History of Medicine

In the beginning there were apothecaries

A historical perspective on the emergence of general practice, the emergence of family medicine, and the research agenda of family medicine.

Adam Garber, Meds 2010
Raza Naqvi, Meds 2009

The emergence of general practice as an academic discipline can be traced over almost two centuries. Major events include the establishment of the College of General Practice, the identification of a defined body of knowledge, the establishment of criteria for certification, and the change of the college’s name to the College of Family Physicians. Of particular importance as well is the development of research networks and methods that amplify on the unique aspects of family medicine.

This article has been reviewed by Dr. Jeffrey Freeman.

The history of family medicine in North America is a rather new one. Within its history there are periods of particular strength followed by periods fraught with struggle. Despite these natural ebbs and flows, family medicine has advanced medical understanding and practice both in the science and the art. That is, family medicine has advanced the medical understanding of care for the individual while at the same time contributing at a scientific and epidemiological level to the body of medical literature. This essay will outline a brief history of the development of general practice and then family medicine as it emerged from general practice. The essay will also address the history of the research agenda of family practice.

The history of general practice begins similarly in Canada and the United States in the early 19th century as both countries closely followed the British model. There were physicians, surgeons, and apothecaries. Physicians were trained through university course work or apprenticeship and were the progenitors of what we now know as specialists. For the most part, they provided care for the affluent. The surgeons were trained in barber schools and were not permitted to prescribe medications. The apothecaries began as shopkeepers that provided medicines. Interestingly, the apothecaries took on the role of conducting initial clinical investigations. The Apothecaries Act of 1815 advanced both the privileges and the responsibilities of apothecaries. The Act required candidates to complete a pharmaceutical chemistry exam and an exam on the theory of the practice of medicine. As well, candidates were required to complete a five year apprenticeship. These requirements allowed the apothecaries to produce income through the prescription of their medicines as well as through their medical practice. It is from these humble beginnings that the ‘general practitioner’ was born. It is also interesting to note that David Woods, a renowned medical writer and educator, suggests that the general practitioner in North America predates the existence of the general practitioner in Europe due to the dispersed settlements and mobile colonies which necessitated the ability of one person to perform surgery, practice medicine, and prescribe medications. The general practitioner enjoyed a number of years of stability despite some public concerns that due to the lack of a more rigorous application system, some general practitioners were under-educated.

By the end of the 19th century however, as the specialist movement gained momentum, some doubts existed as to the future of general practice. Even Sir William Osler expressed this doubt with respect to general practice in an urban setting. The Flexner Report of 1910 furthered the domination of specialist medicine. The Flexner Report, entitled ‘Medical Education in the United States and Canada’, led to the standardization of the medical curriculum and created a link between medical schools and established universities. As a result most clinical teaching was now taking place in urban teaching hospitals. Gutierrez and Scheid point out that by 1935 hospitals became the centre for teaching and technology, specializing was valued highly and required a residency period, as the practice of medicine became a profession for the wealthy. The hospitals, now as specialist centres, left an uncertain role for the
general practitioners who continued to practice within these very centres to a certain extent. The obsession with
scientific and technological advancement that resulted from the World War II placed even more glory on the
shoulders of specialists and the number of students entering the field of general practice consequently declined.

The College of General Practice of Canada, founded in 1954, published a bill of rights for general practitioners. The College was born out of a need to both redefine the role and revitalize the image of the general practitioner. Its initial mission was to improve educational standards and opportunities, certification standards, standards of practice and to help define the general practitioner’s role in the hospital and in the office. Understandably, before implementation of any change, the college struggled with the precise definitions of their ambitious objectives. Two central difficulties proved to be interrelated and took more than a decade to resolve; first, the identification of the body of knowledge that is to be subsumed under the domain of general practice and, second, the issues surrounding the college’s responsibility to certify its members. It was in 1967 that a document entitled

Graduate Training in Family Practice

both specified training requirements but also outlined the body of knowledge that concerns family physicians. The committee responsible for this document also enlisted support from Canadian medical schools that year. It is noteworthy that family medicine residence programs at both McMaster University and the University of Western Ontario precede this document by one year. It was also in 1967 that the college was renamed as the College of Family Physicians, a name which the college president, Irwin Bean, opposed but later acknowledged its necessity. Not surprisingly, this flurry of progress and newfound purpose that seemed to be weaved into the new name of the college, correlated with the inception of Canadian medicare in the 1960s.

Concurrently, in the United States, the Millis Report, the Folsom Report, and the Willard Report were published independently by the American Medical Association in response to the increasing public disapproval of the fragmented delivery of care, the inaccessibility to service, and the “depersonalization” of care. These reports suggested the need for each citizen to possess a personal physician who is sensitive to life context, the impact of illness and the importance of therapeutic options. It is the opinion of some that family medicine was a natural reaction to the counterculture of the 1960s. Stephens argues along these lines when he speaks of agrarianism, humanism, utopianism, consumerism, and feminism in relation to the birth of family medicine in North America.

The discussion surrounding research in family medicine began soon after the emergence of family medicine as a discipline in Canada and the United States. As Herbert explains, the research agenda of family medicine was called into question as early as 1966. The initial idea was that research in family medicine would focus on diagnostic testing, interpretation of symptoms, larger epidemiological studies, as well as development and behaviour. However, this notion was expanded during the 1970s to include other areas of study such as health care services, clinical strategies, biomedical sciences, and the social sciences. The Study Group on Family Medicine Research which took place in 1982 articulated the areas of research to which family medicine could make unique contributions and highlighted the importance of research elective time for students. Perhaps one of the most important shifts in the research agenda of family medicine involved recognition of the importance of each individual’s socio-cultural and environmental context in understanding health and behavior. This idea was highlighted by Nigel Stott in 1987 and by Culpepper in 1991 and required a shift in research methods to account for patient context in the delivery of medical services and the experience of illness.

Since the inception of family practice, it was clear that the family physician’s office possessed a remarkable amount of data relating to disease processes and outcomes. It is this sort of data, Ryan argued, that could help address central issues like diabetes, back pain, and the common cold and help to “bridge the performance gap” and “answer real-world research questions”. While the potential has always been recognized and the particular areas of benefit have long been debated and refined, it is the “harvesting” of the data that has presented one of the greatest obstacles to research in family medicine. Until the early 1980s, research in family medicine was practice-based and therefore, depending on the demographics of the surrounding community, only certain research questions could be adequately addressed. During the 1980s, a move was made towards practice networks and in 1995 the Federation of Practice-Based Research Networks (FBPRN) was born in the United States with the hope of pooling data, brainpower, and resources. Since then practice-based research networks are succeeding in the production of sound research databases. Perhaps the most useful aspect of practice-based research networks is their ability to track many patients for long periods which is conducive to thorough longitudinal studies. Indeed research in family practice has evolved to include large scale longitudinal studies conducted through collaborative research networks.
From apothecary to general practitioner to family doctor, the history moves towards increasing organization and increasing academic ambition. Despite the many important definitions and redefinitions, and the advancements of mission and responsibility, a similar vein strings the history together. That is, each step in this progression, including the research endeavours, seem to be guided by the desire to care for the person while cognizant of intricate social contexts.

References