My grandfather was a general practitioner in a rural midwestern town during the first half of this century. His office consisted of a single examining room in the family home, a tiny waiting area, and little envelopes in which he dispensed medications. Patient hours were in the evening, no appointment necessary. Mostly, folks chatted in the living room with my grandmother while waiting to see “Grandpa Doc.” My grandfather’s nights often included trips to neighbors’ kitchens to deliver babies. Days were time to serve as the county health officer, student health director for the local college, and organizer of the town’s free clinic for indigent patients, based in the Presbyterian church.

For Grandpa Doc, the town was his patient as much as were its individual inhabitants. There was no boundary between the care of individual patients (medicine) and populations (public health). He served one and he served all. He would have found it puzzling at best to separate care of a community from care of its individual members. Today, public health and clinical medicine have drifted so far apart that it takes a major national effort of professional organizations and foundations to try to bring them together.¹

I thought of Grandpa Doc as I attended a meeting conducted at the New York Academy of Medicine, New York, April 9, 1997: “In Sickness and in Health: A National Symposium on the Evolving Relationship Between Medicine and Public Health.” The meeting was convened to present a progress report on a collaborative effort supported by the Robert Wood Johnson Foundation and cosponsored by the American Medical Association and American Public Health Association.

The meeting traced the history of the development of the gulf between medicine and public health since the mid 20th century. The causes of the divide were summarized at the meeting by Phillip Lee, MD, formerly assistant secretary of the US Department of Health and Human Services and currently chancellor of the University of California, San Francisco. One cause was health insurance that paid generously for inpatient and procedural care but little or not at all for outpatient and preventive care. Another was the Hill-Burton Act, which supported the building of inpatient hospitals rather than public health infrastructure. Other causes included the biomedical orientation of research supported by the National Institutes of Health, and the emphasis on categorical public health programs (eg, immunizations, sexually transmitted diseases, and tuberculosis) rather than population-based public health programs.

There are many forces now pushing the 2 communities together. Roz Lasker, MD, director of the Division of Public Health of the New York Academy of Medicine, summarized these forces at the meeting: managed care, which is leading medicine to take over some traditional public health functions; pressure to contain costs; growing interest in documented results (eg, immunization rates), which the public health and medical sectors can achieve only via shared commitment; and the trend toward consolidation of care into integrated systems.

All of these boil down to the recognition that financial profit will now accrue to those health care organizations that learn to provide efficient care to large populations. Willy Sutton is reputed to have said he robbed banks because “that’s where the money is.” It is somewhat startling to recognize that others now see money to be made by bringing a large corporate approach to doing what family physicians have always done. And they are doing so with a vengeance.

The result, as documented with many examples at the meeting, is a new and per-
vasive effort to develop cooperation between public health, medical, and academic institutions. Speakers at the meeting repeatedly emphasized the need to develop a new understanding of health problems as resulting from social, environmental, and behavioral factors inseparable from biological factors. They called for interdisciplinary partnerships between public health, medicine, nursing, health education, public policymakers, business, and others to address the root causes of illness rather than treating its effects after they are well developed. They gave multiple examples of successful collaborations. They agreed with statements like: “education, research and patient care are all increasingly relying on a new set of evaluative disciplines: biomedical and biotechnical ethics, clinical epidemiology, informatics, health services research, outcomes analysis, and values management.”

All to the good, I thought, as I sat in the meeting. As a family physician, I found myself sympathetic with such ideas. After all, I had been attracted to family medicine as a discipline at least in part because it offered an opportunity to care for patients in the context of their social, community, work, and environmental circumstances. I want to prevent illness, not just treat disease. I was pleased that a gathering such as this meeting (monograph on *Medicine and Public Health: The Power of Collaboration* that emerged from the ongoing project) would be calling for care of the kind I want to offer in family medicine. My grandfather might have felt comfortable with many of the ideas expressed at the meeting, although the knowledge and tools available to clinical medicine and public health exceed anything he could have imagined.

But here is my problem: I had been attracted to family medicine because it offered an opportunity to be part of a discipline that was on the cutting edge, a specialty leading improvement of health care. Now, these ideas are being taken over by managed care organizations, academic health centers, and others, often to enhance the profits of large corporations. This financial agenda would have been anathema to our forbears. Its proponents’ commitment to caring for the most vulnerable patients and communities remains to be proven. Such an approach is not what attracted me or most of my colleagues to family medicine.

For a time, family medicine could legitimately claim a position of intellectual and moral leadership. If the New York meeting was any indication, we have lost the initiative. We have allowed our ideas to be co-opted by others. Is family medicine, once “counterculture,” becoming conservative and cautious? Are we willing to let others, who may lack the motivation and long-term commitment of family physicians, control the evolution of American medicine? How can we develop the next phase of family medicine so as to establish an appropriate leadership role for our discipline? It is time to move to the next phase of thinking about what it means to be a family physician, while preserving the essential core of what we do now and what our predecessors did more than 50 years ago.

I hope we can pursue this evolution while continuing the pluralism that characterizes our discipline. Family physicians will continue to practice in a range of settings, from full-spectrum practice, including perinatal care, some surgery, and many procedures, to outpatient family practice, urgent care, practices focused on sports medicine or care of the elderly, and teaching, research, or administrative medicine.

Family physicians in each of these settings may draw on a core set of intellectual skills of the family physicians of the future. These skills have been discussed by others. Family physicians will remain grounded in direct clinical care of patients. However, care of patients one at a time is becoming relatively less important as subspecialists become ever more over-supplied. Family physicians’ time could be saved to do just those things family physicians are best qualified to do—taking responsibility for our patients’ overall care, developing relationships of continuity and trust with patients and their communities, and delegating work to limited medical specialists, physician’s assistants, and nurse practitioners for those activities (specific procedures, intensive in-patient care) where such individuals are plentiful and less expensive than family physicians.

Many family physicians are increasing their expertise in information management, epidemiology, evidence interpretation, community medicine, prevention, and analysis and use of practice guidelines. Family physicians are ideal expert leaders of interdisciplinary patient care teams. They need not deliver all or most care to patients directly, but can delegate much to physician and non-physician colleagues. The family physician can be “captain of the ship,” responsible and accountable to the patient for quality and effectiveness of care delivered. Such leadership by family physicians could help ensure a truly beneficial outcome of the reconciliation between medicine and public health.

Family physicians have an opportunity to be in the vanguard of work to improve the health of our patients and communities. To allow others to adopt our agenda for other purposes would be to betray the legacy of our general practice forebears. As Saultz said, “We have little experience with being powerful.” It is time for us to gain some experience.

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