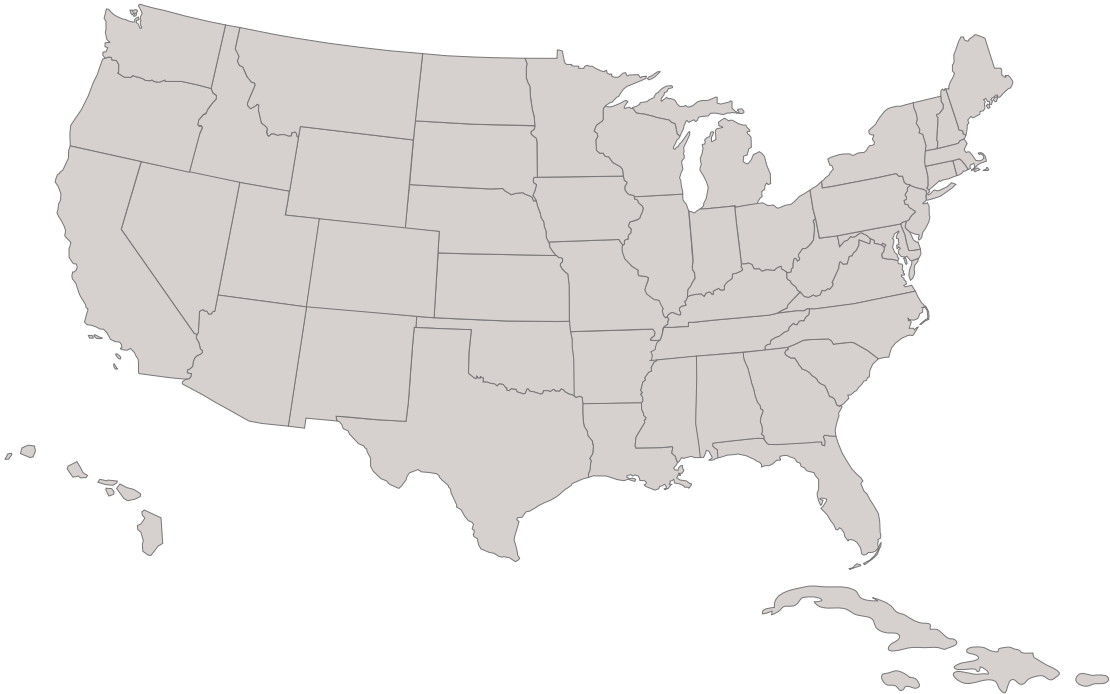


Figure 1.10 Family Medicine Departments: 2009-2012

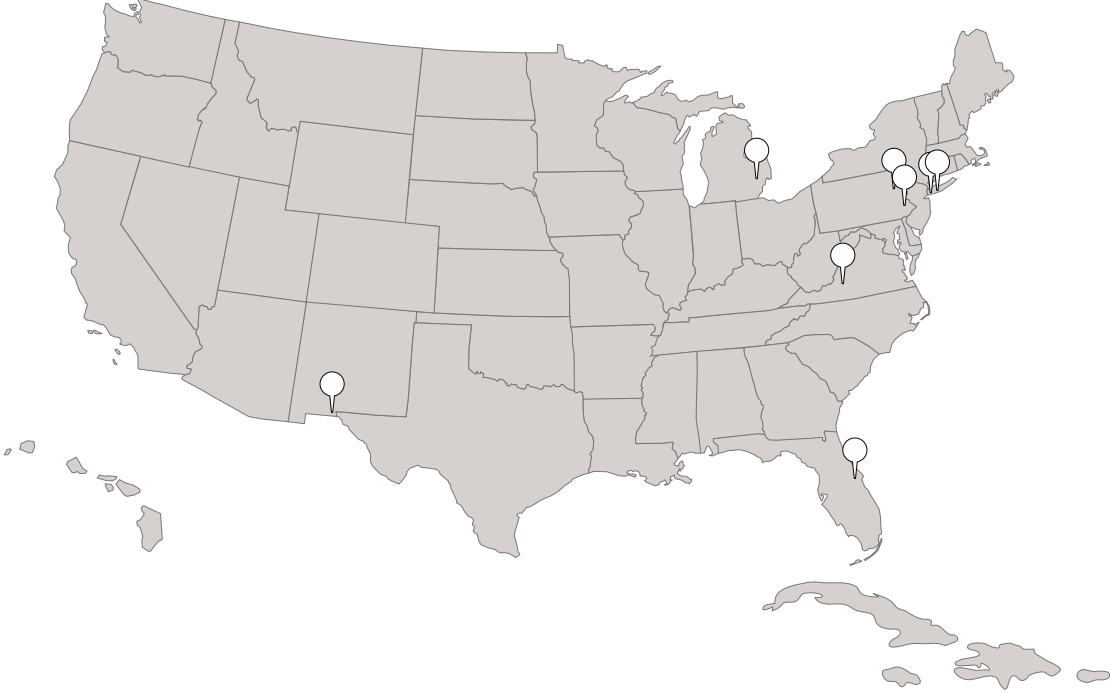
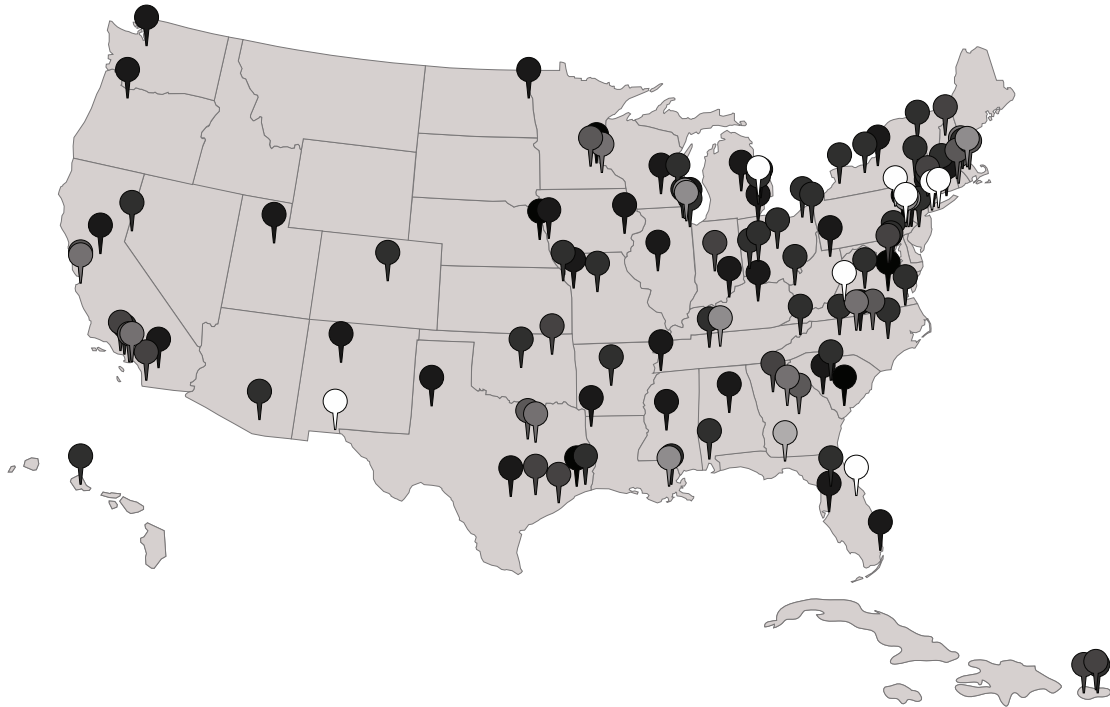


Figure 2, below, combines all of the years together, showing all Family Medicine Departments (a darker “pushpin” color indicates a more established Family Medicine Department and the lighter colors indicate more recently developed Family Medicine Departments).

Figure 2. All Family Medicine Departments: 2013



It is important to note that a handful of elite medical schools⁴ still do not have Family Medicine Departments (Gold 2012).

It is clear that it certainly was not a seamless (nor complete, still) transition for Family Medicine to establish its place in medical schools. What accounts for the difficulty? On a number of fronts, Family Medicine had a hard time finding a place within the medical establishment. For

⁴ Stanford, Yale, George Washington, Johns Hopkins, Harvard, Washington University in St. Louis, Columbia, Cornell, and Vanderbilt do not have Family Medicine departments (although some have a Section or a Center).

example, from where were Family Medicine faculty members to come? Most Family Medicine doctors were practitioners, and not researchers. For an individual physician, joining the faculty of these new departments meant leaving patients in their private practices to inhabit a low status position in the medical school. For, despite efforts to distance itself from the generalists of the past (with his accompanying low status), “several family physicians expressed how family practice is looked down upon in academics, just as general practice had been” (Arroyo 1986:180).

Curriculum was another point of contention for the new specialty. Where would Family Medicine be included in the curriculum, and who would teach it? As Arroyo writes, “getting family practice legitimated is one thing, but getting it taught—in the face of so many other competing specialties—is another” (184).

The role of legislation was also uneven. At a federal level, the first Act that specifically targeted training in primary care training was the Comprehensive Health Manpower Training Act of 1971. “This act was specifically directed at augmenting the development of family practice and increasing the number of physicians training in family medicine” (Arroyo 1986:143). In 1968, New Jersey was the first state to pass legislation addressing Family Medicine and New York, in 1969, followed by requiring departments in state schools (AAFP 1979). However, despite federal support for primary care training programs, primary care did not become the national norm in health care, as hoped” (RWJF 2003:4).

RWJ Generalist Physician Initiative

The Robert Wood Johnson Foundation (RWJF) Generalist Physician Initiative is an example of an effort, outside of national or state legislature, to encourage medical schools to increase the supply of generalist physicians. This initiative was part of RWJF’s “multifaceted grant-making strategy in the 1990s to reduce distribution and supply barriers to basic health

service” (5). From their own report, they cite a huge dip in graduates doing generalist practice (32% in 1980 and 14.5% in 1992), numbers based on what specialty medical students indicated at graduation.

Begun in 1991, the RWJF Generalist Physician Initiative provided up to \$32.7 million dollars to schools chosen for the program, which included a developmental stage and two implementation stages. The RWJF Generalist Physician Initiative aimed to change the culture of medical schools in order to encourage generalism, to develop external partnerships, and to get buy-in from institutions and their leaders.

Out of eighty-six schools that applied for the program, 18 were chosen (see Appendix B for the list of schools which completed the entire project). This Initiative did strive (and succeed) at targeting some of the problems that Family Medicine was having by increasing the support of administrative structure and faculty in leadership roles (RWJF National Program Report 2003:1). Some schools in the program also targeted the admissions process, developed recruitment programs, and redesigned curriculum (2). Ultimately, however, the results from this program “failed to demonstrate any difference between *Generalist Physician Initiative* schools and the schools that applied for but did not get program funding” (RWJF 2003). Examining this program and its lack of success deepens our understanding the challenges and opposition Family Medicine faces; even a program like the RWJF GPI with over thirty million dollars of resources did not yield a difference between the schools included and excluded from the program.

From the beginning, Family Medicine has struggled to find a welcoming place within the profession of medicine and the structure of medical education. Despite the efforts of federal government, state government, and private foundations, Family Medicine, and primary care more generally, continue to struggle to produce enough physicians or to be highly valued. Overall, this chapter has examined the development of Family Medicine after it received an official specialty

board in 1969. It has traced the challenges of the 'new' field to become institutionalized within medical education and accepted as part of academic medicine. In Chapter 2, we consider *why* Family Medicine encounters such disparagement and unwelcome from the medical profession and institutions of academic medicine.

CHAPTER TWO. PERPETUAL PROBLEM, PHILOSOPHICAL ROOTS

In upcoming chapters, we will see that problem of disparagement and disregard for Family Medicine and primary care, more generally, is decades old. Through these chapters, we will also see how the disparagement operates through at an institutional level through the structure, content, and culture of our medical education. Before we explore *how* this devaluing operates, however, we should first examine *why* the problem is so persistent.

In this chapter, I will consider that question: how is the perpetual shortage of primary care physicians connected to their lack of prestige? We should note that a *perpetual* problem is a specific type of problem that, despite multiple efforts, has failed to yield any satisfactory solutions. A perpetual problem forces us to ask more than “how do we fix this problem?” Knowing that the problem has lasted for decades, we must ask—why has the problem not been fixed yet? Why have past efforts fallen short of expectations? Or perhaps, are there parties who benefit from the persistence of the problem and who do not actually desire the problem to be fixed?

Carousels and Screens

In their discourse analysis of North American medical education literature, Whitehead, Hodges, and Austin (2012) noticed a recurring theme: “the need to avoid over-specialization, the importance of generalism.” They also found that this was one area for reform (along with others) that was repeatedly framed as “new,” though it has persisted for many years. They write that medical educators are “Captive on a carousel” and suggest that perhaps “the discourse of novelty reinforce[s] practices and legitimize[s] power relations that might be well served by recurrent

circling back to the same issues.” In other words, talking about the specialization problem as new “operates to eliminate recognition of the historical nature of these issues.” As we have seen, a serious look at the history would quickly throw doubt on the claim that a shortage of primary care physicians is a recent crisis. Whitehead, et al. (2012) also write that framing overspecialization as a new issue “operates to allow the medical education community to avoid embarking on the kinds of systemic change that might truly be necessary to achieve the results supposedly desired.” This sounds strikingly similar to some of the claims about Family Medicine’s birth as a specialty—that it was used by the medical profession to signal change without actually having to change.

Whitehead and her colleagues also note that much of the suggested reform in the literature “emphasizes changes for individual future doctors, thereby limiting consideration of institutional and systemic factors.” Focusing on individual problems and individual solutions is a great way to deflect attention from institutional problems; and as we have seen in the first chapter, the shortage of primary care physicians is a case in which there are indeed institutional problems.

A sociologist who has long studied medical education, Samuel Bloom (1989), investigated why the medical school is so resistant to change. He describes the phenomenon Whitehead, et al. (2012) refer to above as a “history of reform without change” (228). He has his own term for this paradox, as he asserts that “medical education’s manifest humanistic mission is little more than a screen for the research mission that is the major thrust of the institution’s social structure” (228). Bloom also addresses one of the most perplexing parts of this continuing problem. Lack of change would make more sense, perhaps, if there were no evidence for its need. However, it is widely agreed upon that primary care is important for population health, decreasing disparities, and reducing costs of health at an individual and a population level. Given this, how is it acceptable not to solve this problem? According to Bloom, we are looking at the effect of a “process whereby

the scientific mission of academic medicine has crowded out its social responsibility to train for society's most basic health-care delivery needs" (228).

A Philosophical and Professional Challenge

Bloom (1989) also talks about the tension between the different values of the reductionist "what of medicine" and the social ecologist "how of medicine" (231). The first emphasizes "biomedical knowledge and technology" while the latter focuses on social sciences and the "emphasis is on caring as much as curing" (232). As Table 1 below illustrates, the different approaches to medicine are well documented. I argue that this tension leads us to the central reason that Family Medicine has low status within the medical profession: Family Medicine defines the scope of the medical field and their role as physicians in distinct (and unwelcome) ways. The mere presence of these alternate definitions challenges the medical establishment and profession at large because it calls into question who gets to draw the boundaries of medicine and who gets to define the role of a physician. As we will see, the boundaries Family Medicine draws includes additional territory that threatens the precision and control that the biomedical model promises. I argue that the medical establishment deals with Family Medicine's threat by dismissing it, thereby reifying its own tighter, "neater" boundaries.

Table 1. Divergent Philosophies

	Dominant Medical Philosophy	Family Medicine Philosophy
Frameworks and models	<ul style="list-style-type: none"> • Biomedical Model (Engel) • Disease-centered • <i>What</i> of medicine (Bloom) • MD as positivist (Stoller & Dozor) • Reductionist (Bloom) 	<ul style="list-style-type: none"> • Biopsychosocial Model (Engel) • Patient-centered • <i>How</i> of medicine (Bloom) • MD as systems/contextualist (Stoller & Dozor) • Holistic (Horstein)
Basis of expertise and patient contact	<ul style="list-style-type: none"> • Biomedical knowledge • One point in time 	<ul style="list-style-type: none"> • Biomedical knowledge <i>plus</i> relational knowledge: “Need to know intimate facts to be a good diagnostician” (Berger 1967: 73) • Continuous over time: “Unlike other doctors, the general practitioner knows the patient before the disease” (Heath 2007: 68, of McWhinney)
On science and technology	<ul style="list-style-type: none"> • Unconditional faith 	<ul style="list-style-type: none"> • Conditional faith in science (Stephens) • “We simply do not believe that all health problems have technological solutions” (Stephens 1982: 107) • “Technology is the kudzu of medicine. It’s choking all of us.” (physician in McPhee 1986: 61)
On social, psychological, and behavioral dimensions of illness	<ul style="list-style-type: none"> • Dismiss as peripheral to “real work” • The medical problem is reducible to a disease located in body 	<ul style="list-style-type: none"> • Embrace as essential to “real work” • “People are fundamentally the same [...] they want freedom from suffering” (Horstein 2009: 235); suffering is not always physical
Goals	<ul style="list-style-type: none"> • Repair • Cure • Isolate • Fragmented • Body • Science • ERADICATE DISEASE AND DEATH 	<ul style="list-style-type: none"> • Prevent • Care • Integrate • Coordinated • Person • Practice (Montgomery 2006) • PROMOTE HEALTH AND FREEDOM • “a full, not endless, life” (Callahan 2009: 177) • “Medicine practiced in relation to the needs of those it serves” (Bloom 1989: 231)

Abbott (1981) puts forth a theory about professional prestige, in which he argues “intraprofessional status is in reality a function of professional purity. By professional purity, I mean the ability to exclude nonprofessional issues or irrelevant professional issues from practice” (823). According to Abbott’s theory, the segments of a profession that deal with the most “pure” issues enjoy the most prestige. In this system, those at the top of the hierarchy receive issues that are “predigested and predefined” by those below them, who have “removed human complexity and difficulty,” a process easily seen in typical referral processes within medicine (823).

Abbott also argues that “much of the complexity of low status practice is, in reality, extraprofessional,” which helps to explain the frequent comments that Family Medicine is “boring,” despite its substantial variety (823). The disparaging comments indicate that the variety and complexity is seen as “extraprofessional” and thus an un-esteemed type of variety. Family Medicine deals with all of those untidy issues that do not fit neatly into the biomedical model of disease. These workers at the bottom deal with “remov[ing] the human complexity” and refer to the esteemed specialist a more pure medical problem. Stephens (1982) confirms this point: “there is a tendency to see primary care as merely an adjunct to the real work of medicine, which is performed in hospitals. This low view of primary care has made it unattractive to generations of physicians” (86).

The philosophy of Family Medicine, however, argues that their work is actually not extraprofessional at all. Family Medicine advocates a more holistic approach to medicine and believes in the importance of the psychosocial, emotional, and spiritual history of a person for a person’s suffering and health in addition to their physical history. Therefore, the “human complexity” Family Medicine physicians routinely encounter is *precisely* “professional” in nature, and should be considered as such (see Table 1). For those in Family Medicine, providing the best care to patients includes considering factors like social support, living situations, stress, nutrition,

exercise, job status; quality care means treating the patient as a whole, not reducing, fragmenting, and isolating, as advocated by the dominant biomedical model of disease.

Family Medicine's philosophy enlarges the boundaries of medicine in unappealing ways for the rest of medical establishment and profession, however. Lower status segments eliminate pesky human complexity precisely because this complexity is hard to manage, understand, and most importantly, *control*. Consider the way these authors, both Family Medicine physicians, describe it:

The MD as positivist seeks physical causes, limits the investigation, seeks to confirm preconceived hypotheses (pathophysiology), and attempts to control the patient. The MD as systems/contextualist seeks first to observe the patient, then to understand and participate in the experience of a particular person or family in a natural setting (home visit?!), all with fewer controls and less control." (Stoller and Dozer 1988: 252).

Though home visits are increasingly rare, this quote makes clear that the way of the biomedical model (what these authors call a "positivist" approach) seeks to control, while the way of the "systems/contextualist," what we have been calling a holistic approach, consistent with FM's philosophy, practices medicine in a way that yields less control. A holistic approach to medicine argues that the more information the better, that due to the interconnectedness of humans (both mind, body, soul and with each other through family and community), there is no unnecessary or unneeded information. Enlarging the boundaries brings more uncertainty and less control, a reality that jibes with FM's philosophy. As one Family Medicine resident said, "*People who go into family practice are people who aren't afraid of not knowing everything.*" (Arroyo 1986:179). Horstein (2009) writes that the biggest difference between the specialist and the generalists is "their tolerance for uncertainty" (120).

However, from the perspective of the dominant biomedical model, this is not a welcome addition. Abbott again: "the impure is that which violates the categories and classifications of a

given culture system. Through amorphousness or ambiguity it brings together things that the culture system wishes to separate” (824). Family Medicine not only brings together what biomedical model wishes to separate, but Family Medicine has the audacity to argue that the model should change:

for in man the disease at once affects and is affected by what we call the emotional life. Thus, the physician who attempts to take care of a patient while he neglects this factor is as unscientific as the investigator who neglects to control all the conditions that may affect his experiment. (Peabody 1927: 882)

According to the philosophy and practice of Family Medicine, while the non-physical may take “time and energy,” “the social is more important than we are able to give credit for (Hutt 2005:39). Social, psychological, and behavioral components are not and should not be extraprofessional, the Family Medicine perspective argues. They are vitally essential components of people, and thus of health.

In addition to reduced control brought by the inclusion of “human complexity” comes a threat to the role of the doctor as expert. In Family Medicine, I argue that there are different roles for the doctor and patient. While the doctor certainly has knowledge and expertise, the relationship is seen on more equal terms. Family Medicine doctors talk about partnering with patients, and enabling patients to take charge of their own health—a finding we will see in Chapter 5 when Family Medicine residents describe their relationships with their patients. Below, Peabody (1927) describes the importance of relationship between a physician and her patients:

The good physician knows his patients through and through, and his knowledge is bought dearly. Time, sympathy and understanding must be lavishly dispensed, but the reward is to be found in that personal bond which forms the greatest satisfaction of the practice of medicine. One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient. (882).

In addition to partnering with patients, Peabody declares that a good clinician will also engage emotionally with patients, an act that requires vulnerability and further loss of control. In these ways, Family Medicine advocates a definition of medicine and a role of the physician that welcomes complexity and uncertainty, and intentionally gives power away to patients. Thus, it should not surprise us that the medical profession has not been eager to adopt Family Medicine's philosophy as its own. The threat to their way of life and work is dealt with by dismissing Family Medicine as "extraprofessional" and assigning it the low prestige that comes with dealing with issues on the periphery of medicine. Another way to think about this is to consider Fox's [1957] analysis of uncertainty in medicine. She writes that uncertainties stem from three sources: "incomplete mastery of the vast and growing body of medical knowledge," "limitations in current medical knowledge" and finally, the "difficulties in distinguishing between" these first two (Fox [1979]1988:83). Perhaps the profession of medicine, in wanting to solve the last problem and ignore the second, finds an easy solution in associating all of Family Medicine's uncertainty as a weakness, an "incomplete mastery," which also helps to explain the low status of the field.

Finally, at a more basic level, Family Medicine threatens the profession of medicine because it threatens the way that the medical profession "manage[s] their knowledge and work[s] in their own way" (Freidson 1970[1988]: xii). In addition to the reduced control brought by "human complexity," Family Medicine, just by trying to move the boundaries of the profession at all, poses a threat to the autonomy of the profession and their scope of expertise.

Beliefs and Band-aids.

At the core of Family Medicine's perpetual low status is a difference in beliefs. Stephens (1989) recognizes a deep schism between Family Medicine and medicine at large, and describes it this way: "Family physicians have no unconditional faith in science, and this marks us as

belonging to the counterculture” (107). This statement sets us up well to examine the different beliefs that undergird the biomedical model of disease and the more holistic, humanistic model that Family Medicine embraces. Family Medicine questions the wisdom and power—and the ultimately effectiveness—of the biomedical model. Family Medicine challenges the broader medical profession on multiple fronts. The following quote from a Family Medicine physician explains creatively that:

Academicians see family physicians as peons putting bandaids on people while they [the specialists] are doing the real job. The thing they don't realize is that the real job is done by the people putting on the bandaids. That's what most people need. Most people need bandaids, not university centers (Arroyo 1986:181)

Why does Family medicine struggle to have intraprofessional prestige? Why have they always struggled? Because at a fundamental level, Family Medicine’s philosophy disagrees with the dominant cultural model of medicine about almost everything—from the bounds of medicine, the role of the physician to the power of science. Ultimately, they even disagree on the needs of the population, and of individuals. What is “pure” within the profession of medicine? What is central and what is extraprofessional? Family Medicine challenges the dominant biomedical model on these questions, and provides answers that threaten the dominant paradigm. This, I argue, is why Family Medicine has low prestige. Family Medicine embraces the very human complexity that our current model of medicine tries to eliminate.

This chapter has examined the philosophically and professionally roots of Family Medicine’s low status. But how is this disparagement toward Family Medicine and primary care more generally manifested? To begin to answer that question, in Chapter 3, I use oral histories to examine the experiences of individuals graduating from medical school from 1936-1985, spanning before and after Family Medicine was boarded. Findings from oral histories show that

in addition to structural difficulties, the culture and content of medical education are hostile to primary care.

CHAPTER 3. INSTITUTIONAL HOSTILITY: MEDICAL TRAINING'S OBSTACLES FOR PRIMARY CARE

Introduction

Promoting and maintaining an adequate supply of primary care providers is vitally important to the U.S. health care system. Primary care has been shown to improve health, increase access to care, lower costs, and reduce disparities (Starfield, Shi, and Macinko. 2005:458-459; Starfield 2008). The U.S. is already experiencing a shortage of primary care physicians and the Patient Protection and Affordable Care Act (PPACA) will exacerbate the problem by adding an estimated 32 million new patients to the system. While true that PCPs face low reimbursements compared to specialists, research has not been conclusive about the importance or influence of these factors on medical students' choice of specialty. Rosenblatt & Andrilla (2005) found that the effect of debt was "modest when demographic characteristics were taken into consideration" (815) and the American Association of Family Physicians reports "a clear-cut relationship between debt and specialty choice has never been demonstrated." (see AAFP "Study of Factors"). Another aspect of the primary care shortage problem is rarely discussed: the role of institutional hostility. Siwek (1993) wrote that: "yes, there are financial barriers and issues of prestige, but until we can overcome the institutional prejudice that exists against family practice, we will have a tough time recruiting enough students into the specialty that most clearly devotes itself to the primary care needs of Americans" (2434).

This paper examines this understudied phenomenon of "institutional prejudice" against primary care arguing that there are three areas where hostility exists in our current medical training environment: a) the structure of training; b) the culture of training; and c) the content of

training. This paper uses data from the Primary Care Oral History Collection, a collection of interviews of primary care physicians whose medical school graduation dates range from the 1930s to the 1980s. Because the data ranges over decades, these oral histories are able to inform how deeply rooted and entrenched certain obstacles are toward primary care. Second, oral histories provide us with unusual knowledge about why people *do choose* primary care, despite institutional hostility, and how they make sense of their career decision. Finally, taken from experienced practitioners, the oral history data allows us to understand the importance of what is omitted about primary care during medical training. In this case, the rich data of oral histories is able to point us to a central reward of primary care practice that is absent in training.

Background

Primary Care Supply and Specialization

The uncertainties surrounding the supply of primary care physicians in the United States are plentiful and the future of primary care is “precarious” (Boulis and Jacobs 2008:196). Dill and Salsberg (2008), in an Association of American Medical Colleges Report on the supply of physicians, state “the projected shortage in primary care accounts for more than a third of the total projected shortage in 2025” (26). Another recent study called attention to the problem of mal-distribution of primary care (Goodell, Dower, and O’Neil 2011:1).

A number of changes surrounding our health care system make the future of primary care—including who will provide services and who will need services—difficult to predict. Population aging, increasing numbers of patients with chronic conditions, rising patient expectations, and increased value placed on technology are some of the forces that fuel the unpredictable supply of PCPs (Mechanic and Rochefort 1996; Goodell, et al. 2011). Additionally,

the recent Patient Protection and Affordable Care Act (PPACA) will add an estimated 32 million new patients needing PCPs (Goodell, et al. 2011).

Given a growing need for coordinating patient-centered care, the number of U.S. medical graduates choosing to practice primary care medicine is inadequate (AAFP 2012). The Council on Graduate Medical Education (COGME) (2010) report, “Advancing Primary Care,” predicts that our country will need between 63,000 and 100,000 additional primary care physicians to meet our nation’s health care needs.

The overall trend toward specialization and the shift of the center of medicine from the home to the hospital reaches back many decades (Starr 1982; Stevens ([1971]1998). In 1935, for example, 85% of practicing physicians were general practitioners but by the 1960s, that number had dropped to only 30 percent (Stephens 1982). Concern over this shift surfaced as early as 1933, when an editorial in the *Journal of the American Medical Association* talked about the “overgrowth of specialism” (“Diversity or uniformity in medical training,” 1993). Three decades later, Alvey (1961) wrote: “there is a shortage of general practitioners, family doctors, generalists, call them what you may... I do not mean that there is a shortage of physicians, but there is a need for physicians who are interested in the total and continuing care of the patient.”

Institutional Hostility Toward Primary Care

There are many potential reasons for the lack of medical students choosing to become primary care physicians. In addition to generating less income than their peers in procedure-oriented specialties and having less control over their work hours, primary care physicians struggle for respect and prestige in medical schools and academic medical settings. Block et al. (1996), in an interview study of first- and fourth-year students, residents, faculty, program

directors, and deans reported: “students and residents encounter an atmosphere that is chilly toward primary care” (677). Bush (2003), in an article summarizing research in the Future of Family Medicine Project, writes that the findings “confirmed what most, if not all, family physicians already know: Family Medicine does not have strong support in academic settings.” Senf, Campos-Outcalt, and Kutob (2005) find a “pervasive negative relationship between interest in research and interest in family medicine” among students (265). This institutional hostility at medical centers where students train likely poses challenges for medical students interested in primary care. Stephens (1982) argues that “medical school is truly a strange land for family physicians” and elaborates on four dilemmas that makes this so: the dilemmas of time, content, style and faith” (207). Finally, the COGME report identifies four major challenges to “Advancing Primary Care,” and two of them are “the environment in medical schools” and “the graduate medical education environment” (2010:4).

This paper uses data in oral histories to further explore and analyze institutional hostility toward primary care. This paper explores what students are exposed to and what they are not exposed to during training, as both are important for understanding how attractive or unattractive primary care is when medical students choose a specialty. I argue that students are exposed to institutional hostility embedded in the *structure*, conveyed through the *culture*, and present in the *content* of medical education. I also consider what respondents found attractive and worthwhile about primary care that helped them overcome the negative messages that they received.

Data and Methods

Data & Analysis

The data used in this article is oral history transcripts of primary care physicians found in the Primary Care Oral History Collection.⁵ Fitzhugh Mullan, who conducted the oral histories during the years 1995 to 1996, donated the collection to the National Library of Medicine for public access. The entire collection includes oral histories of 62 individuals, 52 of whom are physicians; the remaining ten are nurse practitioners, physician assistants, or nurses. Mullan (1998) used snowball sampling, although he tried to “keep a balance with regard to geography, gender, urban/rural practice, ethnicity, and discipline” (1116). See Table 2 for a breakdown of respondents by gender and medical school graduation year. For this article, data includes all fifty-two oral history transcripts of primary care physicians, whose birth year’s range from 1911 to 1960 and whose dates of graduation from medical school range from 1936 to 1985. While each interview is unique in content, they do follow a similar format. The interviewee talks about growing up and early influences on the choice of a medical career and then addresses the development of their career as well as their personal lives. Mullan usually asked about how generalists are perceived and their thoughts on the future of primary care. Mullan writes that he “was especially interested in their values and the developmental decisions that had drawn them into primary care” (1998:1116). The combined length of the oral histories used for this article is 3,244 typed pages, which averages to around 62 pages per respondent. Throughout this chapter, when including interview excerpts, I have removed names and other identifying information from individuals and institutions.

⁵ Primary Care Oral History Collection. 1995-1996. Located in: Modern Manuscripts Collection, History of Medicine Division, National Library of Medicine, Bethesda, MD; OH 146.

Oral history transcripts were uploaded and analyzed using QSR International’s NVivo9 qualitative data analysis software program. Transcripts were carefully analyzed, and codes and themes developed inductively from the data. Special attention was paid to interviewees’ experiences surrounding the choice of a primary care career, the way in which prestige (or lack thereof) of primary care impacted their decisions, what they found valuable about primary care, and what were the most rewarding or satisfying aspects of work.

Oral histories are particularly useful data because they express the narratives through which individuals remember and make sense of their life choices. I am specifically interested in words, voices, experiences, and moments that respondents see as pivotal in their career and that they use to think about and make sense of their choices. What justification do primary care physicians use to make sense of their decision to enter a specialty with low prestige and respect? As Davidman (1991) argues, “because everyday life encompasses an ongoing process of constructing the meanings of our experience, the ways in which people talk about their experiences are as important as the content of the experiences themselves” (82).

Table 2. Respondents by Gender and 10 - year Medical School Graduation Year Cohort

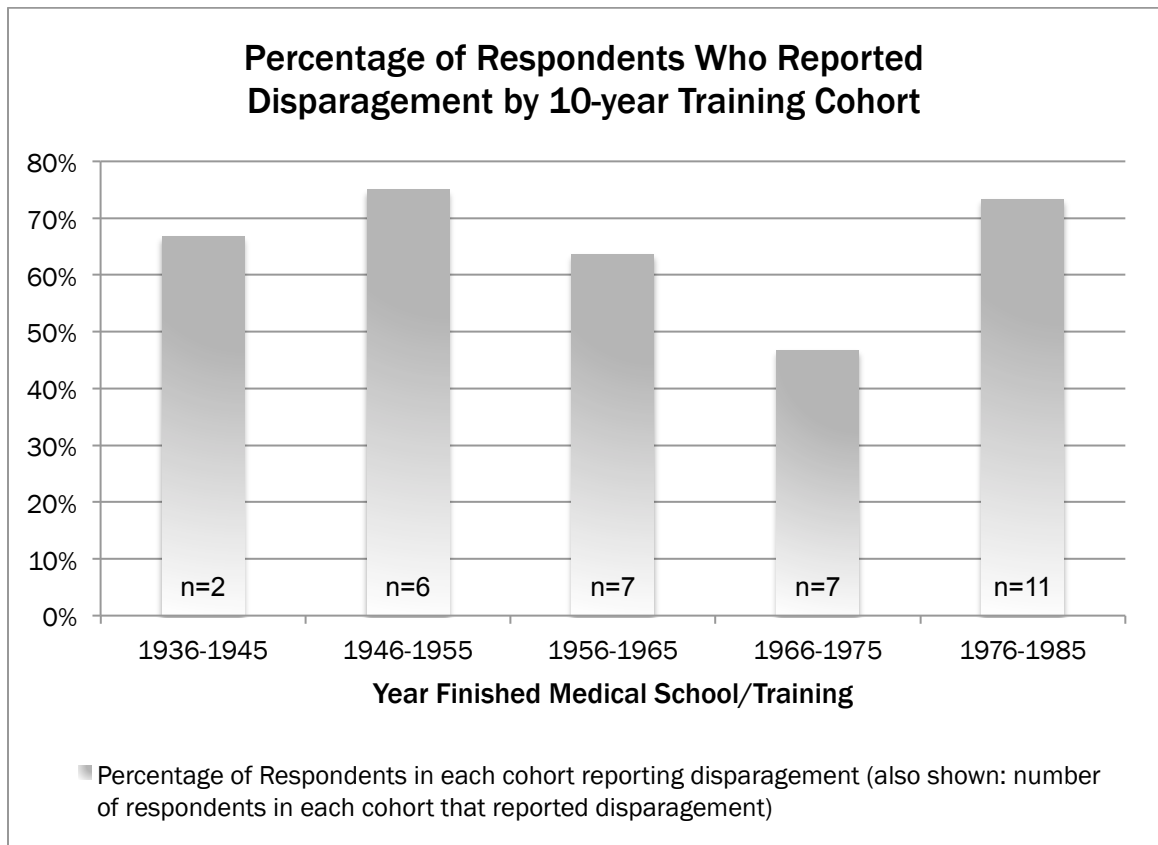
Medical School Graduation Year	Respondents			Cohort as % of Total
	Males	Females	Total (n)	
1936-1945	2	1	3	5.8%
1946-1955	7	1	8	15.4%
1956-1965	8	3	11	21.2%
1966-1975	13	2	15	28.8%
1976-1985	7	8	15	28.8%

Findings

Overall Trends

Over 63 percent of the total respondents specifically mentioned that others discouraged their interest in primary care and/or described an awareness of the low prestige and the low regard that others held for the field. Figure 3, below, shows how these findings varied across 10-year cohorts, grouped according to when respondents graduated from medical school. As Figure 3 indicates, the percentage of respondents in each cohort reporting disparagement ranged from 46.7% (1966-1975 cohort) to 75% (1946-1955 cohort) and that a chilly environment for primary care has persisted at a relatively constant level through many decades.

Figure 3. Percentage of Respondents Reporting Disparagement by 10-year Training Cohort



In the next three sections, I examine hostility toward primary care embedded in the structure of training, perpetuated by cultural disparagement and fostered by the obstacles connected to the content of training, focusing on the mismatch between medical training and primary care stemming from both included and omitted medical training content.

Structure: Embedded Obstacles

The structural makeup of medical schools meant respondents were simply not exposed to many faculty models of primary care physicians, nor were many of their peers choosing primary care. This phenomenon holds true today, and a COGME report (2010) writes that students are “fed a steady diet of subspecialization” (13). Numerous factors contributed to the structural displacement of primary care faculty in training settings. In particular, post-WWII, the government “did much to stimulate and reinforce specialization” (Arroyo 1986:81). Increased government funding made medical schools dependent on specialists whose research could secure NIH grants and other sources of funding. In addition, legislation like the Hill-Burton Act in 1946 stimulated the growth of hospitals and new policies provided support for individuals during residency and gave hospitals an economic incentive to have more resident positions, further stimulating specialism (Starr 1982; Stevens ([1971]1998).

The resulting lack of generalists within medical schools also conveys a normative stance embedded within the structure—that generalist medicine is in fact not as important or valuable as specialty medicine. Structural discouragement is powerful in shaping students decisions regarding primary care, and it reveals an embedded structure where specialism overshadows primary care.

As respondents proceeded through medical school, they noted a lack of mentors and teachers who were generalist physicians. One interviewee described the historical factors that contributed to specialization:

The real shift resulted from the post-World War II federal policy of subsidizing full-time faculty in all the med schools. That guaranteed specialism: the peer models that the medical students got were specialists who, because they chose to go academic, were making a statement that they placed research and education above practice. I could dilate on that, but I think it's a terribly important event, a cultural and academic event. Mind you, who picks the incoming students? The faculty. Who trains them and who tells them what to do with their career as they're leaving? This same faculty almost to a man--mostly a man, an occasional woman--were specialists. So that rapid transformation was facilitated, I think fortuitously, by the generous decision of the public through the federal government to fund full-time faculty. (Internal Medicine, 1947)⁶

Other respondents commented on the dearth of primary care mentors and models during their training. This is consistent with Colwill (1992), who notes a “limited number of generalists to serve as role models” (382).

I think that was certainly reinforced when you went to [school name]--I'm not certain any medical school would have been different in the fifties--that you had no generalist faculty role models to whom you were exposed. (Pediatrics, 1956)

And I think, in those days, as you went through medical school, there were no people in medical school who said to you, "Be a general practitioner..." You never saw a family physician at [school name]. I mean, I didn't see anybody. (Pediatrics, 1964)

The lack of faculty representation contributed to very few students choosing primary care. One interviewee (Family Medicine, 1973) had a class of 106 and only 2 to 3 percent went into primary care. Another stated that only about 5 out of 150 people in her graduating class became Family Medicine doctors (Family Medicine, 1983).

There were very few people in the medical school who went into family practice, and the people who were my best friends... who were very close, none of whom went into family medicine, we've completely lost contact because of that choice on my part, so there were some real disadvantages in making the move. (Family Medicine, 1979)

There was definitely a milieu of "of course everybody's going to sub-specialize." It was weird if you weren't going to. Indeed, of all of my classmates, only me and one other guy in residency became generalists, although a couple of the people who trained in sub-specialties are practicing general medicine. It wasn't that my colleagues would say it was bad, but there was an idea that there was no other way. (Internal Medicine, 1985)

⁶ Each interview excerpt is identified first by the specialty of the respondent (Family Medicine, Internal Medicine, Pediatrics, or Generalist) and followed by year he/she graduated from medical school.

In addition to the embedded structural issues during training, respondents also report a culture dripping with discouraging comments and interactions for students choosing primary care careers.

Culture: Discouraging Interactions & Disparaging Comments

Whether called a “chilly climate” (Block et al. 1996), “bashing” of primary care (Holmes et al. 2008; Hearst et al. 1995), “medical bigotry” (Siwek 1993), or “badmouthing” (Hunt, Zhong and Goldstein 1996), disparaging comments and attitudes toward primary care have been well documented. This institutional culture that enacts and perpetuates a specialty hierarchy (with primary care at the bottom) has been referred to as the “hidden curriculum.” This description alludes to values and attitudes that are not part of the official curriculum, but are powerful teachers nonetheless (Hafferty 1998; Hafferty 2000; Hafferty and Franks 1994; Haas and Shaffir 1982; Hundert, Douglas-Steele, and Bickel 1996). Hunt et al. (1996) write that these types of negative comments are “demeaning of the discipline, thereby demeaning the student who might choose such a career” (665).

What messages did individual primary care physicians receive as students, decades ago when they were deciding what specialty to pursue? For some doctors, the disparagement of primary care began as early as when they applied for medical school. Unaware of the devaluation of primary care in academic settings, some respondents report that they naïvely expressed their desire to pursue a generalist career and were met with mockery and even denial of admission to medical school.

Well, you know, it was interesting. I can tell you my story with [school name]...I had two interviews. I had an interview with the dean of a school...The dean thing went just like you would expect it to...[Then] I had lunch, and I went and talked to some students, and they asked me how the conversation went with the dean. They said, "Well, did you tell him what

you wanted to be?" I said, "Well, yeah. I said I wanted to be a family doctor." And they all sort of looked around like this, and said, "Well, that was the wrong thing to say." [Laughter] And as it turned out, it probably was the wrong thing to say. (Family Medicine, 1979)

I was interviewed by somebody who clearly had the interest of sub-specialty and saw [school name] as putting out specialists. Clearly, if you mentioned the word "general practitioner," you had said something terribly wrong. He asked me, he said, "Well, what kind of physician do you want to be?" And I said, "A general practitioner." And he spent the next twenty minutes berating me, and telling me that I could go to a GP school if I wanted to, but [school name] produced specialists, and was a cut above that kind of interest. ...He told me when I left, "I'm going to highly recommend that you not get into this school..." He said I should go to a school that produces general practitioners, and should never come to an institution like [school name]. (Pediatrics, 1964)

For other physicians, an awareness of the low status of primary care physicians emerged after their medical education began. Many respondents, upon expressing a desire to practice generalist medicine, were told that they were "too smart" for primary care medicine.

But then once you got out into all of the rotations, people kept saying things like, "Why do you want to be a family doctor? You're a smart person. You could do something really interesting," and things like that, so the messages were clearly against it. (Family Medicine, 1983)

It was articulated,...during my training period and just after a decade or more, thereafter, it was well established, equally subtly, but unquestioned, that the hierarchy of values was that specialism was better. Generalism was poorer. (Internal Medicine, 1947)

In the...academic medical community of the 1970s, if you were going into primary care, especially if you were going into family practice, and you had any semblance of professional potential, you were actively dissuaded. (Family Medicine, 1976)

These respondents received messages that being smart, successful, and professional were seen as incompatible with choosing primary care. Others described how choosing primary care was a disappointment to faculty members:

When I first started as a generalist that was not the thing to do...the attitude was that if you were in general medicine, then you were too dumb to get a fellowship. I remember one of my former professors came over to give grand rounds...I hadn't seen him for a couple of years, and he said, "Gosh, hey...what are you doing?" And I said, "Well, you know, I'm in general medicine..." and you would have thought I said I'd been in jail for two years. The look on his face told me that [I] somehow failed. I think that was sort of a prevailing attitude, that there wasn't much merit in generalism. (Internal Medicine, 1971)

Additionally, respondents describe an environment in which teachers belittled primary care doctors in the community. These comments created an aura of disregard and disrespect for primary care physicians.

I didn't feel encouragement about doing general practice. In those days it was the LMD, the local medical doctor, who was always considered the low person on the totem pole in terms of intellect. (Family Medicine, 1965)

And the sense of the generalist as GP, which clearly were maligned initials, so that in every write-up as an intern, I would see descriptors from other residents and attendings that "the local GP" had referred this sick patient, and it might as well have said, 'the local, stupid, incompetent GP referred this patient near death's door.'" (Family Medicine, 1979)

There was a general depreciation of the generalist...we called them LMDs, local medical doctors, were kind of the dummies. (Family Medicine, 1963)

All my life in academic medicine I had had this picture of the practicing physician out there in the community that was somewhat distorted. I don't know whether I thought of them as not quite as bright as the academics or what but it was certainly that flavor that was transmitted by the academic environment. (Internal Medicine, 1973)

Pushing Back: Physician Responses to the Devaluing of Primary Care

As we have seen, many interviewees encountered discouragement—in multiple forms—about choosing primary care as a career. They sensed very acutely that their choice brought with it less prestige and an unflattering judgment about their intelligence. Yet these respondents persevered in their decision to pursue primary care. In this section, I explore the ways that respondents pushed back against assaults on primary care. I describe two methods they employed: a) counter-narratives which discredited specialism and b) finding rare supportive mentors and/or peers.

Discrediting Specialism

One way interviewees responded to criticism about primary care was by developing counter-narratives that attached value to primary care and disparaged other specialties.

Respondents pushed back explaining that actually, it was *other* specialties that were boring.

When I was a resident, one of the residencies I would have gone on in is urology. But the problem with it was that I just couldn't believe that I would spend the rest of my life doing urology, looking at penises and bladders and kidneys. Whereas in general practice, you're looking at a tremendous range of things...I thought that the medical general practice gave far greater diversity and much more enjoyment. You saw eyes, you saw looking at a nose, you did a rectal exam, you did feet. You pared corns and nails and everything. The whole works. (Generalist, 1940)

The other thing I saw, [that] reinforced my enthusiasm and commitment to general internal medicine: it struck me that most of the people who did the subspecialized stuff had a very limited world as far as medical gratification. Explicitly, I was struck with what I thought was the tedium and narrowness, the loss of not experiencing the variety of things that happen in health care, that is the lot of even a busy subspecialist. I'm not about to write off excitement of fixing a crippled hip into a fully usable limb, but I've never been able to understand, no matter how great the economic reward, how an otherwise normal human being could do that all day, every day...The other critique that I make of surgeons, which is obviously a cheap shot, is that they're dealing with their patients when they're asleep. That doesn't seem to me a particularly attractive side of medical practice...it seemed to me duller, more monotonous, more mechanical, however great the tactile skills. (Internal Medicine, 1947)

Respondents also found the content and method of generalist medicine to be attractive. Their intellectual interests were a better fit with generalist medicine than with specialties, so much so that the pull toward generalism was stronger than the plethora of discouraging voices. General practice was appealing because of the inherent variety that results from seeing people of all ages.

Every individual's different. In primary care, you really get to appreciate that. It's sort of a privilege, a professional privilege to be able to see how the same physiology, i.e., a ruptured disk, plays out in different people, and I think that's fascinating and interesting. (Internal Medicine, 1971)

I became more and more convinced to go into family medicine. In fact, the more people discouraged me, the more I identified with the generalist...I mean, he knows everything about the family, he becomes part of the community, and he does a little of everything. I

enjoyed that. I liked to do the psychiatry, I liked to deliver babies, I liked to do minor surgery. I enjoyed it all. So that pulled me to it. (Family Medicine, 1963)

It became clear to me real early that the joy and the comfort and the satisfaction mostly lay in seeing all kinds of people with all kinds of illnesses. (Internal Medicine, 1947)

For other generalists, the frustration with the fragmentation of specialty medicine was a motivator in their choice of primary care.

I listened, and every time I was alone with a patient, I found myself frustrated that I might only know about their heart, when, in fact, they wanted to talk to me about their depression, or what was going on with their wife, or their ingrown toenail, and I found myself in every specialty rotation in medical school continually frustrated that I couldn't put it all together. (Family Medicine, 1979)

When I was in my third year, and thoroughly enjoyed delivering babies, and sewing up lacerations, and splinting casts, I shifted from what I thought was an internal medicine future into family medicine, because it was the way of not giving up any of the clinical areas of medicine, and being fully grounded as a community physician. (Family Medicine, 1975)

Support for Primary Care

Physicians were also able to push back against the pervasive devaluing of primary care through the support of a key mentor or peer. Support for primary care through peers and mentors was rare, but when it existed, it was powerful.

I had an extraordinarily interesting class, and I think that's what sets my experience at [school name] apart from other medical school experiences...My classmates were such an enriching experience in many ways. That particular class turned out one of the highest percentages of primary care physicians, and was particularly not held in high esteem by the medical school. (Family Medicine, 1982)

One respondent decided to work at the same institution where she did her training because “I had mentors within the institution that were really encouraging me to stay, primary care doctors working at [school name]. So I felt that you could be primary care oriented and survive” (Internal Medicine, 1985). Respondents convey that a core group supporting primary care, even if in the minority, can be significant. One respondent (Family Medicine, 1975) shares that he was

intrigued by the Family Medicine specialty, but could not find any Family Medicine physicians at his medical school. He met with his dean, who connected him with a generalist in the community, who then served as a key mentor.

Finally, several respondents described how the disparagement of primary care actually drove them toward it even more.

I identified all through medical school with the guys the medical schools were always criticizing, that he didn't discover the weird cancer or didn't recognize the rash was [rare] fever or whatever. And they were always criticizing him, and it made me angry, finally. This guy's out there busting his ass as a family doctor in a community - I identified with the underdog. So that didn't discourage me. In fact, it made me probably attracted to family practice even more. (Family Medicine, 1963)

Content: Mismatches between training and primary care practice.

Thus far, I have outlined a number of ways that individuals were discouraged from choosing a career in primary care. In the section below, I examine another obstacle for primary care that is found in the content of medical training: it is ill suited to illuminate the real work of a generalist physician. One respondent expresses this idea:

It's hard, because there's no way to know what general internal medicine is, on the basis of a medical residency in a hospital. It just ain't there. I mean, there's no overlap, all the things you do as a medical resident, while it gives you a lot of knowledge and certain skills, has very little to do with the real life of a practicing internist which is overwhelming with outpatients. Now a surgeon, I think, he's learning in the hospital what he's going to be doing. He's doing what he's going to do. The internist doesn't. (Internal Medicine, 1947)

Another respondent explains how his prestigious fellowship left him completely unprepared for the typical problems he saw in clinical practice.

I didn't see a single case of [relatively common condition] but I saw 400 cases of serious [rare disease]. I mean, it's very distorted. And so I actually went into practice thinking I knew what I was going to do in practice... And I will tell you that I learned all that I really learned mostly in the first six months I was in practice. It was really scary. How little I really knew about clinical care after that kind of a fellowship experience.

Thus, when primary care-inclined students are actually at the point of *choosing* their specialty, they appear to be able to identify that they like diversity in content of work and/or that they were frustrated and wanted to be able to ask about and care for the entire patient, but the aspects of primary care that the literature espouses, such as the role of physician as healer and witness, and the importance of relationships with continuity, etc., seem to be more fully recognized only after they are actually practicing physicians. This is significant because the very benefits seen as most important and most rewarding, which we will examine shortly, cannot be known through the structure of medical education because these benefits inherently require many years of time to emerge.

In other words, physicians cannot actually experience the fulfilling aspects of a primary care career—which reflect divergent values from specialty medicine—until they have actually practiced primary care medicine for some period of time. Furthermore, researchers have shown that attempts to introduce more exposure to primary care medicine during medical schools through more time in outpatient clinics or other ambulatory settings are still likely to misrepresent the typical work (and rewards) of a primary care physician and can actually *discourage* students from primary care (Keirns and Bosk 2008). These researchers argue this is because resident clinics are often “understaffed and dysfunctional,” and some residents learn “only that providing high-quality primary care is a frustrating and unrewarding form of labor” (498).

Relationships as Emerging Reward

One benefit of using oral histories is the ability to gain insight about not only the time when specialty decisions were formed, but also later, after decades of actually practicing primary

care. Respondents describe meaningful relationships with their patients throughout their careers as central to satisfaction as a primary care physician, and as important for quality patient care.

Doing any kind of practice in a rural small town means developing this long-term continuity with patients that has a lot of power to it, in terms of healing, and in terms of knowing what is the right thing to do. That can be on a lot of different levels. So, I really feel like I've been very fortunate to have this very long-sustaining relationship with most of the people I see every day. That just makes it a joy. Makes it a sorrow, too. But that's part of it. We really entwine with all the lives around us, but it's well worth it. (Family Medicine, 1973)

The wanting to help people, the altruistic things are certainly fulfilled. The intellectual interest is still always there... There's no way that you can understand the impact that you can have on people's lives, not only that you can save somebody's life, but that you can drastically improve somebody's life, and accompany them on their road. The emotional rewards of what we do are profound. There's no way I could have known that. (Internal Medicine, 1985)

Part of it is just being a doctor, but it's particular being a generalist because people understand that they can talk to me about anything, and they do... They do think that there is a relationship between how they feel and their psychological state and their medical problems. They want to talk about all of it. I talk about their sexuality, and I talk about their children, I talk about their mother-in-laws, I talk about medicine, I talk about how I think about medicine, how they think about medicine, and I particularly talk about what they do. That's the great privilege of being a doctor, ...to just talk to people as a generalist and not just be focused on their particular problem. (Internal Medicine, 1974)

It's been a more intensive experience than I could have could have anticipated, just being part of people's lives like this, their births, their deaths, their marriages, their divorces, emotionally very challenging, but also very rewarding. If I had it to do over again, I would certainly choose to do what I've done. I would not make a change. It's been the most satisfying, gratifying thing I could have ever imagined having done. (Family Medicine, 1973)

In these excerpts, we see some of the deeper philosophical primary care values expressed—of doctor as companion and witness to life and death, to sickness and health. Respondents also pointed to long-term relationships with patients as important for patient care.

I think that the care our patients get by being less fragmented can be, in a lot of respects, a lot better than what they get by going to seven or eight different styles of specialists... I think that's part of having a relationship with somebody over a fifteen-, twenty-year period. When somebody comes in with headaches and you know the stressors that are in their life, you know how they've responded to previous stresses, you know how their mother and their sister respond to stress in their life, and it all fits a pattern, you're far less likely to go ahead

and go chasing zebras. On the other hand, if you see someone absolutely isolated, and they come in and tell you they're having the worst headache they've ever had in their life, your first response is to go ahead and get a CT scan or an MRI. (Family Medicine, 1973)

I also do feel that my ability to care for a very sick patient is to some extent improved by knowing the patient when he or she is healthy. I want as much knowledge of that patient. I ask them what they eat for breakfast and what they eat for lunch and what they eat for dinner and what they snack on and what their hobbies are and what their husbands do for a living and are there any health problems in the family, do they have any pets. All these things, I feel, give me a context for treating the patient. So if I turned over the routine stuff to somebody else, I don't think I could be as good a doctor. (Family Medicine, 1969)

A number of respondents referred to the satisfying opportunity for continuity of care that is uniquely found in generalist medicine, both within communities and specifically across generations.

That, to me, has been one of the nicest things about family practice, to see three generations of a family, and there are a couple of families in which I've had four generations. (Family Medicine, 1969)

My perception is that you have the possibility of patients coming back again overtime, even across generations--the continuity seen in family practice. You don't have to do everything all at one time in one shot. You could use your fifteen minutes for some aspect, perhaps a concrete example of what they're struggling with, and deal with that, and then schedule them to come back again later, if they feel that they want to. But I think the most important thing is that element of trust, that patients feel that you have their interest at heart, that they can trust you with intimate information about themselves. It's always a privilege. (Family Medicine, 1958)

Competing Low Statuses: Gender

While the sample size prevents concrete conclusions, analysis points to an interesting gender story. While disparagement of primary care was reported relatively consistently throughout the cohorts, this is not the case when looking at gender over time. First of all, more female respondents *did not* report disparagement when compared to male respondents. 47% of all the women (n=7/15) did not report disparagement of primary care, as compared to only 32.4% of men who did not report it (n=12/37). An interesting discrepancy emerges (Table 3), however,

when examining women reporting disparagement over time. Of the women who graduated from medical school prior to 1977, only two women reported disparagement about choosing primary care. After 1976, 100% of women (n=6) report disparagement of primary care.

This data suggests that future research should further explore the status of being a woman in medicine, and how that status interacted with the obstacles and disparagement associated with choosing primary care. Notably, of the seven women prior to 1977 who did not report disparagement about choosing primary care, five of these women did discuss difficulties and obstacles to choosing medicine *as a woman*. One explanation for fewer women reporting disparagement about primary care during the earlier cohorts is that they had to first and primarily deal with the discouragement and challenges they faced as women entering a historically male-dominated profession. The struggle of proving oneself as a woman in medicine (in any specialty—even primary care) could have eclipsed the struggles associated with choosing primary care medicine. By the last two cohorts, the profession of medicine was more inhabited by and hospitable to women. In 1965-1966, for example, only 6.9% of medical school graduates were women. Ten years later, the percentage had more than doubled to 16.2%. And by 1985-1986, women represented 30.8% of medical school graduates (AAMC 2011). The feminization of medicine potentially allowed women to experience fewer obstacles tied to their gender, and therefore they noticed more discouragement about choosing primary care—the same type of discouragement that their male counterparts reported more consistently over time.

Table 3. Women Reporting Disparagement When Choosing Primary Care

	Proportion females reporting PC disparagement	Percentage females reporting PC disparagement
Medical School Graduation Through 1976	2/9	22.2%
Medical School Graduation After 1976	6/6	100%
Total Sample	8/15	53.3%

This paper has explored the institutional hostility experienced by individuals as they journeyed toward and chose to practice primary care medicine. Findings show that hostility exists in the (1) structure, (2) culture, and (3) content of current medical training, which combine with the fact that primary care's most significant rewards and satisfactions do not emerge during hospital-based training to contribute to primary care's devaluing at the time when career choices are made.

Findings confirm the "chilly atmosphere" toward primary care that Block et al. (1996) reported, and show that institutional hostility toward primary care is not a modern phenomenon, but has persisted throughout decades. Using oral histories, this paper is able to point to another very significant finding: primary care physicians report the joy and reward that comes from sustaining relationships with patients over many years, in the context of family and community. Oral histories provide the unique ability to capture rewards that emerge over time and are not represented or experienced within the time-bounded and largely inpatient focus of training.

Discussion

The demand for more primary care physicians does not show signs of abating. We need to better understand the journey medical students take, the environment they encounter, and the

ways that primary care physicians create personal value and meaning in and from their work, despite the hostility and disparagement they encounter from training institutions. This paper argues that greater attention needs to be given to the lack of alignment between primary care's greatest rewards and the structure of training.

There are numerous policy recommendations for increasing the supply of primary care physicians, such as payment reform, loan repayment programs, increased funding for primary care residencies, and increased funding for programs like the National Health Service Corps (COGME 2010). It is important to remember, however, that a tension exists on a deeper level than mere economics. Hostility toward primary care medicine reveals a deeper disregard for the countercultural professional values the field embodies (see Stephens 1989). Primary care's struggle for prestige highlights a deeper conflict of values about what is considered intelligent, interesting, and worthy medicine, a conflict that is reflected in the hostile structure of training.

The primary care shortage, and its unfavorable representation during training is a multifactorial problem. Further, as the evidence in this paper indicates the nature of the cultural and structural problems for primary care are not new, this means we should not expect to find an immediate or simple solution to this problem. Institutional hostility, both overt and embedded, in culture, structure, and content of training, creates barriers to the portrayal of primary care as appealing and rewarding.

It could be argued that the mismatch between medical training and actual practice exists for all specialties and is not specific to primary care—no one can fully experience or understand the contours of the type of medicine they are choosing until after training. While this is true to a certain point, there are some key differences worth noting. First, the mismatch is more extreme for primary care than for many other specialties. As mentioned before, training focuses on acute inpatient care, where as most primary care is outpatient. Second, more of the rewards in other

specialties are immediate and thus able to appear in the time-bounded nature of residency (e.g., replacing a joint or identifying and removing a tumor). However, long-term patient relationships, the principal reward of primary care identified in this paper, are rarely apparent during training. Finally, primary care lacks some of the additional (extrinsic) rewards that the other specialties enjoy: higher salaries, greater prestige, and controllable work hours. Until these circumstances change, it becomes even more important to showcase and expose the (relational) rewards that primary care can offer to interested professionals.

Certainly training cannot be extended for a lifetime in order to capture the emergent rewards of primary care, but it could be that in light of the impossibility of enjoying the rewards of long-term patient relationships within the time-bounded nature of residency, the next best way to convey this central reward of a primary care career is through mentors who are themselves enjoying, modeling, and sharing these patient relationships. Kutob, Senf, and Campos-Outcalt (2006) studied role models in primary care and found that “respondents most valued their role models’ patient relationships” (244), a finding that was highest for family medicine graduates. Hearst et al. (1995) iterates that: “since most positive feedback comes from comments and role modeling by family physicians, it would seem important to increase student contact with family physicians (370).

As the COGME calls attention to, “physicians- in-training need to see primary care as a rewarding and well-organized career choice that offers both a practice environment and lifestyle attractive enough to warrant 30 years of challenging practice” (10). Whatever the method, we need to find ways to overcome the “institutional prejudice” (Siwek 1993) found in training and to communicate the reward of primary care to students, providing them the opportunity to taste the joy of long-term relationships with patients and their families. We need to continue to

understand the interplay and construction of values surrounding primary care medicine in order to fully understand the chronic mal-distribution and shortage of its practitioners.

In Chapter 4, we will continue to explore the institutional environment surrounding primary care through exploration of medical schools' mission statements. While we have seen institutional hostility embedded in the culture, content, and structure of medical education, is there hostility in the official values and mission of these institutions? We will also consider how the content of mission statements is related to a school's production of primary care physicians.

CHAPTER 4. THE UNHIDDEN CURRICULUM: MEDICAL SCHOOL MISSION STATEMENTS AND PRIMARY CARE

Introduction

A wide body of research shows that primary care specialties struggle to command prestige within academic medical settings and medical education more generally. Block et al. (1996), in an interview study of students, residents, faculty, directors, and deans report “students and residents encounter an atmosphere that is chilly toward primary care” (677). Lynch et al. (1998) also find that students become less interested in primary care during medical school itself, with first year students more likely to find primary care attractive than fourth year students. The Council on Graduate Medical Education (COGME), in their *Advancing Primary Care* 2010 report, confirms this finding: “while many students express interest in primary care when they first enter medical school, this interest may erode by the time they choose their graduate medical education specialty” (7). The structure of medical schools varies as well, with ten schools still lacking a Department of Family Medicine, one of the main primary care specialties (Gold 2012).

Some scholars point to the “hidden curriculum” as a culprit for the decreasing interest in primary care. Medical sociologists use the term hidden curriculum to refer to the culture, attitudes, and habits that are not explicitly or formally taught in the medical school curriculum but are nonetheless formative for medical students during socialization into the medical profession (Hafferty 1998; Hafferty 2000; Hafferty and Franks 1994; Haas and Shaffir 1982; Hundert et al 1996). The COGME report, for example, cites the hidden curriculum a problem because it “actively discourages student interest in the adult primary care specialties” (3).

While the hidden curriculum communicates unspoken values, the official curriculum conveys spoken and explicit values. This paper argues that by focusing on the role of the covert, opportunities to examine the “unhidden curriculum”⁷ have been overlooked. This paper examines medical schools’ mission statements, considering them to be a key component of their official, unhidden curriculum. What goals are present in the official mission statements of medical schools, and how are those explicit commitments related to schools’ production of primary care physicians?

Mission Statements and Organizations

One central component of the unhidden curriculum of a medical school is the mission statement. Mission statements are a publicly visible articulation of what an organization values and believes, and how it desires to present itself to stakeholders and audiences. Ramsey and Miller (2009) write that “mission statements capture and express the heart and soul of an organization” (1475). Another way of thinking about mission statements is to consider them as a piece of an organization’s ideology, or as Kunda (1993) puts it, as a piece of “culture codified” (50).

Studies have shown a connection between mission statement content and an organization’s outcomes and practices. For example, Blair-Loy, Wharton, and Goodstein (2011) explored the relationship between financial services firms’ mission statements and their work-life practices, finding that “mission statements of firms recognized for their work-life initiatives were more likely than those of competitors to emphasize the value of employees and less likely to stress shareholder value” (427). Weiss and Piderit (1999) analyzed public school mission statements and found a connection between performance and mission statement content. Considering that a mission statement reflects and articulates an organization’s goals and values, it makes sense that

⁷ See D’Souza (2004) for previous use of the term “unhidden curriculum” in medicine.

researchers find a correlation between mission statement content and organizational practices.

This logical connection between mission statements and the actual behavior of an organization should not be assumed, however. Organizational theory, especially neoinstitutional theory, calls attention to the fact that organizations exist as part of an “organizational field,” within which they compete with other similar organizations. DiMaggio and Powell (1983) state, “organizations compete not just for resources and customers, but for political power and institutional legitimacy, for social as well as economic fitness” (150). Thus, how organizations think about their goals and values, and how they write about them in their mission statements, is affected by surrounding organizations. DiMaggio and Powell argue that this competition often leads to a high degree of similarity between organizations through isomorphic processes (147).

So, it could be that medical schools use mission statements to achieve legitimacy, by mimicking the content of other medical schools’ mission statements. If this is the case, mission statement content might be loosely coupled with actual organizational activities, and more influenced by external expectations and norms than by goals and commitments unique to the institution. This possibility of official statements being used for something *other* than to represent the goals of an organization creates space for decoupling between the mission statement values and the actual values or behavior of the organization to which it belongs. Meyer and Rowan (1977) explain that organizations “tend to buffer their formal structures from the uncertainties of technical activities by becoming loosely coupled, building gaps between their formal structures and actual work activities” (341). So perhaps the mission statements of medical schools conform to the organizational standard, and are “buffered” from on-the-ground realities of the medical school. Even with the possibility of decoupling, however, mission statements remain a central piece of official culture, conveying the purpose of the organizations.

Mission Statements and Primary Care

Several studies included mission statements as one of many independent variable factors influencing medical students' specialty choice. In Senf, et al.'s (2003) review article of this literature, they find that "two studies suggest that a school's mission is related only indirectly to graduates' selection of family medicine (508). Both studies use choice of specialty as outcome (not actual primary care practice) and neither performs a more in-depth analysis of content of mission statements (Senf, et al. 1997; Kassebaum, Szenas, and Schuchert 1996).

Mission statements have also been identified as one place where schools can make changes in order to help with the primary care shortage problem. The Council on Graduate Medical Education (COGME), in their "Advancing Primary Care" report, identified the "medical school environment" as one of four challenges to production of primary care physicians (4). Within medical school environment, one recommendation is that: "Medical schools and academic health centers should develop an accountable mission statement and measures of social responsibility to improve the health of all Americans" (31). Thus, mission statements are important to examine because they are identified as one way that medical schools can take a more active role in helping eliminate the primary care shortage.

Methods

Measures

Mission statements were chosen to operationalize unhidden curriculum because these statements are a public presentation of what a school values. Mission statements are analyzed to the exclusion of other supplementary official documents (such as History, Vision, and Dean's Welcome) because the mission statement is the most condensed and focused effort of a school to articulate their mission.

Medical schools' production of primary care physicians was measured using data from the appendix of Mullan, et al.'s 2010 paper in which they ranked medical schools according to a "social mission score," which is a composite score of a) production of primary care physicians, b) adequate distribution of physicians to underserved areas, and c) production of minority physicians (804). For this paper, I will focus on one part of the social mission score: the percentage of physicians graduating from the school that are practicing as primary care physicians. Mullan et al.'s (2010) data is gathered from the AAMC Physician Masterfile, and measures physicians who are already practicing primary care medicine. This ranking is used because it is more accurate than other measurements which approximate primary care physician production by counting the number of medical school graduates who are entering primary care specialties: family practice, pediatrics, and internal medicine. As other scholars have pointed out, this latter form of measurement *artificially inflates* the number of primary care physicians because many of residents entering the latter two specialties subspecialize and never practice primary care (Martini et al. 1994).

Data Collection and Analysis

Mission statements were collected⁸ for 141 medical schools⁹ (both allopathic and osteopathic) in the United States. Necessary decisions were made during collection of mission statements about what to include and what to exclude. In some cases the mission statement was interwoven with goals, objectives, or vision. When making these data collection decisions, the aim was to isolate the mission statement to the degree possible. Text paired with the mission

⁸ For the majority of schools, the mission statement was accessed through the school's website. In a few cases, other reports, like the "2013 Osteopathic Medical College Information Book" was utilized to obtain mission statements.

⁹ The 141 mission statements that were analyzed corresponds to the medical schools included in Mullan, et al. 2010 data about PCP production. It includes schools that graduated physicians between 1999-2001.

statement was cut from the sample when it was linguistically or graphically cued as separate from the core of the statement (e.g. the mission statement was bolded and other text was not).

Mission statements were uploaded to QSR International's NVivo 9 qualitative data analysis software. The content of the mission statements was analyzed for each medical school. Missions were coded inductively, allowing themes to emerge from the data. Special attention was paid to if the statements explicitly mentioned primary care medicine.

Results

Collected mission statements ranged in length from 8 to 511 words, with a median of 55 words and a mean of 70 words. Overall, mission statements were strikingly similar, a finding consistent with the prediction of neoinstitutional theory that institutional isomorphism is a characteristic of organizations competing in the same domain. A generic script that fits most medical schools' mission statements is as follows: "X medical school is committed to improving the health of the residents of x state, through education, cutting-edge research, and compassionate patient care."

Complex missions

Medical schools are organizations juggling a number of competing goals and audiences, a reality that emerged in mission statement analysis. Particular attention was paid to sentences that listed a series of goals in a sequential order, with each goal in the list separated by a comma. The chart below outlines the findings of this part of the analysis, which resulted in 5 key mission codes, outlined below in Table 4. As seen, the majority of schools included *education*, *patient care*, and *research* as central goals in their mission statements. Fewer schools included content coded as *service* or *other* codes.

Table 4. Mission Codes

Mission Code	Example of words & phrases included in code	Percentage (number) of mission statements with code
Education	medical education, teaching, training, learning	99.2% (129/130) ¹
Research	biomedical research, innovative scientific achievement, advancing knowledge, discovering and disseminating new knowledge	95.4% (124/130)
Patient Care	medical practice, health care delivery, patient-centered care, clinical practice, improving health of public	83.8% (109/130)
Service	service, community service, public service	26.9% (35/130)
Other ²	creative community partnerships, health care policy, public service outreach, leading efforts to eliminate health inequalities	16.2% (21/130)

¹ N=11 mission statements were coded as “vague” and they are excluded from analysis.

² Note: This code of “other” refers to mission statements that sequentially listed the more common goals, but showed equal linguistic value to an “other” goal in place of or addition to other goals. Additional mission statements besides the 21 here certainly had additional content, but not in the specific ordered sentence format that was analyzed here.

Ramsey and Miller (2009) write “most frequently, leaders of academic medicine describe a tripartite mission consisting of education, research, and clinical service” (1475; see also Lewkonia 2001). Notably, the phrase “clinical service” was not included in any of the 141 mission statements, and findings would suggest this concept has evolved into two more specific goals: patient care and service that perhaps overlaps but are not synonymous with clinical service. Ninety-two mission statements included patient care (but not service); 20 included both, and 14 included service only (and did not mention patient care).

These results also indicate that the mission of a medical school is becoming even more complex. A number of schools (n=21) included a specific unique “other” goal to the more traditional missions. Table 5 shows the breakdown of mission statements based on their number of sequentially listed missions and shows that about 26% of the mission statements have four goals, an increase from the traditional tripartite mission.

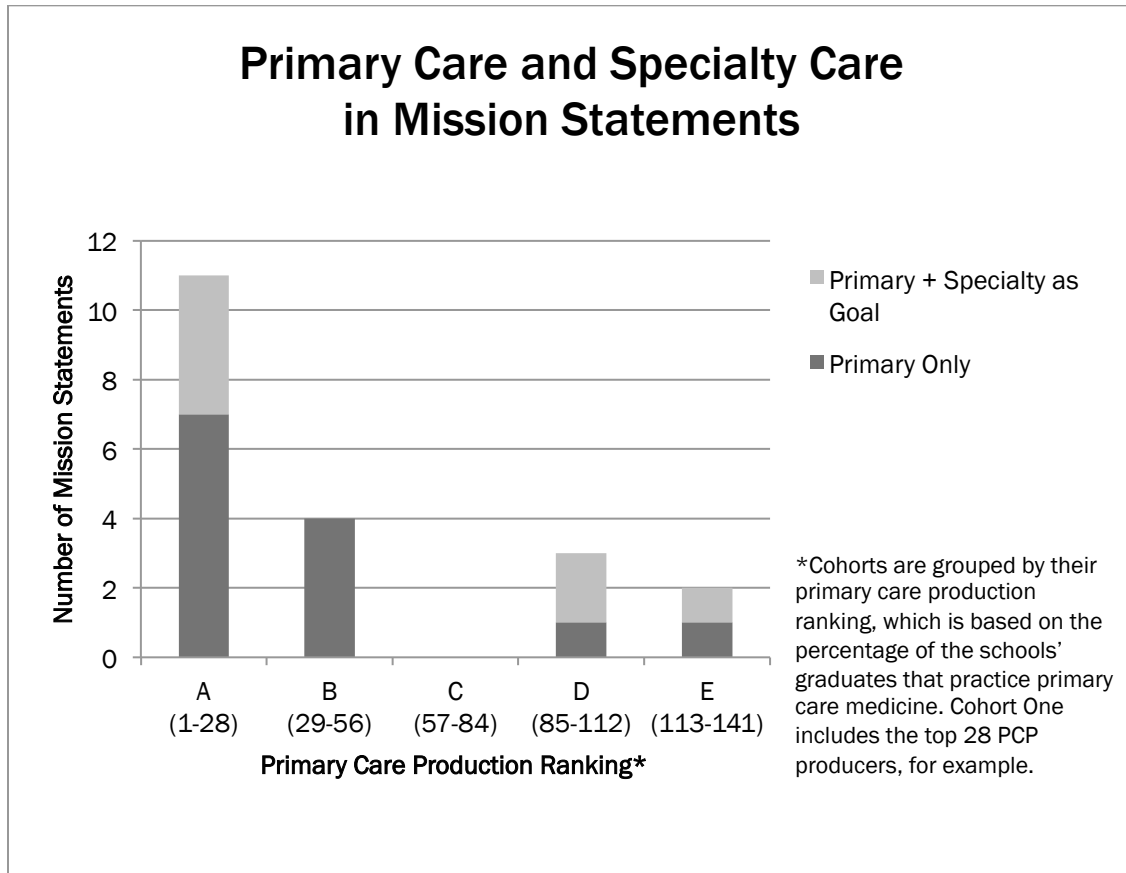
Table 5. Number of Sequentially Listed Goals in Mission Statements

Number of Goals	Number of Statements	Percentage of Overall
One	3	2.1%
Two	4	2.8%
Three	86	61.0%
Four	37	26.2%
Vague	11	7.8%

Primary Care

Of the 141 medical school mission statements analyzed, 20 (14%) of them referred to primary care, using the words “primary care” or “primary health care” in 18 of the cases; “family medicine” in one case; and “generalist training” in one case. Of the 20 mission statements that included primary care, over half belonged to schools in the top fifth of primary care production. These mission statements were then further examined to see if specialists or specialty medicine was also included, or if primary care was exclusively mentioned, and Figure 4, below, illustrates this breakdown by cohorts. As a point of reference, there is substantial variation in medical school production of primary care physicians: at the top ranked school (Cohort A, #1) 53.5% of their graduates are practicing PCPs, and at the last ranked school (Cohort E, #141), production is only 18.5%.

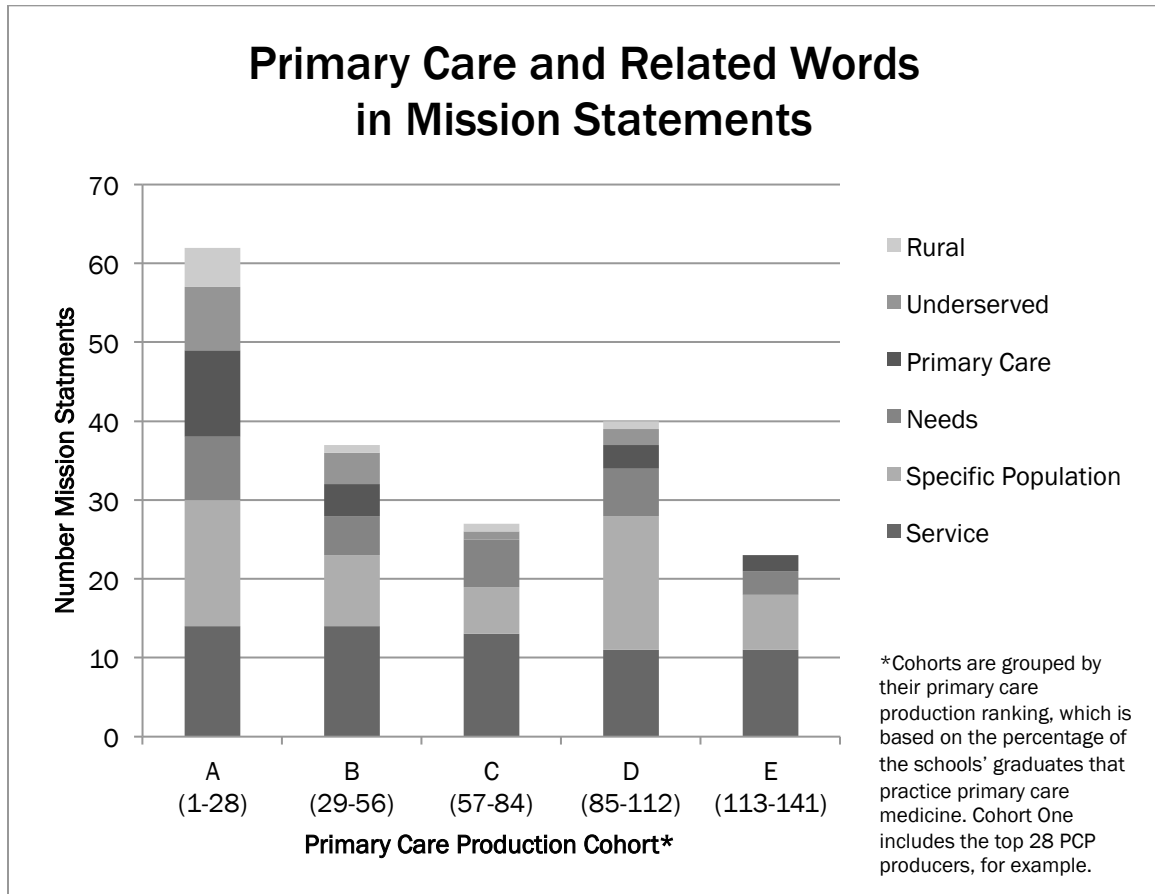
Figure 4. Primary Care and Specialty Care in Mission Statements



As a reference, the mean percentage of primary care production for the schools that did include primary care in their mission is 41% as compared to the average of those who did not include primary care, which was 34%.

Mission statements were also coded for their inclusion of words closely connected to a primary care mission, including “rural,” “underserved,” “service,” “need,” and if they mentioned serving a specific population. All of these words convey values closely associated with primary care, as they focus on patient care (as opposed to research in an academic center) and emphasize serving a community. Figure 5 illustrates the aggregated frequency of the presence of primary care and the five other, related words for each production cohort.

Figure 5. Primary Care and Related Words in Mission Statements



As Figure 5 illustrates, when these related codes are aggregated, a moderate positive correlation emerges between the percentage of PCP production and the aggregate score of primary care-related words for the school's mission statement $r=0.36, p \leq .001$. Table 6 shows the distribution of the primary care related word scores.

Table 6. Distribution of Aggregate Scores of Primary Care and Five Related Word Codes

Aggregate score of PC and related words [†]	Zero	One	Two	Three	Four	Five	Six
# of statements with score	42	48	29	11	7	2	2
(% of total statements)	(30%)	(34%)	(21%)	(8%)	(5%)	(1%)	(1%)

[†] A score of One, e.g., indicates the presence of one of the six related word codes (primary care, rural, underserved, needs, service, and reference to a specific community).

Discussion

This paper found a moderate positive correlation between a medical school's production of PCPs and their inclusion of primary care and related words in their unhidden curriculum. While the correlation is significant, the strength of the relationship is only moderate. Some high producers of PCPs did not mention primary care in their mission statement and some low producers did include it.

How do we make sense of this inconsistency that weakens the correlation? It could be that medical schools perceive primary care as lacking prestige and thus they are not inclined to include in their official curriculum their success at the low status task of producing primary care physicians. But then what explains the schools that *do* include primary care as a central goal, despite their low production of PCPs? Perhaps these schools are committed to primary care and are trying to raise their production of PCPs but are failing. Another possibility, however, is that the mission statements themselves (and other official documents) act strategically to buffer the public from the real goals and aims of the schools. So perhaps including primary care in the mission statement is an easy way to signal concern about the public's need for primary care without having to change the structure of the medical school.

This paper aims to understand the question of how the explicit values and commitments surrounding primary care that are found in the unhidden curriculum of medical schools are connected to PCP production, and these findings yield a number of implications for this question. On one hand, it is encouraging that 14% of schools specifically mention primary care as a central component of their mission. At least these 20 medical schools demonstrate a willingness to publicly value primary care as integral to their mission. Given the disparagement of primary care in academic medicine, this should not be dismissed as inconsequential. However, this also means

that 86% of schools did not include PC in their mission; furthermore, 30% of medical schools did not include *any* of the primary care-related word codes (Table 6). Schools are not explicitly disparaging primary care; however, the majority is not including it as a central goal, either. With the aging population of patients, the nearing retirement age of many current PCPs, decreasing interest in primary care by students, and the additional 32 million patients from the PPACA, our country needs more than 14% of medical schools need to embrace and advocate for primary care as a mission in order to supply the projected primary care need.

As noted earlier, there are recommendations that mission statements be used as vehicles of accountability to meet population needs. Even given the moderate correlation between PCP production and the unhidden curriculum found in this paper, we should be cautious about settling for valuing primary care in official documents only. Bloom (1989) points out that “medical education’s manifest humanistic mission is little more than a screen for the research mission that is the major thrust of the institution’s social structure” (228). Already, medical schools tout the percentage of their graduates entering primary care specialty residencies, knowing full well that many of those very graduates will specialize and never practice primary care medicine.

For reform to be effective, the mission of primary care needs to be more than a “screen” for medical schools. Publicly valuing primary care through the unhidden curriculum must be accompanied by structural changes that support the production of more primary care physicians who actually practice primary care. While this paper showed a correlation between PCP production and inclusion of primary in mission statements, it is not able to measure causality or direction of possible causality. Does the inclusion of primary care in a medical school’s mission increase its production of PCPs? And if so, what are the mechanisms? Or, does a school have a high production of PCPs and then include it in their mission statement? Further research should

examine these questions also take into consideration new medical schools explicitly trying to produce primary care physicians.

In light of the hostility toward primary care and Family Medicine shown in Chapters 3 and 4, how do individuals make sense of their decision to pursue a career in Family Medicine? In Chapters 5 and 6, I continue analysis through examination of Family Medicine biosketches of residents in reference to biosketches from three other specialties (Obstetrics and Gynecology, Emergency Medicine, and Neurosurgery). I ask two central questions: (1) how these individuals construct value and appeal in their work, and (2) why individuals commit to a specialty with such low status.

CHAPTER 5. MAKING WORK GLORIOUS: RESIDENTS' CONSTRUCTS IN FOUR SPECIALTIES

Having explored the historical journey of Family Medicine to its current status as an accredited specialty and the reality of the institutional obstacles for primary care in the structure of medical education, we now turn our focus to Family Medicine residents. As they are unlikely to have experienced the rewarding long-term relationships with patients like the long-practicing physicians that Chapter 2 documents, what attracts new residents to Family Medicine? What are the routinely generated scripts or schemas that residents use to explain their choice of Family Medicine, and how are those different than the scripts or schemas of residents in other specialties? Three other specialties: Emergency Medicine, Obstetrics and Gynecology, and Neurosurgery will be used as comparison groups.

Biosketch Methodology

The next two chapters analyze data collected from resident biosketches. In both chapters, I am interested in the constructs of meaning and value Family Medicine residents use to shield against the disparagement and disdain that they experience.

Biosketch Specialty Sample

I compare the biosketches of Family Medicine residents, to the biosketches of three other specialties, that were strategically chosen to provide comparative leverage on the two chosen variables: a) the variety of patients/problems that physician within the specialty encounter and b) the frequency and opportunity for physicians within the specialty to have relationships and continuity of care with patients (see Table 7 below).

Table 7. Biosketch Specialty Sample Strategy

		Variety of Patients & Problems	
		More	Less
Patient Relationships & Continuity of Care	More	Family Medicine	Obstetrics & Gynecology
	Less	Emergency Medicine	Neurosurgery

Family Medicine offers to its physicians relationships with patients and a variety of patients and medical problems. Emergency Medicine has a great deal of variety in patients and problems seen, but little opportunity for relationship or continuity with patients. Obstetrics and Gynecology is the specialty that, along with Family Medicine, is more likely to frequently have continuity of care with patients, but with less variety of patients and problem. Neurosurgery has generally few patient relationships (unlike neurologists, who are more likely to follow long-term neurological issues) and less patient and problem variety. Again, this sampling strategy aimed to provide specialties that, within reason, are located on different ends of 1) the patient relationship continuum and 2) the variety of patients and problems continuum.

Table 8 shows a few selected characteristics across the four specialties to give a better idea of the size, length of training, annual salary¹⁰, and level of competition (as indicated by the percentage of positions filled by US medical graduates and filled overall). As we can see, there are substantial differences in most of these categories.

¹⁰ The low salary of primary care physicians is often a suggested place for reform. However, the salary range for Family Medicine reported here represents a relative, not absolute deprivation (Merton 1968; Merton and Rossi 1968).

Table 8. Summary Characteristics of Four Specialties

	Family Medicine	Emergency Medicine	Obstetrics & Gynecology	Neurosurgery
Number of PGY1 positions	2740	1668	1240	196
Positions filled with US graduates	48.2%	80%	73.6%	86.7%
Positions filled—total	94.6%	100%	98.6%	99%
Residency length	3 years	3 years	4 years	6-7 years
Fellowship length (optional)	1 year	1-2 years	1-3 years	1-2 years
Approximate annual salary range*	\$175–\$220	\$239–\$316	\$252–\$327	\$287–\$637

* in thousands

Source: AAMC and NRMP data

Data Collection and Analysis

Biosketches were collected between October 2011 and March 2013. For each specialty, a complete list of accredited residencies was accessed from the Accreditation Council for Graduate Medical Education (ACGME) site and the American Academy of Family Physicians (AAFP) site.¹¹ These lists were referenced to access each residency’s website and to find biosketches for the entire population of residents. Biosketches were sorted and collected according to type of content. Because I was interested in how residents talked about their specialty choice and their work, selection was based predominantly on inclusion of this type of information. For example, Family Medicine resident biosketches were sorted into five different “Grades,” ranging from A to E. Grade A biosketches had the most thorough information regarding the construction of the specialty; Grade B biosketches followed a template but usually were more personalized than Grade C, which strictly adhered to a template and were usually brief. Grade D was some combination of name/education/picture only; and Grade E was assigned if no resident information could be found. See the Appendix C for examples of each category of biosketch.

¹¹ <https://www.acgme.org/ads/Public/Reports/Report/1>; <https://nf.aafp.org/residencydirectory/>

Analysis in this chapter focuses solely on the 1789 Grade A Family Medicine biosketches. Because of the smaller size of the comparison specialties, as well as the smaller percentage of residents with biosketches, Grade A and Grade B biosketches were collapsed for each of the three comparison specialties in order to increase the size of these groups and explore meaningful differences. All analysis found in Chapters 5 and 6 refers to the biosketches included below.

Table 9. Biosketches Across Four Specialties

	Family Medicine [†]	Emergency Medicine ^{††}	Obstetrics & Gynecology ^{††}	Neurosurgery ^{††}
Number of biosketches	1789	220	116	25
Percent of overall sample	83.2%	10.2%	5.4%	1.2%
Residents with biosketches	19%	4%	2.4%	2.3%
Residencies with biosketches	18%	8%	6%	4%

[†] grade A

^{††} grade A and grade B

Table 9 illustrates the breakdown of the analyzed biosketches across the four specialties. As shown in Table 9, Family Medicine biosketches make up the majority of the overall sample and are written by 19% of all Family Medicine Residents. The percentage of analyzed biosketches is smaller for the other specialties: 4%, 2.4%, and 2.3% respectively. There are a number of possible explanations for this difference, and I would argue that this difference is an important finding in and of itself. Perhaps this reflects a difference between the type of people that enter each residency, or the type of people that run each type of residency (it is unclear who decides if residents write biosketches, and who, if anyone, reviews and approves the content). As noted above, because biosketches are used at least in part to attract and recruit potential residents, it is definitely plausible that with a much lower US student fill rate, Family Medicine residencies and residents go to greater lengths to advertise the glories of their field and residency.

For what purpose are biosketches written? While the purpose of biosketches is somewhat ambiguous, some residents included “welcome to our residency” or “good luck with the match,” indicating that their writing is at least partially aimed at attracting medical students to their residency. Because it can be reasonably argued that biosketches are at least in part used for recruitment, they are particularly excellent source for how residents make their work glorious.

Background

Biosketches are explored to understand how residents construct the fields in which they work: how do they present it to others? What is attractive, appealing, and valuable about it? Everett Hughes (1951a) refers to “the social and social-psychological arrangements and devices by which men make their work tolerable, or even make it glorious to themselves and others” (342) and biosketches provide data on how residents make their work glorious to themselves and others.

I am particularly interested in how Family Medicine residents construct their field. I argue that how they value and glorify their work is of particular sociological interest because they are a group located at the low status end of a high status profession. Hughes again: “in things of less prestige, the core may be more easy to access” (342). The position of primary care within the profession can be compared to the position of public defenders within law (see McIntyre’s (1987) *The Public Defender: The Practice of Law in the Shadows of Repute*).

Furthermore, how Family Medicine residents make their work glorious to themselves and others is interesting because the rest of this dissertation has documented many ways that others assert precisely the opposite—that is, the lack of glory, or value in a career in Family Medicine. The reasons to sidestep and avoid primary care are plentiful—so what are the reasons to choose

it? For this chapter, my broad research question borrows from Hughes, asking what “constructions of glory” Family Medicine residents use and how they differ from the constructions of residents in other specialties.

I focus in this chapter on two variables a) variety of patients and problems and b) opportunity for patient relationships. Literature and oral history findings from Chapter 3 suggest that both of these aspects of Family Medicine and primary care are important and seen as central to the appeal of the specialty, and what makes it unique? Does the biosketch data indicate that these aspects are also prominent components of Family Medicine according to its residents? Are they a part of how they construct their field, how they make their work “glorious?”

Findings

Table 10 shows how the four specialties compare across a number of word frequencies—the number of times each word (and those sharing the same root word) appears in all of the biosketches combined. As one can see, many words are statistically significant—the actual observed frequencies differ significantly from what we would expect to find if the word was distributed evenly across the four specialties. In the sections below, we will examine the ways that residents use “patient relationship” and “variety” in their biosketches to construct their respective fields.

Table 10. Selected Word Frequencies Across Four Specialties

Word[†]	Family Medicine (Frequency)	Emergency Medicine (Frequency)	Obstetrics & Gynecology (Frequency)	Neurosurgery (Frequency)
Community***	913	33	40	4
Relationship**	170	7	13	0
Research***	343	53	20	31
Rural***	503	15	6	0
Serve**	535	34	28	9
Underserved***	402	7	12	1
Variety***	156	44	3	0

Using χ^2 test: $p < .01$ **, $p < .001$ ***

[†]Each word includes the entire word family (all words with same root word). For example, “serve” included serve, serves, served, serving, service, and services.

Patient Relationships

Chapter 3 found that primary care physicians in the Primary Care Oral History Collection cited long-term patient relationships as the greatest reward of a primary care career, and Chapter 3 also pointed to the rarity of this reward appearing during training. How does talk about relationships in biosketches match up with this finding? Are patient relationships a key way or frequent way that residents think about the field of Family Medicine? How does the content of what was coded as “relationship” compare between the four specialties? I will examine the findings that emerged for each specialty, starting with Neurosurgery. Table 11, below, provides summary statistics for both patient relationship and variety codes across the four specialties.

Table 11. Distribution of Code Frequencies Across Biosketches for Four Specialties for “Patient Relationship” and “Variety”

	Family Medicine	Emergency Medicine	Obstetrics & Gynecology	Neurosurgery
Code = “Patient Relationship”				
Residents with code**	228	9	16	0
Residents in specialty with code	13%	4%	14%	0%
Code = “Variety”				
Residents with code***	330	96	29	1
Residents in specialty with code	18%	44%	25%	4%

Using χ^2 test: $p < .01^{**}$; $p < .001^{***}$

Neurosurgery.

First, none of twenty-five Neurosurgery analyzed biosketches had content that was coded for relationship.

Emergency Medicine.

Nine Emergency Medicine residents (4%) referenced patient relationships in their biosketches, a finding somewhat unexpected given the distinct lack of continuity typical experienced in the Emergency Room and the field at large. Emergency Medicine doctors manage and triage acute situations, and are not primary care physicians. So, what kinds of relationships are described in these nine references? Emergency Medicine residents do not talk about long-term relationship with patients but instead emphasize “interactions” with patients at significant moments in the patients’ lives. These excerpts included descriptions like:

*I enjoy and value being there as an advocate for my patients in their moments of need.*¹²

¹² The narrative point of view varied between biosketches and quotes throughout the paper reflect that variation, though this indicates a style difference and there is no indication that the author is anyone other than the resident. Additionally, names have not been changed.

Comforting and helping someone early in an undiagnosed stage of their medical issue is a powerful and rewarding interaction.

There is nothing more gratifying than helping those in need at their most desperate and vulnerable times.

While clearly a different type of connection than what we will see in both the Obstetrics and Gynecology and Family Medicine biosketches, these residents explicitly talked about their time and specific interactions with patients as a reason that Emergency Medicine was appealing to them. The opportunity to be present for their patients in these times—though often for merely minutes—was still a reality that made them enjoy and appreciate Emergency Medicine.

Obstetrics & Gynecology.

Obstetrics & Gynecology is one of the two specialties in my four-specialty sample where relationships with patients were anticipated to be of importance (see Table 7). Sixteen Obstetrics and Gynecology residents (14%) constructed their field and their choice of it in a way that included the importance of relationships.

Not surprisingly, Obstetrics and Gynecology residents discussed the important relationships they are able to have with a particular type of patient: women. These residents emphasize the continuity of care that they provide for women throughout their lives.

It is a privilege to serve as the point of contact for young women facing various medical issues, to be a part of one of the most important times in one's life - childbirth, to help women confront the transition into menopause, and to be an advocate throughout a patient's life.

Continuity of care throughout the nine months of pregnancy was also reported as rewarding:

I remember following my first patient from her very first OB visit to the day of her delivery and realizing this is what I wanted to do with my life. Seeing patients on a regular basis for prenatal care and getting to know them and their family is constantly rewarding.

Speaking of pregnancy, a number of residents also commented on the special bond of delivering someone's child: "Women allow us to be apart of one of the most intimate moments in their lives, and we are forever remembered as the doctor that brought their child(ren) into this world!" In addition to maintaining relationships with patients throughout their pregnancies and their lives, Obstetrics and Gynecology residents talk also about various facets of their relationships with patients; the below quotes push beyond the typical role of physician to that of friend, steward, and encourager.

First and foremost, I'm a people-person and I love the opportunity to form lasting relationships with my patients throughout the arc of their lives. I see my role as similar to that of a trusted friend, here to help steward women through some of life's most intense experiences.

As I started my residency and became more exposed to the field, I began to appreciate the unique relationship Ob/Gyns have with their patients. Patients come to you in their most vulnerable state and trust you to guide them through some of the best, and sometimes the worst, experiences of their lives. A compassionate and competent Ob/Gyn can positively impact a woman's self-confidence in addition to her health and can greatly increase the quality of a woman's life. This makes the field a very rewarding one.

It is clear that 1) Obstetrics and Gynecology residents view part of their role as obstetricians and gynecologists as developing close and meaningful relationships with patients and 2) development of said relationships is a source of fulfillment for these residents.

Family Medicine.

Relationship themes emerged in Family Medicine biosketches that are similar in some respects to those found in Obstetrics and Gynecology biosketches. In the quotes above, we saw Obstetrics and Gynecology residents referring to themselves as a patient's "advocate" and "trusted friend." Family Medicine residents mentioned several more roles that they occupy in relationships with their patients:

Becoming a family physician does not only mean providing healthcare to my patients but also becoming their advocate, friend and counselor. This is one of the aspects about family medicine that made me choose this as my profession.

Patty chose family medicine as her specialty because it will allow her to not only be a care provider in a patient's moment of pain, but also to act as an advisor and educator for her patients.

Family Medicine offers me the opportunity for making long-standing relationships with patients and families during times of health and indisposition. I will have the privilege to be the patient's advocate, guardian of their stories and provider of disease prevention and curative means.

Family Medicine gives a physician the opportunity of really knowing a patient and approaching healthcare in 360 degrees. Becoming a family physician opens the connection not just to a patient but a human being.

During medical school, I knew that whatever my chosen specialty would be, it would have to include long-lasting, meaningful relationships with my patients. Family medicine was the perfect choice for me, there is no other specialty that cares for the entire family unit as a whole and combines relationships, medicine, and fun all in one.

Like the Obstetrics and Gynecology residents, Family Medicine residents describe relationships with patients that are not confined to the traditional doctor-patient interaction but that also include the roles of advocate, counselor, guardian, and fellow human being.

While it is certainly possible that residents in other specialties agree, Family Medicine residents are the only ones to explicitly articulate that relationships are important because they are a crucial means of delivering better patient care. Through the biosketch quotes below, it becomes clear that Family Medicine residents believe good care includes good communication and relationships, and that good relationships in turn make patient care more individualized, effective, and efficient.

Paige is a huge proponent of the patient physician relationship and the kind of high quality care that can be forged through good communication.

I believe that high quality patient-physician communication is at the heart of every healing encounter. I strive to create an environment where my patients feel comfortable discussing their health, emotions, and social situation openly.

Lisa already has a deep understanding of the therapeutic relationship: that the best medicine is provided not just through high-tech diagnostic testing, but through listening to each person and individualizing their care based on that knowledge.

Another difference surfaces in the relationship theme between Family Medicine and the other specialties. When the Obstetrics and Gynecology residents talk about roles beyond that of the standard physician, they still describe patients coming to them as the source of advice, wisdom, and help. Here, though, in Family Medicine biosketches, we see glimpses of a more equal partnership between doctor and patient. In the quotes below, Family Medicine residents talk about listening to their patients, working *with* patients, and enabling patients to invest in their health. Though subtle, there is an important shift in the power dynamic of the relationship and with regard to who is doing the caring and curing.

While at Loyola, Lisa realized the importance of listening to a patient's story and was drawn to family medicine because of the emphasis placed on valuing patient relationships just as much as treating illness.

During this time she witnessed how long term relationships with physicians help patients and inspire them to invest in their own health.

I believe that the most effective way to practice medicine is to form a relationship with your patients and to work with them to achieve health goals. Family medicine fits this ideal for me.

In light of Chapter 3's conclusion that the structure of medical education largely prohibits the experience (and thus satisfaction) of long-term relationships, a final question emerges surrounding with the relationship references in Family Medicine biosketches: how and when have these residents experienced the importance and fulfillment of these patient relationships? When have they experienced continuity that comes through relationships? Examination of the tense and content of these references suggests multiple answers to this question. Some of the quotes about the importance of relationships are forward thinking—they want to establish long-term relationships and look forward to having them in the future.

I look forward to a career where I can form lasting, caring relationships with patients and their families.

It is my intent to establish caring and trusting relationships with my patients and ultimately to interact with children, their parents and grandparents in profound and meaningful ways.

Especially important to me is continuity of care and the unique and deeply meaningful relationships that can only develop with time.

This last quote recognizes that it takes time for relationships to develop—and is in agreement with the finding of Chapter 3. A number of other quotes, however, mention observing the power of relationships that their mentors had with patients.

Her earliest impression of medicine came from her family's own physician. She recalls how he made her and her brother feel that they could trust him whether they were sick or not. At that moment she learned that a family physician can have a positive influence on a patient's life far beyond the traditional role of a doctor.

During medical school Dr. Payan, would observe Family Physicians and was intrigued how they always knew their patients and the families. She quickly realized that Family physicians could influence the health outcomes of their patients over time.

I was drawn to Family Medicine ultimately by the inspiring mentorship of a Family Physician, in whose solo practice I saw come to life the magic of a physician's decades-long longitudinal care for his patients and community. I love the specialty for the intellectual excitement in its unmatched diversity of patient encounters and modes of care, and for the integrative perspective it nourishes on human health.

For a few residents, however, the endorsement of patient relationships as one of the best parts of Family Medicine came not from watching the “magic” of another, but instead from their own experiences. Exposure to Family Medicine had already demonstrated the reality of relationship and continuity of care during training.

Most of all, I loved the idea of continuity of care. Believe it or not, as an intern just 6 months into residency I have been able to take care of whole families. Just the other day, I delivered the baby of a patient I had seen in prenatal clinic, and the baby and her sister, as well as the patient and her husband, are now calling ME their primary doctor! In no other field would I get such an opportunity.

She was lucky to be in the Integrated Clerkship for her third year at Cambridge Health Alliance, where she followed a patient panel longitudinally and saw the rewarding relationships and complex medicine that evolves in a primary care practice.

I became most interested in Family Medicine during RPAP (Rural Physician Associate Program) where I got drawn into the relationships with patients that exist nowhere else and realized that through these relationships family medicine doctors, in my opinion, provide better care.

Real experience with continuity of care, as with these above residents, was rare, but these occurrences are encouraging nonetheless and point to some possible avenues of reform for medical education, to encourage more students to choose Family Medicine.

Variety

The second aspect in the sampling strategy is variety. According to the logic of the sampling strategy, two of the fields contain significant variety and two of the fields are more narrowly focused. Compared to the relationship theme, the variety theme was a bit more evenly split over all four specialties. As with the relationship code, I will walk through each specialty independently to consider what constructs of variety its residents use, and the degree to which they differ from one another.

Neurosurgery.

Even a narrowly focused field like Neurosurgery had variety to be celebrated, according to the one neurosurgery resident (out of 25): *“neurosurgery program as his top choice for residency training based on the extensive operative experience provided at NYU, and the breadth of cases trainees are exposed to.”* So even within a field that focuses on a surgical approach to one body system, a resident still applauds the “breadth of cases” and the “extensive operative experience.”

Obstetrics & Gynecology.

The number of Obstetrics and Gynecology residents that commented on the variety of their field, and the appeal of that variety was an unexpected finding. In fact, a higher percentage of Obstetrics and Gynecology residents (25%) talked about variety than Family Medicine residents (18%) Obstetrics and Gynecology physicians generally take care of female reproductive organs (although this is not always the case). According to these residents, there is a great deal of variety in their work, focused on two main spectrums. The first is what they refer to as a wide range of “pathologies.”

There is a great range of conditions and a large volume so you really get great experience.

I wanted to go to a place that had a high volume of not only obstetrics but gynecologic cases, as well; I wanted to be able to see and learn to manage a broad spectrum of pathologies.

Another more prevalent type of variety, however, was that the Obstetrics and Gynecology field provides variety through offering a combination of both medicine and surgery.

Once I completed my 3rd year Ob/Gyn rotation in medical school, I knew exactly that Ob/Gyn was what I was meant to do. For me personally, it is the best of both worlds. I love the mixture of primary care with surgery.

There are few specialties that allow us to enjoy a primary care type of relationship with our patients while also allowing us to diagnose and definitively treat them in the operating room.

I initially chose to pursue a career in Ob/Gyn because of the unique combination of both medicine and surgery.

Emergency Medicine.

Variety was a more expected finding for the field of Emergency Medicine physicians, who had the highest percentage of resident biosketches with the code at 44%. Like Obstetrics and Gynecology residents, EM residents mentioned the variety of pathology that they encounter.

Extremely high volume of patients and extremely wide variety of pathology, from Peds to elderly and from common to very rare pathology.

You are not going to find an ED that has such a spectrum of pathology, from the very old, to the neonate, from the simple to the multi-trauma.

Why I chose EM: The diversity of patients, disease processes and procedures that are seen on a daily basis.

During my third and fourth years of medical school, I fell in love with the fast paced world of emergency medicine. I love the idea of taking care of patients of all ages with diseases in all organ systems.

Also similar to Obstetrics and Gynecology residents, Emergency Medicine residents talk about the combination or variety of medical skills/approaches in their work.

EM incorporates the perfect combination of procedural work and diagnostic reasoning.

The diversity of the patients, the pace, and EM provides a good mix of medical and procedural skills.

Where as obstetricians and gynecologists praised their combination of surgical and medical skills, Emergency Medicine residents enjoy their procedural and medical variety.

There are key differences between how Obstetrics and Gynecology and EM residents talk about variety in their work, however. One resident describes EM as “*where the outside world meets the hospital. We see everything and everyone.*” Furthermore, in the Emergency Room, you never know which “everything and everyone” you are going to take care of. Because of this unpredictability, one resident described EM physicians as having an open mind and describes the variety of patients and conditions they might see:

They don't mind taking care of a homeless intoxicated patient. They are able to take care of an elderly patient with multiple medical problems. They know their ways with unconscious victims or really sick patients. They are able to perform all the life saving procedures and all the procedures to decrease patient suffering.

The fact that the variety of EM work is closely entangled with the unpredictability of the work is a fact that appeared repeatedly. One resident even wrote that “variety + adrenaline = EM”. The

variety of Emergency Medicine has a different flavor, however, one that is closely entangled with unpredictability and excitement.

Favorite thing about practicing Emergency Medicine: Anything and everything will roll through that door.

From the first day, I was hooked by the excitement and diversity of illnesses that came into the department. The emergency physicians were like the cowboys of medicine...

Favorite thing(s) about emergency medicine - That it's like a box of chocolates...

While Emergency Medicine's variety overlaps with both Obstetrics and Gynecology and Family Medicine's, the pace and the unpredictability of that variety makes EM unique, according to its residents. In the world of emergency medicine, "you never know what you're gonna get."

Family Medicine.

Family Medicine residents routinely referred to their training as being "broad-spectrum" and used phrases like "cradle to grave" and "womb to tomb" to describe this spectrum. Three hundred and thirty Family Medicine residents (18%) talked about enjoying variety in their work:

Brock chose family medicine because he feels that this specialty does not place an age limit or gender limitation on the types of patients it cares for. Family medicine cares for the family at all stages.

Chioma chose family medicine as her specialty because it provides the opportunity to see, treat and manage a wide spectrum of diseases involving all organ systems as well as providing care for different generations.

[She] was instantly beguiled by primary care and the idea of community-centered, family-oriented medicine. She enjoyed caring for individuals across the age-spectrum – inquiring about develop mental milestones for burgeoning infants to engaging in end-of-life discussions with patients nearing their final days – so Family Medicine was the natural fit.

As a family doc, I can manage people in an ICU, perform cesarean sections, and treat anything from depression to HIV.

Interestingly, we also see statements about the other specialties that are very similar to the “counter-narratives” that we saw in Chapter 3, the oral history chapter. These statements equate Family Medicine’s variety with a holistic approach, and criticize the less varied, focused, and fragmented scope of other specialties.

She likes Family medicine also because it creates an opportunity to treat patients... in totality-not confined to one organ system or one particular kind of illness.

I wanted to learn how to take care of patients, not just hearts or hernias or kidneys.

She doesn't like being minimally involved in a patient's care and wants to be a part of the entire picture.

Another resident uses a counter-narrative to respond to a critique that Family Medicine is boring and devoid of interesting variety:

I chose family medicine because I love the diversity of what you see and do. Don't let anyone tell you it is all colds and runny noses. I love being able to deliver babies, see kids, care for newborns and nursing home patients, and do procedures.

A few other described the glory of Family Medicine in that its variety was actually composed of the combination of all the other specialties—that Family Medicine was some sort of overarching umbrella under which the rest of the specialties existed.

Dain loved every medical school rotation and initially had a hard time picking which area to specialize in. Unwilling to settle for one, he decided to specialize in all of them as a Family Physician.

He is impressed with Family Medicine because he feels that it requires detailed knowledge of all specialties to be efficient.

In addition to the personal rewards from providing care for families, family medicine also offers great intellectual enrichment. The fact that it blends many fields of medicine into one is extremely appealing to me.

A final interesting finding about why Family Medicine residents say that variety in their work makes it glorious is by increasing possibilities for practice location:

I chose to specialize in Family Medicine because I will be equipped with the knowledge and skills to treat a broad range of diseases that afflict patients throughout the course of their lives, anywhere in the world.

As such, I entered family medicine, with an aim to serve any age or gender and employ my interests in multiple medical arenas, both here in the USA and overseas.

Since I may be the only doctor for hundreds of miles or work in a hospital or train residents – I know I want the best training possible for me and that means full spectrum Family Medicine.

I have always had a goal of contributing to a rural community like the one in which I grew up. These communities have many needs and demand physicians with diverse and practical skill sets. Family physicians care for a wide variety of patients and problems, making them well rounded and ideal for serving rural areas.

For these residents, the variety in Family Medicine is necessary (and thus well-appreciated) because it prepares them to serve particular communities. We will return to this reality and explore it further in the next chapter.

When the sampling strategy was developed, “variety” was operationalized by type of patients seen and type of problem seen (organ/body system). From biosketches, we have learned that a) there are many more types of variety and b) residents all comment on variety and speak of it as a good thing, as a piece of what makes their work glorious. Variety was a quality that residents in all four specialties use to describe and “glorify” their chosen field. Thus, variety is not a distinguishing factor for Family Medicine in particular.

Discussion

In this chapter, we have explored how residents construct the “glory” of their specialties—what is unique, enjoyable, valuable, or attractive about their specific field of medicine? We

examined the ways that residents build constructs of glory around two specific themes: patient relationships and variety. Patient relationships were a theme in Obstetrics and Gynecology and Family Medicine, with a doctor-patient “interaction” variant emerging for Emergency Medicine. Findings also indicate that residents from all four specialties consider variety to be an appealing aspect of their field. Variety constructs that emerged from the data enlarged the original conception of variety (type of patient or type of problem) to include variety of medical solution (medical, procedural, surgical) as well as variety of practice location.

Continuing to use the biosketch data represented in Table 9, in the next chapter we will turn to what I argue emerged as the most important difference between the specialties—a finding predominant in Family Medicine biosketches while showing up much less predominantly in the other specialties: a social justice schema that can withstand the assault of medical education disparaging and the other factors that discourage a choice of primary care.

CHAPTER 6. A SCHEMA THAT WITHSTANDS: FAMILY MEDICINE & SOCIAL JUSTICE

In the last chapter, we examined the different ways that the four specialties of Family Medicine, Emergency Medicine, Obstetrics & Gynecology, and Neurosurgery used patient relationships and variety to construct their fields, and to emphasize the unique “glory” of their chosen specialty. In the biosketch data, as we saw in the last chapter, residents generally esteem certain qualities of their specialty including the excitement, variety, and continuity of care found in their work. In this chapter, I will consider three distinct relationship pathways between service and specialty choice found in the biosketches. I argue that two of the pathways, both predominately found Family Medicine biosketches, are evidence of a powerful “social justice schema.”

The term *schema* that I use here draws from Anthony Giddens’s (1984) structuration theory (*The Constitution of Society*) and Sewell’s (1992) “theory of structure.” Schemas are resources individuals can use, which “empowers and constrains action.” This term has also been more recently used by Blair-Loy (2003) in her study of women executives. She refers to two “schemas of devotion” that these women have: the “work devotion schema” and the “family devotion schema.” Blair-Loy elaborates on schemas in her work in a way that is helpful and fitting for us here. Schemas are not just “cognitive maps” but also “moral and emotional maps,” she argues. According to Hughes (1951b), “work [...] is in all human societies an object of moral rule, [and] of social control in the broadest sense” (325). Blair-Loy (2003) writes that schemas are “particularly gripping, cultural models that orient us toward where we devote our time, energy,

and passion. In a historical time and place, they tell us what to care about and how to care about it” (176).

This broader scope of schemas developed by Blair-Loy is useful for thinking about the social justice schema that emerges in the biosketches. It is not just a rational decision, a mental calculation, or a partial commitment, but a whole mind and soul belief in one’s purpose and place in the world—a purpose that demands steady commitment. A schema is powerful and it withstands narratives that value other things and is ready to make sacrifices to uphold its values. Certain decisions “make sense” within this schema, and certain decisions do not; it is a meta-narrative that directs the rest of life’s decisions.

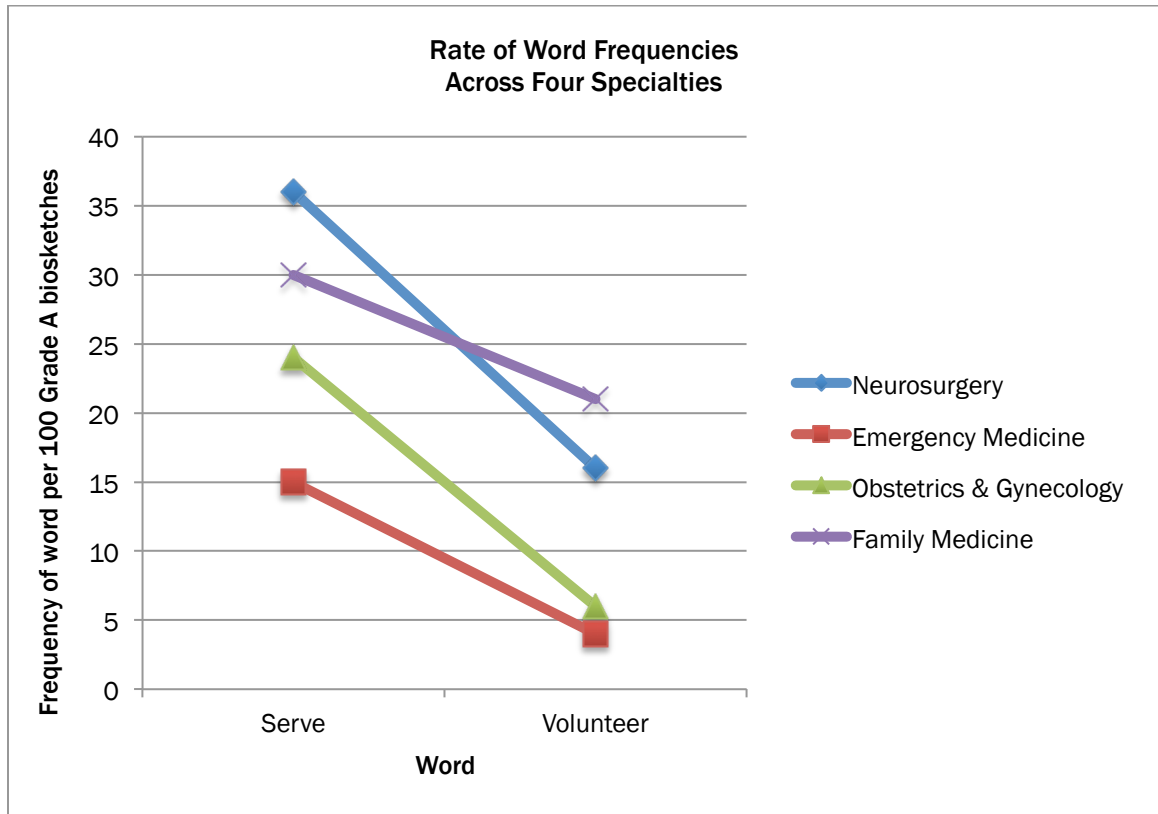
Descriptive Statistics

Before examining the three pathways and the social justice schema that emerged between service and specialty choice, I will first briefly discuss the presence of service more generally in the biosketch data. The word “serve” (and other members of the word family)¹³ showed up 606 times in all the biosketches combined, and “volunteer” showed up an additional 390 times.

We could hypothesize that service and volunteering would be more frequent for Family Medicine than for other fields. However, interestingly, the results of the word frequencies does not offer strong support for such a hypothesis. Figure 6, below, allows us to compare the specialties by comparing rates: this charts how many times each word appeared per 100 biosketches. So, for example, for every 100 biosketches, 36 in Neurosurgery will have “serve,” as will 30 in Family Medicine, 24 in Obstetrics and Gynecology and 15 in Emergency Medicine.

¹³ A word family refers to a base word plus all other words with the same base word. For example, I included serve, serves, served, serving, service, and services.

Figure 6. Rate of Word Frequencies for “Serve” and “Volunteer” Across Four Specialties



So while Family Medicine certainly does not stand out in terms of including the words “serve” or “volunteer,” mere word frequencies are a rather blunt measurement. Do any meaningful differences emerge with a closer examination of the way that service is connected to specialty? Walker, et al. 2010 found that having a “mission to serve” was an important theme separating physicians who practiced in urban underserved areas from those who did not (2168).¹⁴

This chapter presents evidence from the biosketches for three pathways, or relationship between service and specialty choice. Table 12 below illustrates the three different pathways.

¹⁴ These authors also call for continued research to “characterize humanistic- and intrinsic-level factors among premedical students that are linked to eventual practice in underserved areas.” (2174). While we focus here on choosing Family Medicine (and not on practicing in an underserved area specifically), the social justice schema found here could be considered as similar to these authors’ “humanistic/intrinsic factors.”

Table 12. Service and Specialty Choice Relationship Pathways

	Pathway	Location	Schema
A	Service → Specialty	All four specialties	No
B	Service → Service + Specialty → Social Justice	Mainly Family Medicine	Yes
C	<div style="display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 10px;">Social Justice</div> <div style="display: flex; flex-direction: column; align-items: center;"> <div style="margin-bottom: 5px;">↙ ↘</div> <div style="display: flex; gap: 20px;"> Service Specialty </div> </div> </div>	Mainly Family Medicine	Yes

The first pathway is found in the biosketches of all specialties. In Pathway A, residents talk about a service experience as formative to their choice of medicine and/or their particular specialty. In this pathway, service functions as a tool or a means to the end: specialty choice. The second and third pathways indicate evidence of a social justice schema connected to service and choice of specialty. We will examine each pathway more closely, starting with Pathway A.

Pathway A: Service as Tool

Quite a few residents described opportunities for service that they had along the path to residency as formative to their choice of a medical career and their specialty more specifically. This phenomenon was found in all 4 specialties. Below are excerpts from the biosketches that describe formative service experiences which led residents to choosing medicine as a career.

I took a wonderful year off to volunteer at an AIDS orphanage in South Africa and decided after this experience on a career in medicine [Family Medicine Resident]

Throughout undergrad I had many wonderful experiences, including a medical trip to Costa Rica, which showed me how rewarding medicine can be. I ultimately realized that nothing could be as universally beneficial as healthcare and decided to become a physician. [Emergency Medicine resident]

To gain health care experience I worked as a medical assistant at a homeless clinic... and realized I wanted to be involved in primary care. [Family Medicine Resident]

During medical school, he served a medical mission in the Dominican Republic and hopes to use neurosurgery to participate in international health [Neurosurgery resident]

During her third year in college, she was fortunate to spend a summer working in a hospital in the West African nation of Ghana. It was this endeavor that opened her eyes to the privilege of practicing medicine and the field of women's health. [Obstetrics & Gynecology resident]

Following this, I ventured to Jamaica, West Indies for a couple of years [...] I lived in the mountains outside of Kingston and worked primarily doing social work projects and working in 2 different schools. I had always considered the possibility of going into medicine, but it wasn't until my experience abroad and working with the poor that I decided to apply to medical school. [Family Medicine Resident]

My interest in Family Medicine developed when I started going to clinics. My volunteer activities in rural India confirmed my belief that I wanted to become a family physician. [Family Medicine Resident]

This venture took me to Togo, West Africa where I worked for the Peace Corps for over two years. During this time assisting local midwives and nurses with rural medicine, I realized Obstetrics and Gynecology was my future [Obstetrics & Gynecology resident]

In these examples from the four different specialties, we hear how service experiences, from caring for orphans to the homeless to international medical trips, were formative to residents deciding to pursue medicine and in choosing their specific specialty. In all of these cases, the formative experience or the desired attribute is the means leading to the end goal of a career in medicine. Even though I exclude this pathway from the social justice schema, these formative experiences are still consequential in terms of possible efforts to recruit more students. However, as we have seen, this pathway is not specific to Family Medicine and it is therefore not clear how to facilitate service experiences that would recruit students to Family Medicine as opposed to other specialties.

Pathway B: Service and Specialty Intertwined

The second pathway emerged predominantly in the Family Medicine biosketches.¹⁵

According to many Family Medicine residents, service experiences not only led them to medicine but also continue to be a central and key aspect of what practicing medicine means to them; medicine and service go hand-in-hand. In other words, service experiences led them to commit to medicine *and* a life of service. Furthermore, much of the focus is specifically on meeting need in marginalized and underserved communities, and eradicating disparities. I refer to a desire to serve and commitment to meeting the needs of vulnerable communities as a *social justice schema*. For these residents, practicing medicine cannot be separated from the idea of serving marginalized communities—they are committed to both.

Biosketch excerpts show that service and being a doctor go together for these residents. The following residents describe an experience that was formative for developing a social justice schema, within which a decision to practice Family Medicine then makes sense. Family Medicine is chosen in order to actualize their social justice schema, which they were led to by particular experiences that they describe.

I spent the next year living and working in various public health and clinical settings in Guatemala, Peru and Tanzania – an experience that confirmed my desire to spend my life finding ways to provide healthcare services to the world’s most vulnerable populations. [Family Medicine Resident]

I wanted to incorporate my interest in health care and my altruism so I decided to go to medical school with the goal in mind that I would use my skills to give care to my community [...] After a medical trip to Ecuador where I helped treat patients in the Amazon, I knew I wanted to use my career to give full scope medical care to underdeveloped countries. [Family Medicine Resident]

¹⁵ Findings included one Emergency Medicine biosketch illustrating Pathway B and one Obstetric and Gynecology biosketch illustrating Pathway C.

His desire to serve people led him to primary care upon entering medical school, where he can care for people at all levels of the social spectrum domestically and do service work overseas. [Family Medicine Resident]

As a committed volunteer, Tony also embraced family medicine as the best path to gaining the broad skills necessary to address the health needs of underserved communities. [Family Medicine Resident]

It was due to community service both during and after college that Sophia decided what she really wanted to do is to take care of underserved communities holistically. Without knowing it, she was destined to be a Family Practice doctor before even starting medical school! [Family Medicine Resident]

The following excerpts describe a life committed to meeting need and eradicating disparities, and talk about the way that medicine and service are intertwined to serve those in great need.

Dr. Chavez has always felt the desire to help the poor in other countries, in 2009 she traveled to Haiti to help with relief efforts after the massive earthquake. Dr. Chavez believes as a family doctor she will be able to continue her efforts in working with the poor both at home and in other countries. [Family Medicine Resident]

Like many students, Joe began medical school without a clear idea of his specialty choice. During his third year primary care rotation, one of the doctors described a family physician as a doctor who can help people anywhere in the world. Having witnessed the conditions in rural Dominican Republic where his brother is a missionary, Joe realized that family medicine complemented his desire to serve those whose healthcare needs are often neglected, both in the United States and abroad. [Family Medicine Resident]

Following college we went to Zambia for one year where we volunteered for an orphanage and a women's group. That experience solidified my desires to live simply, and give back to those with less, although, I wished I had a more concrete skill to offer. On my return to the U.S., I started medical school at Dartmouth. [Family Medicine Resident]

I went on to undergrad at UC Berkeley and started becoming interested in medicine and the underserved as I volunteered at a hospital and a free clinic and completed an internship in public health. After college I worked as an Americorps member, coaching kids and teaching them about healthy play at a low-income public elementary school in San Francisco. This experience further solidified my desire to serve my community and dedicate my life to those in need. [Family Medicine Resident]

In Pathway B, a service experience is formative, as in Pathway A. The difference is that the resident describes the experience as formative to developing inseparable commitments to both service *and* medicine, as opposed to just medicine.

For some Family Medicine residents, their commitment to a social justice schema through service and medicine was connected to a specific community or type of community:

[I spent my] senior year in the Dominican Republic studying and volunteering at a clinic in a small village outside of Santo Domingo. It was in that clinic in the Dominican Republic that I discovered that my loves of medicine and Latin America were compatible, and that I'm happiest taking care of patients in underserved areas [Family Medicine Resident]

Some of the most influential trips were to very rural parts of West Virginia. I fell in love with the small, close-knit communities and the extremely simple way of life [...] I decided that the way for me to be of the most help to these people was to follow my dream of becoming a doctor and filling some of the huge holes in rural health care. [Family Medicine Resident]

Once I got to medical school, I realized that the way for me to be of the most help as a physician was to become a family doctor. I then dreamed of being able to join a rural community with little access to health care and providing everything it needs: medicine, pediatrics, obstetrics, etc. [Family Medicine Resident]

So through all of these quotes, we see that it was not that these residents entered medical school and they were so attracted to Family Medicine in and of itself, but more that through formative experiences, they became committed to a social justice schema, and then they chose Family Medicine because it allowed them to realize that schema, committed to both medicine and service.

PATHWAY C: Specialty as Tool

What began to emerge in the data is that Family Medicine residents had a certain idea about who they were, their place and purpose in this world, and they decided that Family Medicine was the best route or method of actualizing and living out their purpose. In the third pathway, residents talk about the role service played in their choice of Family Medicine in a different way. These residents describe a commitment to social justice more explicitly, and

indicate that this orienting schema preceded both service and specialty choice. A number of Family Medicine residents talked about the close connection between social justice and medicine:

I believe that Family Medicine answers the call for social justice in medicine and is the vehicle for improving patients' access to care.

My passion for social justice led me into the field of medicine.

A number of residents explicitly talked about medicine-as-tool for carrying out their larger social justice schema:

Sharlene became captivated with social activism, especially in the eradication of homelessness, and soon realized that medicine may be a productive avenue to fight for social justice.

He originally pursued interests in mathematics and the humanities, but ultimately settled on medicine as the best field to further his commitment to social justice and meaningful action in the world.

Growing up she felt solidarity with and a calling to serve all marginalized communities. A need for social justice would be her driving force to achieve and serve. After college and a few diversions in life, she decided medicine would be the tool for social change. She saw a career in health as the most unifying approach to access a myriad of social and health problems.

In each of these quotes, it becomes clear that a commitment to social justice is the cognitive, moral, and emotional map on which other decisions are charted and by which they are made. In the second and third pathways, residents chose both medicine and a specialty (Family Medicine) that fit with their central commitment to social justice. And in these cases, the residents decided on medicine, not as an end in itself, but as the pathway to continue their lives' dedication to social justice issues.

Discussion

This chapter has traced the presence of service in resident biosketches. All four specialties contain residents who both serve and describe service experiences that were formative in choosing a career in medicine. Less evenly distributed across specialties, however, was a social justice schema, which is defined as an overarching commitment to service, especially to the marginalized, that is of equal or greater importance than medicine in their lives. Some residents with this schema report service and medicine as hand-in-hand for their goals (Pathway B). Other Family Medicine residents are even more radical, reporting Family Medicine to be a tool through which they accomplish their commitment to social justice (Pathway C).

The implications of a social justice schema are quite significant, especially in light of the substantial discouragement about primary care documented in earlier chapters. I argue that the social justice schema, which orients where individuals “devote their time, energy, and passion,” allows them to withstand the disparaging messages they receive about primary care throughout medical education. They choose Family Medicine because it is the specialty that is most aligned with their view of the world and their place in it. Commitment to the social justice schema gives individuals power to overcome the biomedical schema communicated throughout medical education and equips them with a persuasive meta-counter-narrative that directs their actions and describes a way of living that is consistent with choosing Family Medicine.

For residents with a social justice schema, Family Medicine serves either as an equal partner to their social justice goals or as a means to their social justice goals. Once medicine is not the sole “ends” for the individuals, they are better able to withstand negativity about primary care specialties. This stands in contrast to the individuals in Pathway A, for whom medicine is their main “ends.” Precisely because medicine is their central and orienting goal, individuals in Pathway A are likely to be shaped by the disparaging messages they receive during education and

are more likely to want to pursue “attractive” specialties, as defined by those dominant voices within their chosen profession.

In sum, one way that individuals choose Family Medicine and persevere with their decision even through the numerous challenges is by having a social justice schema that directs their decisions limits the influence of pervasive disparagement and devaluing. The social justice schema makes Family Medicine an appealing choice that is better aligned with their commitments to social justice, service, and medicine than any other specialty.

CHAPTER 7. CONCLUSION

Through the use of oral histories, mission statements, and biosketches, this dissertation has examined Family Medicine's perpetual struggle for status and the implications of this struggle on the primary care shortage more broadly. This project expands knowledge of the ways that the current organization of medical training is problematic for primary care specialties. Analysis of oral histories showed that disparagement of primary care in training settings has been present for decades. Additionally, an inherent mismatch emerged from the data between the reported benefits of primary care medicine, such as building relationship with patients over time, and the structure of medical training itself.

Analysis of medical school mission statements examined the relationship between medical schools' unhidden curriculum and primary care, which yielded a moderate correlation between the inclusion of primary care and related words and the production of primary care physicians. However, few schools (14%) of the 141 schools examined publicly value primary care in their mission statements.

I have argued that this pervasive and perpetual disparagement stems from a deeper conflict between the values of Family Medicine's holistic philosophy and those of the medical profession's more dominant biomedical model. In light of the entrenched structural hostility toward Family Medicine and primary care more generally, another possible way to think about the physician supply issue is to consider the individuals who choose Family Medicine despite the disparagement. How do they make sense of their decision? Do they find value and appeal in their work in a way that is distinct from residents in other specialties? In analysis of biosketches, a social justice schema emerged that is able, I argue, to withstand the discouragement earlier

chapters documented while simultaneously enabling Family Medicine to uniquely “make sense” as a specialty choice to these residents.

In this final chapter, I will consider the role of money, intelligence, and the public in the shortage and disparagement of primary care before I discuss implications for reform and suggestions for further research.

Money

This dissertation has focused largely on the role of prestige in the primary care shortage problem and more specifically, the problem of low status for Family Medicine. But, what role does economics play? Many people talk about the salary issue, arguing that if Family Medicine doctors received higher reimbursements and salaries, more students would choose the specialty. Based on the results presented here, I am skeptical that individual salary is the central problem (or solution). Certainly money is connected to prestige. Hypothetically, if primary care doctors’ salaries matched those of their specialist peers, it is likely that more students would choose Family Medicine or another primary care specialty with the goal of practicing primary care medicine. A higher salary would make the field more appealing, and at some point, the prestige needle would probably start to move in Family Medicine’s favor. However, the role of economics here is a complicated story at best.

First, as we have seen, from the perspective of the medical profession, there are fundamental reasons to oppose and disparage Family Medicine. Family Medicine is on a trajectory that is contrary to the biomedical model. Hence, I think there would still be disparagement of Family Medicine that will not go away with higher salaries, because Family Medicine threatens the biomedical model’s very mode of operation. As we have seen with other

reforms that threaten the medical profession's domain, the resistance can be quite strong.¹⁶

Increased salaries could recruit more individuals but would fail to address the profession's underlying reason for disparagement.

Second, as we saw in Chapter 4 through mission statements, medical schools have many competing goals, and producing primary care physicians is not high on their list. 95.4% of statements referred to research and just 26.9% included service in their mission. A number of things are happening that exacerbate the problem. On one hand, Family Medicine is not oriented toward research. According to Bloom (1989), "the research enterprise of academic medicine has forged collaboration with specialty medical practice, and the two together have been a powerful lobbying force in both the creation and maintenance of government institutions which, themselves, combine active research and research-support functions" (236). The strong collaboration has forged "new links with corporate for-profit medicine" as well (236).

In agreement with Bloom, my research indicates that the contributory power of economics in this problem operates primarily at the institutional level, through the incentives of medical schools which leads to a hostile structure (as shown in Chapters 3 and 4), rather than at the individual level, where attention is frequently placed, despite the lack of research to support such a claim (Rosenblatt & Andrilla 2005; AAFP "Study of Factors;" Siwek 1993).

Intelligence

In Chapter 3, we saw through oral histories that individuals encounter the opinion that people choose a primary care career when they are not smart enough to choose another specialty.

¹⁶ Consider, for example, the surgical response to duty hour restrictions. Though a reduction in work hours makes the field more appealing to recruits, the profession's predominant response has been resistance and concern. The very same change can make a field more appealing while also evoking strong resistance from the medical profession.

This dissertation offers two responses to the claim that primary care physicians are doctors who could not “make it” in any other specialty.

The first response is that the medical profession has its own reasons for associating primary care with low intelligence. To refer back to Fox (1957), there are two sources of uncertainty in medicine: “incomplete mastery of available knowledge” and “limitations of present medical knowledge.” It is strategic (and understandable) that medicine as a profession would attribute the uncertainty in primary care to the incompetency of individual physicians as opposed to the weaknesses (and ultimate failure to prevent death) in their field. Additionally, the viewpoint that specialists are more intelligent and have more knowledge reveals an assumption Stephens (1982) points out, “*To know an object best, one must know it in its smallest dimensions*” (6). This is not a self-evident claim; we could imagine a situation in which knowing only the smallest dimensions of an object is considered inferior to having a broader knowledge. When the claim is made that those in primary care are less intelligent, it is important to recognize the inherent judgments about what knowledge is as well as the strategic reasons the profession has to point their finger at “incompetence” and away from inadequacies in their own knowledge and power.

Now, the second response is more practical. Looking back at Table 8 in Chapter 5, for example, the reality is that Family Medicine (and other primary care specialties to a less extent because they include many people who will subspecialize) is simply less competitive. This likely means that the field(s) must be less selective in who they accept. In supplementary interviews, I asked respondents about this very issue, and they acknowledged it. One said that an advisor had told her that there are two kinds of people in Family Medicine—those who are passionate about it and those who cannot do anything else; he told her she should be prepared for that. Another said that sometimes people describe the people who enter Family Medicine as “martyrs or morons.”

I think it is a reasonable assumption that biosketches analyzed in Chapter 6 and Chapter 7 are more likely to represent individuals who are passionate about Family Medicine, and less likely to represent those who are not. This limitation and selection issue would be present with any methodology, barring mandatory response. Those who love the specialty they chose are more likely to want to talk about it than those who are unhappy. However, given the vast differences between the philosophies of Family Medicine and the biomedical model, I think it is clear and believable that some individuals choose Family Medicine because it is the only specialty of medicine that “makes sense” to them or that embodies how they want to practice medicine and serve.

NPs and PAs: The future of the field?

There is much “buzz” about shifting primary care from physicians to nurse practitioners and physician assistants. The patient-centered medical home model, for example, utilizes increased team-based care including these physician extenders. What are the implications of the increased outsourcing of primary care to non-physicians? To answer this question, consider the following quote from the Millis Report (1966):

The first necessity is for organized medicine to recognize—not merely in a formal sense, but sincerely—that comprehensive health care is a high calling, different from specialization in thoracic surgery or hematology or something else, but not inferior—not inferior in training, in rewards, or in position within the house of medicine. (38)

To push the analogy a little further, this dissertation shows that “comprehensive health care” in the form of Family Medicine, has *never* been welcomed into the “house” of medicine. The transfer of generalist medicine to physician extenders—of lower prestige than physicians—is just pushing Family Medicine a little further out the front door of medicine.

This shift certainly has implications for the physicians themselves, but I think there are even larger implications for us to consider as a society. What kind of care can be transferred to lower-status professional groups? Transferring primary care work to lower status groups is not value neutral; it conveys that this kind of work does not really require the knowledge, expertise, or training of a medical degree. Primary care is outside the bounds of the medical profession—which as we saw in Chapter 2, is consistent with its low intraprofessional status and exclusion from the “house of medicine.”

The Role of the Public

Abbott’s (1981) theory of intraprofessional status was used in Chapter 2 to understand why the profession of medicine dislikes the “impurity” of Family Medicine. However, his explanation does work out quite so nicely when we consider professional status assigned by the public. According to Abbott, those standing inside and outside a profession think about status very differently: “Publicly venerated professional roles are often those least respected by the professionals themselves” (819). While intraprofessional status is based on the “purity” of one’s work, he argues that public status is based on “effective contact with the disorderly” (830). He writes:

The admired specialties are not referral specialties with their high incomes, but front-line, lower income specialties in immediate contact with disorder. Even the poorest country doctor can look death in the eye (830).

However, I think the status attached to the “poorest country doctor” is actually similar among patient and physician alike. There is no “paradox” of status for Family Medicine physicians—just consistently low status. There are a few possibilities for this: as individuals have increasing access to medical information, perhaps they are less awed by a primary care physician. Perhaps

individuals have already done the “ordering” of their own disorder before they even see primary care physician.

Or perhaps the public has bought into “the false promise, that science offers a cure for every ill and the indefinite postponement of death” (Heath 2007:102). In our technological age, perhaps the public believes that, with the right specialists, and the right tests at the right times, they will avoid the need for a doctor who can “look death in the eye.” Finally, perhaps members of the public, like members of the medical profession, also do not want to deal with the “untidiness” that Family Medicine’s holistic philosophy brings together.

The public’s values are a factor here as well. It is not simply the medical profession or the ways that research is rewarded in medical schools. The American public also consistently demands the best and most cutting-edge care, which has implications for primary care as well as health care costs. Callahan (2009) puts it this way:

If we as individuals do not bring some greater realism to our health, some willingness to put up with our mortality and vulnerability, and the anxiety that goes with its recognition, then there is no hope that costs can be controlled, hardly any technologies that can be limited or denied” (155).

Implications for reform

My dissertation has documented the problematic nature of medical education for Family Medicine and primary care more generally. Medical education could be restructured in ways that work on this issue. As we have seen, there is an imbalance of specialists and generalists teaching, mentoring, and modeling a career in medicine. But, as Bloom (1989) cautions us, “the resistance to change in US medical schools is certainly more than structural inertia” (236). Tracing the various efforts for restructuring and reform in Chapter 1, we have seen that changing the institutional obstacles and transforming the profession’s disdain will be a long road. In the

meantime, my research suggests two very practical reforms that that do not require major structural or institutional change:

- 1) Provide more opportunities for students to observe “magic” of long-term patient relationships, as one resident described. And it should be noted that there is a difference between throwing students into an unorganized hospital clinic to see continuity of care and providing them opportunities to visit primary care physician offices in the community (see Keirns and Bosk 2008). Though relationships span years and decades, students will be able to see the impact, reality, and fruition of these relationships during a week, (even a day) of observations.
- 2) Admit more students with a social justice schema to medical school. In light of the years of reform without change (Bloom 1989) and the profession’s deeply rooted motivations for ostracizing Family Medicine, one needs rose-colored glasses to think we can change the structure with its embodied values and embedded obstacles—in any case, change will not happen quickly. So, understanding the individuals who choose it and understanding how they make sense of their choice is another way to deal with the supply issue. There are reports that newer medical schools (e.g. the Frank Netter School of Medicine at Quinnipiac University) are specifically trying to target students who will go into primary care practice (Cohen 2013). Focusing on the presence of a social justice schema, as described in Chapter 6, could further enhance these efforts.

Future research

- 1) Longitudinal studies of medical students are needed to more fully understand how decisions are made, change, and are understood through time. Additionally, longitudinal

research would help refine how to measure this social justice schema that emerged in the biosketches.

- 2) More research on the public's use and perception of medical providers is needed (see Pescosolido, Tuch, and Martin 2001). Additionally, an analysis of medical television shows would be interesting, focusing on how are medical professionals presented and if there is there a change over time in what type of physicians are in the television shows (e.g. *Marcus Welby* versus *Grey's Anatomy*).

In closing, Samuel Bloom (1989) poses the simple yet poignant question: "Are we training doctors for the real needs of the population?" and writes, "the answer to that question continues to be essentially negative" (238). In studying Family Medicine, we encounter individuals who are not content with this "essentially negative" answer. In many ways, Family Medicine is "countercultural" to the rest of medicine (Stephens 1982). As we have seen, Family Medicine doctors have a broader view of health, one that emphasizes the importance of relationship and healing (see Table 1).

This broader view is also a minority view within medicine, and one, which, we have seen is closely tied to issues of social justice. While biomedicine seems to be focused on providing the best care to a few people, Family Medicine is more oriented toward providing good care for more people. This dissertation does not dispute the beneficial progress achieved through scientific advancement. Instead, my research argues that these goals are pursued in an imbalanced way that brings with it significant social and economic costs.

Despite spending "two-and-a-half times more than the OECD average health expenditure per person," the United States is below the OECD average for "life expectancy, infant mortality and potential years of life lost," and inequalities and millions of uninsured citizens remain (OECD

2011). The OECD's additional report on "Why is Health Spending in the United States so high" shows that the United States' health care spending issues derive from the fact that "the primary care sector is still underdeveloped, adding financial burden to the health system" and goes on to say that "the shortage of family doctors contributes to the poor primary care performance" (6).

Family Medicine, through its deeply rooted challenge to the reign of biomedicine, invites us, as a society, to ask: on what front are we winning? What are we winning? In our historical moment, the alternate narrative of Family Medicine questions our blind worship of technology and specialization that tolerates great inefficiency and inequality. Family Medicine's philosophy pushes us to ask hard questions about our health care system, refuses to accept the status quo, and equips us with another way of living and dying. This, I argue, is the value of Family Medicine, and the hope—that the answer to Bloom's question can be "essentially yes, we can train doctors for the real needs of the population."

APPENDICES

Appendix A: Timeline of Events

Chart taken exactly from:

http://www.aafpfoundation.org/online/etc/medialib/found/documents/programs/chfm/abfmtime_line.Par.0001.File.tmp/ABFMChronology.pdf



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Administered by the
 American Academy of Family Physicians
 Foundation

TIMELINE OF EVENTS LEADING UP TO THE CREATION OF THE AMERICAN BOARD OF FAMILY PRACTICE 1941-1969

<u>Date</u>	<u>Event</u>	<u>Organizations Involved</u>
June 1941	Resolution requesting certification for general practice (Rejected)	AMA
	Request for Section on General Practice at AMA (Not approved)	AMA
June 1947	Special committee to study conditions of general practice appointed on recommendation of president	AMA
June 1948	Report of Special Committee to Study Conditions of General Practice (members included Drs. Paul Davis and Stanley Truman of the AAGP) (Approved)	AMA
June 1949	Resolution on establishment of Committee on General Practice to report directly to House of Delegates at next interim session (Approved)	AMA
	Resolution that graduate and postgraduate education for general practitioners be made more widely available and that two-year rotating internships especially designed for training for general practice be set up as rapidly as possible. (Adopted)	AMA
June 1950	Report of Committee on General Practice, chaired by Dr. Truman (Approved)	AMA
Dec. 1952	Resolution on Training of the General Practitioner – asking for increase in residencies for general practice and decrease in specialty residencies (Referred to Council on Medical Education)	AMA
Dec. 1954	Resolution calling for exhaustive study of problems of general practice, including adequate educational programs (Referred to AMA Board of Trustees)	AMA
	Report of Special Committee on General Practice prior to Specialization – interim report	AMA
June 1955	Report of Special Committee on General Practice prior to Specialization (Accepted and referred to AMA Board of Trustees for consideration)	AMA
Dec. 1955	Resolution for study of general practice from 1954 clinical meeting, considered by AMA Board of Trustees; study not implemented because of required funds, but data on preceptorships, undergraduate and graduate programs in general practice to be reported in the next Directory of Approved Internships and Residencies	AMA

Rev. 07-24-12

<u>Date</u>	<u>Event</u>	<u>Organizations Involved</u>
Dec. 1956	Committee on Medical Practice report on directive to “utilize all possible means to stimulate the formation of a department of general practice in each medical school” stated that much needed to be done to properly define general practice “to determine more adequately the avenues of approach to the best indoctrination today for the individual who plans to enter the field of general practice.”	<i>AMA</i>
Sept. 1957	Minimum Uniform Standards in Education (MUSE) Committee formed by AAGP Board of Directors	<i>AAGP</i>
Dec. 1957	Joint committee, with representation from AMA, Council on Medical Education, AAMC, and AAGP, established by AMA to address itself to the directives in report of Committee on Medical Practice and to proceed “to objectively analyze and make recommendations as to best background preparations today for general practice.” (Committee met in January, May, June, September, October, and December of 1957 and February and May of 1958.)	<i>AMA, AAGP</i>
March 1958	MUSE Committee report to AAGP Congress (Referred back to committee)	<i>AAGP</i>
June 1958	Committee on Preparation for General Practice report presented as Supplementary Report A of the AMA Board of Trustees, as a preliminary report of the committee (Accepted for information)	<i>AMA</i>
Aug. 1958	Joint Committee of AMA GP Section and AAGP Executive Committee – to study possible Board	<i>AAGP, GP Section</i>
April 1959	MUSE Committee Report to AAGP Congress of Delegates – MUSE Committee was then discharged and AAGP Board of Directors was authorized to continue liaison with AMA GP Section on the subject	<i>AAGP</i>
June 1959	Final Report of Committee on Preparation for General Practice approved, referred to Council on Medical Education for implementation and committee discharged	<i>AMA</i>
Dec. 18, 1959	Independent group (not officially with AAGP or Section) filed articles of incorporation for “American Board of General Practice, Incorporated” in state of Maryland	
1960	AMA pilot programs in general practice and family practice eliminated requirement for training in obstetrics and surgery	<i>AMA</i>
April 1, 1960	AAGP Congress adopted Board report which stated “We repudiate the creation of an ‘American Board of General Practice’ without the knowledge, consent, or approval of the only national society of general practitioners in America... We deny responsibility for its parentage and we recommend that members of AAGP decline to affiliate with this or any other board which is without official status in organized medicine.”	<i>AAGP</i>
June 1960	Section on General Practice introduced a resolution requesting that the AMA support position that training in obstetrics and gynecology be a requirement for preparation for general practice. (Referred to Council on Medical Education)	<i>AMA, GP Section</i>
June 1961	Number of resolutions introduced protesting content of pilot programs, requesting that AAGP have input in determining content of training; a substitute resolution called for AMA to develop other pilot programs to comply with obstetrics and surgery training request (which was subsequently adopted)	<i>AMA</i>

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<u>Date</u>	<u>Event</u>	<u>Organizations Involved</u>
June 1962	Interim statement on “An American Board of General Practice for Family Physicians” prepared by AAGP Executive Committee and the Executive Committee of the AMA Section on General Practice, following joint meetings at the direction of the AAGP Congress and the AMA Section to “determine whether or not a board of general practice is feasible.” Published in <i>GP</i> with request that it be studied and comments forwarded to the AMA Section and Academy members to inform delegates of their stand when the subject comes up for vote.	<i>AAGP, GP Section</i>
March 1963	A number of resolutions (two for, two against certification) were introduced, but not adopted at the AAGP Congress.	<i>AAGP</i>
July 1963	Citizens Commission on Graduate Medical Education (Millis Commission appointed)	<i>AMA</i>
April 1964	One resolution introduced in AAGP Congress supporting formation of board (Not adopted)	<i>AAGP</i>
Sept. 1964	Ad Hoc Committee on Education for Family Practice (Willard Committee) appointed by AMA Council on Medical Education with concurrence of Trustees	<i>AMA</i>
April 1965	AAGP Congress of Delegates considered seven resolutions on the subject of a board pro and con. ALL rejected. Adopted a statement from the Report of the Chairman of the Board which concluded with: “The Board of Directors recommends that it be authorized to proceed with the establishment of a certifying mechanism and that it report back to a regular or special session of the Congress for approval or disapproval before the program is inaugurated.”	<i>AAGP</i>
June 1965	Four resolutions introduced in AMA House, calling for establishment of a certifying board in general practice. ALL referred to Council on Medical Education.	<i>AMA</i>
Feb. 1966	Liaison Committee for Specialty Boards considered a preliminary application from the Academy and Section. (Application prepared by CORC.) Application called “premature” by LCSB, and Academy asked to withdraw it until Citizens Commission and Ad Hoc Committee reports were concluded.	<i>AMA, AAGP</i>
Aug. 1966	Millis Commission report, “The Graduate Education of Physicians” published.	<i>AMA</i>
Oct. 1966	CORC report to AAGP Congress—including “Core Content of Family Practice” (Adopted)	<i>AAGP</i>
Nov. 1966	Report of the Ad Hoc Committee on Education for Family Practice, “Meeting the Challenge of Family Practice,” issued.	<i>AMA</i>
Dec. 1966	Another preliminary application submitted.	<i>AAGP, GP Section</i>
Feb. 11, 1967	Advisory Board for Medical Specialties unanimously approved preliminary application.	<i>AAGP, GP Section</i>
Oct. 1967	CORC report presented to AAGP Congress, with appendices of “final application form, proposed constitution & bylaws, proposed articles of incorporation and charts of application, procedure, outline of 3-year training program and Evolution of a New Specialty.” (Adopted)	<i>AAGP</i>
Feb. 10, 1968	ABFM, in acting on final application, adopted motion to defer action for modifications, requested “clearer definition, etc.”	

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<u>Date</u>	<u>Event</u>	<u>Organizations Involved</u>
April 1968	Joint Conference of AAGP, GP Section members and AMA Committee on Family Practice and representatives of various specialties. Ad Hoc Committee formed to draft "Essentials."	<i>AAGP, AMA, GP Section</i>
Dec. 1968	The Essentials—"Special Requirements for Residency Training in Family Practice" (Approved)	<i>AMA</i>
	Resolution in AMA House: " <i>Resolved</i> , That the AMA affirm the importance of providing appropriate recognition for family physicians through approval of a primary specialty board for family practice and that the Council on Medical Education be encouraged to continue its efforts with the American Academy of General Practice and the AMA Section n General Practice to achieve this goal." (Adopted)	<i>AMA</i>
	Another application drafted to be considered the following February.	<i>AAGP, GP Section</i>
Feb. 6, 1969	Liaison Committee for Specialty Boards considered application, recommended changes.	
Feb. 7, 1969	Application and LCSB recommendations considered by Standards Committee.	
Feb. 8, 1969	Three more considerations: a) Application and all recommendations considered by ABMS (49-member board) b) Considered by full Council on Medical Education c) Application and all recommendations returned to LCSB for final consideration and action that night. (Approved granted)	
Feb. 15, 1969	Date of incorporation of the American Board of Family Practice (ABFP; now the American Board of Family Medicine)	

Source: *Family Practice: Creation of a Specialty*. Kansas City, MO: The American Academy of Family Physicians, 1980, pp. 53-59.

Appendix B: RWJF GPI Schools

The Robert Wood Johnson Foundation Generalist Physician Initiative included 1.5 years of a Developmental Stage for each of the schools involved and 2 Implementation States (3 years each).

List of Schools that completed the entire project:

Boston University School of Medicine, Boston. (MA)
Case Western Reserve University School of Medicine, Cleveland.
Dartmouth Medical School, Hanover, N.H.
East Carolina University School of Medicine, Greenville, N.C. (NC)
Georgia Medical College, Augusta, Ga. (GA)
Allegheny University of the Health Sciences (which became MCP Hahnemann), Philadelphia.
University of Massachusetts Medical Center, Worcester, Mass.
University of New Mexico School of Medicine, Albuquerque, N.M.
New York Medical College, Valhalla, N.Y.
Pennsylvania State University College of Medicine, Hershey, Pa.
State University of New York at Buffalo Medical School, Buffalo, N.Y.
University of Texas Medical Branch-Galveston, Galveston, Texas.
The three Virginia medical schools that applied as a consortium—University of Virginia School of Medicine, Charlottesville, Va. Virginia Commonwealth University Medical College, Richmond, Va. and Eastern Virginia School of Medicine, Norfolk, Va.

Appendix C: Biosketch Methodology

Biosketches were sorted into 5 grades based on their level of information:

Grade A

Erik was born and raised in the beautiful Pacific Northwest spending his days hiking the rugged mountains and sipping the best coffee in the world. In high school he participated in mission trips to the middle east and east Europe where he developed a love for foreign cultures and the joy of service. As an undergraduate student at Whitworth College, Erik majored in chemistry with an emphasis in Chinese languages. A US State Department scholarship provided funding for a year long academic exchange to study chemistry and Mandarin at the Chinese University in Hong Kong. His love for China and its people grew large, which led him to pursue further work after graduation with a development NGO in western China. God has given him a love for its people and he hopes to return some day to work in long-term development work. Prior to medical school, he worked as a nursing assistant in a nursing home and hospital that exposed him to both the challenges and great rewards of patient care. Having never been to the east coast, Erik spent the next 4 years in Philadelphia at Jefferson with many wonderful life-changing experiences while working in an urban setting. He is excited to be spending his training years at Lancaster General Health, and blessed to be apart of such an amazing community of residents and faculty. He owes his love for medicine to his mother, who is the bravest person he knows.

Grade B:

Originally from Yardley, PA, Deborah attended college at the University of Pittsburgh. She then completed medical school at Jefferson Medical College. In medical school, she was involved in many community outreach programs, focusing on urban underserved and immigrant communities. She currently lives in Bryn Mawr. In her spare time, she enjoys reading, baking, hiking, trying to improve her Spanish, and spending time with friends.

Grade C:

Sarah Grewal, MD

St. George's University

Interests: reading, traveling, spending time with friends and family

Grade D:

Second-Year Residents

John Paul Abroguena, MD

Maria Theresa Belicena, MD

Frisha Glori, MD

Shami Goyal, MD

Gopi Vadlamudi, MD, Assistant Chief Resident

Akhil Vats, MD

Grade E: Nothing found.

Appendix D: Sociology & Family Medicine

Sociology + Family Medicine

As a sociologist, it would be hard to study Family Medicine and not begin to notice similarities between the two fields. In fact, after Stoller and Dozer (1988) presented their article, someone responded: “Wait a minute, are you physicians or behavioral scientists?” (*Family Systems Medicine* 6(2):248).

1) Sociology and Family Medicine share a number of central commitments and beliefs:

- Importance of larger social environments on individuals’ well-being
- Importance of social determinants of health
- Commitment to reducing inequalities and promoting justice.

2) Sociology and Family Medicine also have similar positions in relation to their respective nearby fields. Sydney Halpern, in her book on the founding of pediatrics in America, writes “physicians in organ and technically based specialties often depict psychiatry, public health, general pediatrics, and family practice as soft or unrigorous, much as academics in the physical sciences portray social science disciplines” (11).

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