specialization was associated with fragmentation in medical education and imbalance in delivery of health care. Their report helped establish a philosophical base for family medicine by emphasizing the importance of continuous and comprehensive care for all. The committee also insisted that training programs be affiliated with academic centres in order to assure quality education comparable to that of other specialties.

Another report with far reaching consequences was published one month later. It was prepared by the Ad Hoc Committee on Education under the chairmanship of William Willard, M.D.[17] . Dr. Willard's committee defined the family physician more succinctly, provided a structure for training such physicians and stressed the necessity for board certification with periodic recertification.

Both studies focused on the need for a personal physician who would view patients as unique individuals; identify problems within the framework of their family, society and culture; manage the majority of these problems; seek appropriate consultation when indicated; and co-ordinate their overall health care throughout their lives. This physician was eventually termed a "family physician" after considering many other titles such as general practitioner, personal physician, first contact physician, comprehensive care physician, and primary physician.

The "Millis" and "Willard" reports gave considerable impetus to the family medicine movement. Furthermore, during the mid sixties rising social consciousness in the United States reinforced the concepts articulated in those two documents. The conclusions of these committees were published in newspapers and magazines. Public awareness increased and citizens became concerned. Legislators and government officials responded with interest. Specialty status was now considered seriously by the appropriate medical organizations. On February 8, 1969, three and one-half years after publication of these reports, the Council on Medical Education of the American Medical Association and the American Board of Medical Specialties approved the new specialty of Family practice [18].

Fifteen residencies were started, and the first board examinations were given in 1970. During the next ten years the movement developed rapidly. Many highly ranked medical students chose family practice residencies. [19, 20]. And by July 1980, there were 6,735 residents in training (figure 1). The fifteen original residencies expanded to 382 (Figure 2). Over 85% of all medical schools now have departments, divisions, or sections of family practice [21], and approximately 15% of United States medical school graduates enter family medicine residencies. (Unpublished data, A.A.F.P. residency census information). In spite of this growth of residency positions, it is difficult to accommodate the number of applicants and recommendations have been made for even more training programs in the immediate future. The American Academy of Family Physicians has had a long standing goal that 25% of all medical school graduates should enter family medicine residency training. Over the past several years, the United States congress provided financial incentives to induce medical schools to place 50% of their graduates in primary care residencies by 1979 [22] . (In this context primary care refers to residencies in family medicine, general internal medicine and general pediatrics.) However, a recent national committee studying health manpower policies has concluded that this figure is too low and has recommended that 60-70% of graduates enter primary care[23]. Thus even though the rate of expansion is decreasing as shown in figure 2, residency positions in family medicine could increase considerably over the next decade.

LOCATION OF GRADUATES

Although it is still too early to determine definite patterns, it appears that graduates are locating in areas of need. Preliminary surveys by the American Academy of Family Physicians indicate that approximately 50% of graduates are practicing in small towns of less than 25,000 population and over one third of this group have chosen to live in communities of less than 2,500. Approximately 4% of graduates are working in inner city low income areas, [24] while over 53% practice in regions designated by the federal government as Health Manpower Shortage Areas.

IMPACT ON GENERAL PRACTITIONERS

The concerns of many older general practitioners proved to be unfounded. One major reason was that general practitioners were permitted to take the family practice specialty examination if they met the following criteria :

1. Active general practice for a minimum of six years.
2. Proof of completing at least 300 credit hours of continuing education study acceptable to the American Board of Family Practice.[18]

Although the examination was difficult, most physicians agreed it was fair. If they failed, applicants were allowed to repeat the examination each year. To date, more than 14,000 general practitioners

have successfully passed this examination and are now certified as specialists in family medicine. This represents approximately one-half of all those who were eligible. (Personal communication, Nicholas Pisacano, Executive Director and Secretary A.B.F.P. June 10, 1980).

The above provisions were in effect for ten years following the inception of this specialty. This was sufficient time for practicing physicians to prepare themselves adequately. Now it is necessary to complete a three-year residency in order to be eligible for the certification examination in family practice.

There was potential for tension between the new class of specialists and those general practitioners who decided against certification or failed the exam. This strain did not develop to a serious degree. One reason was that the AAFP created a fellowship status for members who had been in good standing for six years or more. Also many general practitioners were asked to teach residents on a part-time basis. This arrangement helped to establish good working relations between practicing physician and the academic community. Residents also benefited from the older practitioners' wealth of experience. There appeared to be no financial discrimination towards these generalists. Their practices were well established and their patients continued to come to them.

Overall, the standing of the practicing family physician improved dramatically from that implied by the 1970 regulations of the Joint Commission on Accreditation of Hospitals as exemplified by the following resolution passed by the AMA House of Delegates in July 1979:

"Resolved: that it is A.M.A. policy that individual character, training, competence, experience and judgment be the criteria for granting privileges in hospitals; and be it further.

Resolved : that physicians representing several specialties can and should be permitted to perform the same procedure if they meet this criteria."

Likewise, over the past several years hospital regulations indicate increasing acceptance of family medicine and the hospital accreditation manual now accords family practice equal status with other specialty departments[26] [27].

RECERTIFICATION

In order to maintain specialty status, family physicians must take a recertification exam every six years [18] . Those who fail are given an opportunity to repeat the exam the following year before their certification is withdrawn. The Board requires 300 hours of accredited medical education during this time period. Another requirement is that applicants must submit audits of their office records which are evaluated according to approved standards of care. These examples provide further evidence of the high standards associated with the rejuvenation of general practice.

WORLD-WIDE MOVEMENT

Expansion of family medicine has not been limited to the United States. The movement appears to be a world-wide phenomenon. For instance, the World Health Organization has stressed the need for more family physicians and has emphasized the importance of postgraduate education programs designed specifically for all physicians entering family practice [28]. Family medicine is well established in Canada where about one-half of the country's doctors are considered primary physicians [29] . Every Canadian medical school has a department of family practice. Mexico has at least 22 residencies with over 1,800 graduates [30] . Recenty the Pan American Federation of Associations of Medical Schools held a series of conferences devoted to the concepts of family medicine and implementation of residencies. Programs have been started or are being planned in Panama, Venezuela, Colombia, Bolivia, Brazil, Argentina, Ecuador, and Peru [30] . General practice vocational programs have been functioning in England, Ireland, Australia, New Zealand and Israel for some time [31 – 33]. West Germany has developed family practice residencies with training analogous to that of other specialties. However, most other European countries have not taken definite steps toward a similar goal [33 – 35] . The movement is also evident in the East. A family medicine residency was initiated at Seoul National University in March 1978. Medical students at Yonsei University, Taegu, and Pusan have expressed interest in this specialty[36] and it is likely that many more family medicine residencies will be started in Korea and Japan. Also an experimental training program has been developed in Punjab, India [37]. Coming back to the Middle East, Egypt is developing a vocational residency program which will be linked to medical schools at Mansour, Suez Canal and Alexandria[38].

CONCLUSION

Many countries throughout the world need physicians to provide the benefits of modern medicine to their citizens in a personal, humanistic, cost-effective manner while taking into consideration the influence of the patient's family, culture and society. They require physicians who are able to work closely with other specialists as well as those in allied health fields such