

EDITORIAL

On the Birth of US Family Medicine and the Residency Assistance Program

Valerie J. Gilchrist, MD^a; Robert Graham, MD^b; Norman B. Kahn, MD^c; Daniel J. Ostergaard, MD^d; Kelly Heide, MLS^e

AUTHOR AFFILIATIONS:

^aDepartment of Family Medicine and Community Health, School of Medicine and Public Health, University of Wisconsin, Madison, WI^bDepartment of Health Policy, School of Public Health, George Washington University, Washington, DC^cDepartment of Family Medicine, University of Kansas School of Medicine, Kansas City, KS^dDepartment of Family Medicine and Community Health, University of Minnesota School of Medicine, Minneapolis, MN^eCenter for the History of Family Medicine, Leawood, KS

CORRESPONDING AUTHOR:

Valerie J. Gilchrist, Department of Family Medicine and Community Health, School of Medicine and Public Health, University of Wisconsin, Madison, WI, gilchrist@wisc.edu**HOW TO CITE:** Gilchrist VJ, Graham R, Kahn NB, et al. On the Birth of US Family Medicine and the Residency Assistance Program. *Fam Med*. 2026;58(7):478–480. doi: [10.22454/FamMed.2026.516578](https://doi.org/10.22454/FamMed.2026.516578)**FIRST PUBLISHED:** July 9, 2026

© Society of Teachers of Family Medicine

This editorial complements the excellent article “Residency Program Solutions at 50: A History of Promoting Excellence in Family Medicine,” by Dr Mary Nordling et al in this issue by describing the critical preceding history. Explosive growth and change marked the emergence of family medicine in the late 1960s and the early 1970s. This account of those early years comes largely from three physicians who were present and helped it happen, while working for the American Academy of Family Physicians (AAFP, established in 1971 from the American Academy of General Practice [AAGP]) in the Division of Education (authors R.G., D.O., and N.K.) with the invaluable help of Kelly Heide, archivist at the Center for the History of Family Medicine (CHFM).

According to Dr Ostergaard, “We all knew that this was history in the making. If alone from the sheer numbers of new family practice residencies across the country,” and Dr Kahn recalls:

“I finished my residency in 1977 and became a director in 1980, which is a little young to be a residency director, but, you know, it was rural family medicine, and there weren't a lot of us. I was informed by the hospital medical director that I was the only experienced, residency-trained, board-certified family physician in the county.”

After the *Flexner Report*¹ called for medical training in “a scientific manner” and funding for science increased in the 1950s, there was a surge of medical specialization. However, by the 1960s there was a demand for a specialty characterized in the American Medical Association (AMA) *Report of the Citizens Commission on Graduate Medical Education* as “A physician who focuses not

upon individual organs and systems but upon the whole man.”^{2,3} In the context of challenges to every sector of society through the 1960s, this report along with two other influential reports, the *Willard Report* (1966),⁴ and the National Commission on Community Health Services *Folsom Report* (1967),⁵ the country was ready for family physicians and a training model of collaborative care in both the community and hospital.

Nonetheless the creation of the specialty of family medicine was neither straightforward nor without challenges. Initially the AAGP rejected certification concerned about restrictions of practice and both the American Board of Pediatrics and the American College of Physicians felt that “...the new specialty was unnecessary because internists and pediatricians provide continuous comprehensive primary care.”⁶ The first application for a Board in Family Practice was submitted to the Liaison Committee for Specialty Boards (LCSB) in 1966 by the AAGP and the AMA-GP. The application was rejected as premature. Dr Nicholas Piscano worked to get the American Board of Family Practice (ABFP) accepted by the American Board of Medical Specialties (ABMS) while concurrently Drs Lynn Carmichael and Lee Blanchard began working for the AMA Council on Education with the explicit task of identifying and supporting potential training sites for FM.

In 1968 the AAGP/AMA-GP submitted a second application. It was a full year later, after the AMA's approval of the “Essentials for Training in Family Practice,” several preliminary site visits done and approved, and the Residency Review Committee (RRC) for Family Practice had formed, that the revised application was finally accepted by the LCSB for consideration by the ABMS, with the ABFP becoming the gatekeeper for the new specialty. In November 1969 the first

meeting of the RRC for family practice was convened, including members from the AMA Council on Education (COE), AAGP, and ABFP.⁷ In 1969 there were 15 family practice residency programs accredited, a year later there were 49 and before the Residency Assistance Program was established in 1975, there were more than 200 family medicine residencies.⁷ The Residency Assistance Program would be renamed to “Residency Program Solutions” (RPS) in 2007.

Many contributed but the work of four men was critical to the success of family medicine. Drs Carmicheal and Blanchard were described as “traveling missionaries for family medicine,” recruiting and supporting developing family medicine residency programs. From 1966 through 1972, Dr Carmichael traveled through the eastern half of the United States and Dr Blanchard traveled through the west.⁸ Meanwhile, Dr Tom Johnson travelled extensively for the AAFP to hospitals interested in transitioning both rotating internships and 2 year general practice residencies into 3 year family practice residencies. As Dr Graham recalls of Dr Johnson, “Just him, his Cadillac Convertible, and a carton of Lucky Strikes, because he didn’t fly.”

Dr Tom Stern, a past residency program director (Santa Monica) and medical advisor to television’s *Marcus Welby, MD*, joined AAFP in 1974 as Education Division Director. While he and Dr Graham, and later Dr Ostergaard, traveled to developing programs, it became rapidly apparent to Dr Stern that the demand was too great for just two people. So even in 1974, the idea of a RAP type of program was developing and may have been mentioned at the 1974 program director workshop. The need was vast and the experience slim. Dr Ostergaard recalls, “I had completed several developing program consultations in a specific state following which the Dean of the major medical school in that state phoned me and asked, ‘Dan, how many FPs must a medical school have on its faculty to have a department of family practice?’”

Ultimately, the vital support for the expansion of FM residency programs came from the AAFP. Critical 3-year startup funding for the RAP from a Kellogg Foundation grant was acquired through the Family Health Foundation of America (FHFA, established in 1966 as the philanthropic arm of the AAFP). The RAP Project Board was established with Dr Jack Stelmach of the FFHF as Chair and Dr Tom Stern the first RAP Program Director. Subsequently, the Vice President of Education or Education Division Directors have always acted as program director of the RAP/RPS. The AAFP staffed and ran all the Program Directors Workshops, RAP workshop, and the undergraduate workshop. In 1988, FHFA became the AAFP Foundation (AAFP-F) and the AAFP assumed full administrative and financial responsibility for RAP.

The famous quote by Martin Luther King, “We do not make history; we are formed by our history,” captures the sustaining principles of RAP/RPS. Dr Stern in his 2003 video interview for the CHFM, is very clear that RAP consultations be “collegial, entirely elective, confidential, and for quality

enhancement.”⁹ Family medicine was the first and possibly still the only discipline to establish a peer-review consulting process like RAP/RPS. Initially based on the AMA Special Essentials for Family Practice Residencies, the RAP criteria, developed by the RAP consultants, were peer-based, criterion referenced, and confidential. The emphasis was on the RAP criteria as the basis of consultations, not on the Accreditation Council for Graduate Medical Education (ACGME) criteria. The RAP Criteria for Excellence (CfE), codified in 1978 and regularly edited by a panel of RAP consultants, serves as an independent (from ACGME) set of criteria for program improvement recommendations. Interest in developing their own discipline-specific CfE has emerged from other disciplines (eg, physician assistants, obstetrics and gynecology, internal medicine, and surgery). Beyond the United States, the global impact of the RAP/RPS is evident as CfE has been translated into Spanish, Russian, and Japanese to be used for quality improvement and to guide curriculum in family medicine.

RAP/RPS played a key role in the development of family medicine in the United States and continues to guide residency education excellence. We hope this editorial gives valuable insight into the early days of FM. Many others helped build family medicine and we invite comments, anecdotes, or remembrances from them in response to this editorial, to further preserve the history of family medicine in the United States.

AUTHOR NOTES

Dr Robert L. Graham was Assistant Education Division Director of the AAFP (1973–1975) and later Executive Vice President of both the AAFP (1985–2000) and AAFP Foundation (1988–1997) and after whom the Washington-based Robert Graham Center was named.

Dr Daniel J. Ostergaard was Assistant Director (1976–78) and then Director (1981–83) of the AAFP Division of Education after which he continued as a full-time staff Vice President with varied portfolios including Education, International, and Interprofessional Activities (1983–2013).

Dr Norman B. Kahn, Jr, was initially the Director of AAFP Education Division, then Vice President for Education and Science (1999–2007), and later Executive Vice President/Chief Executive Officer for the Council of Medical Specialty Societies (2008–2018).

Ms Kelly Heide, MLS, is the archivist for the Center for the History of Family Medicine in Leawood, Kansas.

ACKNOWLEDGMENTS

The authors thank Nathaniel Javid, BA, Administrative Specialist in the Research Division of the University of Wisconsin Department of Family Medicine and Community Health for his technical help in preparing this manuscript.

REFERENCES

1. Flexner A. *Medical Education in the United States and Canada: A Report to the Carnegie Foundation for the Advancement of*

- Teaching*. Bulletin No. 4. New York, NY: Carnegie Foundation for the Advancement of Teaching. 1910. Accessed May 13, 2026. http://archive.carnegiefoundation.org/publications/pdfs/elibrary/Carnegie_Flexner_Report.pdf
2. Citizens Commission on Graduate Medical Education [John Millis, Chair]. *The Graduate Education of Physicians*. American Medical Association; 1966.
 3. Carek PJ, Anim T, Conry C, et al. Residency training in family medicine: a history of innovation and program support. *Fam Med*. 2017;49(4):275–281.
 4. Willard WR, ed. *Meeting the Challenge of Family Practice: Report of the Ad Hoc Committee on Education for Family Practice of the Council on Medical Education*. American Medical Association; 1966.
 5. National Commission on Community Health Services. *National Commission on Community Health Services. Health Is a Community Affair: Report of the National Commission on Community Health Services*. Harvard University Press; 1967.
 6. Adams DP. A brief history of the American Board of Family Practice: the second annual memorial lecture. *J Am Board Fam Pract*. 1996;9(2):109–113.
 7. Adams DP. *American Board of Family Practice: A History*. American Board of Family Practice; 1999.
 8. Bishop M. S. *STFM: The First 25 Years - Celebrating Our Past, Creating Our Future*. Society of Teachers of Family Medicine; April 1992.
 9. Video Interview With Dr Thomas Stern by Dr Dan Ostergaard. Center for the History of Family Medicine: Oral History Collection. [Recorded January 26, 2003]. Accessed June 4, 2026. https://centerforthehistoryoffamilymedicine.aviaryplatform.com/collections/2195/collection_resources/162457