

Voices From Family Medicine: Thomas Leaman

John J. Frey, MD; William B. Ventres, MD, MA

Thomas Leaman's relationship with the community of Hershey, Pa., extends over a period of 42 years. He began his commitment to that small central Pennsylvania community as one of its doctors; later he served as the first chair of the Department of Community and Family Medicine at the Pennsylvania State University School of Medicine in Hershey. He chaired the department from 1967 to 1987 and has been professor emeritus since that time.

Dr. Leaman was president of the Society of Teachers of Family Medicine in 1982 and has continued to have an active role in many aspects of the Society, including the Long Range Planning and Medical Records Committees. He also served as a founding member of the Association of Departments of Family Medicine. This article is edited from interviews that occurred in May 1991 and July 1992.

(Fam Med 1992; 24:544-7)

A lot of people decide they want to go into medicine and then take that direction. I didn't. I backed into it. I went off to college to study business administration because my dad was a grocer. I later got interested in psychology because I read a book on abnormal psychology and decided that I wanted to be a psychiatrist. Then I talked to a psychiatrist and found out you had to have an MD. I got a C in my first college chemistry course—I never had gotten a C in anything before—so I thought I couldn't be a doctor. I would be a psychologist. About then I got drafted. The Army asked me what I wanted to study, and I said psychology. They sent me to Baylor in Waco, Tex., for a pre-engineering course that was pretty much liberal arts.

When I finished that, they said, "Now you can stay in pre-med if you like or you can go back to the troops." Pre-med sounded pretty good, and by then, I had done well in chemistry and organic chemistry. I went on to medical school and lost all interest in psychiatry.

My training was as a general practitioner. In 1948, I did a 1-year internship in Lancaster and was looking for a place to practice. One of the senior surgeons in Lancaster told me about the town of Hershey, about 35 miles away, where they needed a doctor. I had already looked at my home town of Lititz, Pa., and decided I didn't want to practice there. Hershey looked very good to my wife and me. Both of us came from

small towns; it's where we wanted to live and raise our kids.

One doctor in Hershey was in the process of retiring, and he agreed to turn his practice over to me. So we went there, rented an office, and just opened the doors. Hershey had fewer than 5,000 people then. There were only three or four other doctors in town, and we were just overrun by patients.

I had a small office and house right next to the hospital. It was a small hospital, about 35 beds. It handled about 600 deliveries a year, and surgeons came up from Lancaster or Harrisburg to do surgery. After a year or two I moved into my predecessor's office. I inherited all his medications, including 75 gallons of some kind of cough syrup with morphine that I poured down the drain because I didn't know what it was and was afraid to use it. He had passed the word around that I was a wonderful doctor. His



favorite expression to his patients was: "He's so good he ought to be in medical school."

I had accumulated a lot of debts by this point. I had one jacket and two pairs of pants. When the jacket went to the cleaners, I didn't wear a jacket. But the practice grew fairly rapidly. I got called back into the service during the Korean War and went off for 2 years. When I came back, some patients came back and some did not. I worked at the emergency room in the chocolate factory for a while until the practice built up again. It did, but then it got too large.

I was in solo practice all the time. I guess I liked to be in charge. I sensed that if there was no one I was going to see eye to eye with, I would rather do it myself. I would never do that again—it's not a decent way to live. Three or four other doctors in town agreed to an on-call system for coverage if we were out of town. But on our days off or at night, if we were in town, we would see our own patients.

Practice in a rural community in the 1950s was different from that of new physicians in the 1990s. The nature of practice was a small business, full of demands and rewards, very much dependent on the ability of doctors to build trusting relationships with their communities and patients. The rewards were more interpersonal than economic.

The biggest challenge was trying to keep up with a difficult schedule. I took Wednesdays and Sundays off, had Saturday morning and Saturday evening hours, but took Saturday afternoons off. After awhile, my wife successfully talked me out of having Saturday evening hours, and I was down to office hours only 4 nights a week. I would start at 8 a.m. and work through until 11 a.m. and then make four house calls before lunch, depending on how far out they were. I came back to the office at 1 p.m. and worked until 5 p.m. I went back to the office again at 7 p.m. I loved it; I felt good. I thrived on the busy-ness of it.

In retrospect, I really did not have much family time. To be more a part of the family, I always had the office and the house together. But there were too many days off when I would have a delivery, too many family times that got interrupted by some kind of emergency. I tried, when I was not seeing patients, to be there with my family. I didn't golf or do anything else that would take me away from family; I just did things that we could do together, whether it was mowing the grass, going on a picnic, or whatever. So that was good.

As far as taking care of myself, I didn't do very much of that. On a day off, I knew I was going to see half a dozen patients, so I would just pool them in the afternoon. Even on quiet days, I risked getting disturbed. I thrived on being extremely busy and needing very little sleep. I got a big charge out of being busy.

.....

I didn't mind getting up at night. It never bothered me. I had the feeling it was important to the person who called, and that made it worth doing. Even if it didn't sound important, I could be wrong. Early on in practice, a family called about 2 a.m., said that their mother was sick, and asked if I could make a house call. I asked what the trouble was, and they said she had a cold. I gave her an appointment first thing in the morning. They called back 15 minutes later, and I asked again what the trouble was. "Well, she has this cold," they said. I said that I would come by before office hours. Fifteen minutes later they called a third time. "Come see Mom," they said. By then I was getting angry, which is not easy for me. When I arrived, the whole family was gathered around the bedside. The woman was in pulmonary edema. All they could tell me was that she had a cough, and to them that was a cold. We hauled her off to the hospital, and she died. Had I been a little smarter or asked the right questions or not even argued, it wouldn't have made a difference, but I would have felt better about it.

.....

I have been deeply involved with patients—this is my choice. One woman, a widow, remarried and asked me to come give her away. I did that. Later, before she and her new husband died, they asked me to be the executor of their estate, which they wanted to turn over to the Lutheran Church. And I did that.

Another woman, a simple country person, had all kinds of complaints and would call day and night. She would talk with my wife, Jeanne, or me, but she had to talk to somebody. Her husband had died, she had a little child, and she was living with another man, but they weren't married. That bothered her. She felt guilty about it. I said, "Well, why don't you marry him?" She said she couldn't because then she wouldn't get Social Security. We talked over a period of time, and I said, "You know, you've got to marry him." Finally one day she said, "All right, I'll get married." I suggested they make arrangements with the justice of the peace. She said, "Oh no. It's too important. It has to be in a church." She didn't have a church but knew I did, so I said, "Okay, I'll make the arrangements." I called the Episcopal priest, and he agreed to marry them. Jeanne and I were the witnesses, and our daughter played the organ.

Another patient with amyotrophic lateral sclerosis was married to a man who never learned to read or write. When he died, she asked me to conduct the funeral service. I did.

I think people basically want to trust their physicians. They want somebody who cares for them. If

you really do care, they accept it. To me, the most joyous part of having a practice is interacting with people on a trusting basis—they trusting that I care.

After about 10 years in practice, Dr. Leaman began to think differently about his practice and his work.

I saw so many people with things that could have been prevented. A lot of this was related to how they lived their lives. Some of their problems had to do with what I saw as stress in their lives, but I didn't know what to do about it. I was getting interested in what I then called the psychological aspects of people. Then I found this book by Michael Balint, *The Doctor, His Patient, and the Illness*.¹

When I later went overseas, one of the things I wanted to do was meet Michael Balint. I called Balint and went with my daughter to see him at his home. We had tea with him and his wife, Enid. I asked him to allow me to come to one of his sessions. He was very reluctant because it interfered with the dynamics of the session. But seeing as I had come all this way, he allowed me to attend a couple of sessions. He introduced me, and I stayed outside of the circle of participants. Afterwards, though, I went to the pub with a couple of doctors and discussed what had happened.

.....

In the summer of 1964, we took a month off and took our kids out West. On the way back, we passed a newsstand and there was this big headline: "Medical Center to be Built in Hershey." It just boggled my mind. It turned out that the Milton S. Hershey Foundation had told Penn State University it would build a medical center in Hershey and give \$50 million, a huge amount of money, toward its development.

A year or two before this, I was beginning to feel a little guilty. Here I was in practice. I had finally paid off my debts, and things were going well. I wondered whether maybe I ought to be in some underdeveloped country where there was more need. I went on a church retreat and asked for time to meet with my bishop. I told him this whole thing, and he said, "If God wants you to be someplace, He'd have to let you know." When I saw that headline, I thought, "Ah ha! There's something else for me here in Hershey."

The new dean was George Harrell, who had founded a medical school in Florida before. He was a very intellectual guy who saw the broad picture and had a sense that medicine ought to be people focused. When he started the school at Hershey, he wanted a department of family and community medicine, a department of medical humanities, and a department of behavioral sciences. All three of those were new.

The Pennsylvania Academy of Family Physicians appointed Ed Kowalewsky and me as liaisons to go

meet with the new dean. The dean was located in a farmhouse, which is still behind the medical center. We made an appointment and went out to meet with him. It was a memorable ride—it was spring, and we drove out across a field newly spread with manure. Ed said, "Tom, remember this. It may be significant."

We met with George Harrell and complained that there weren't any family doctors because medical schools didn't teach family medicine. He sat there, listened to the whole thing, and said, "Well, if you're really serious, I plan to start the first department of family medicine in the country, and you could join it." Then he added, "There are three conditions: One, you have to work at an academic salary; two, you have to bring your practice with you; and three, you must get a year's experience working with medical students and residents before you come on board." I went home and thought about it. The more I thought, the more excited I got. When Jeanne realized what this was all about and what I wanted to do, she was completely in favor of it. The kids were very supportive, and that was a big help.

Only I couldn't leave my practice; there was no one else to take care of my patients. I went back to see the dean again. He said all I had to do was find someone who wanted to do the same thing. One person would stay and take care of the practice while the other went off for 3 months, then the roles would be reversed. I couldn't find anyone else in town who would consider it.

I then talked with Hiram Wiest, whom I had known in internship, and he got interested. Finally he called and said, "Damn you, Tom Leaman. We've got to do this." He sold his house and moved to Hershey with his five kids. We formed a legal partnership. We practiced together for 1 day, February 28, 1966. The following day, I went to my alma mater, George Washington University, and signed on as a first-year medical resident. At that point, we had four children. I had been in practice for 17 years and was in my early forties.

I was a resident for 3 months. Hiram ran the practice and supported both families. I came back, and he went to Penn for 3 months. I later went to St. Christopher's Hospital for Children in Philadelphia and spent 3 months going to places like Miami, to see Lynn Carmichael, and to Harvard and McGill. The dean said that one block of time should be overseas, so I also went to England. Seven or eight schools over there were beginning to do things. They had not really done much; it was mostly talk.

All of this was done at our own expense. The academic salary, which sounded great at first, turned out to be \$25,000. I had been netting \$54,000. I just couldn't do it. Jeanne and I struggled and struggled with this. I went back to the dean prepared to bargain for \$28,000. Before I made my offer, he offered me \$30,000. I never told him.

I never thought of this decision as a risk. My friends all talked about the risk, but I was sure that it had to work. I was sure that the best way to practice was family practice and that a lot of people wanted to do it. Part of my comfort was being able to continue in my same practice; I didn't need to start over. Hiram had to start with a new group of patients, and that was a lot harder.

We started in September 1967, practicing in my office with students there. When the dean designed the school, he translated philosophy into architecture. He put family medicine on the first floor between the medical school and the hospital, right across from the library. It was a small space that included eight examining rooms, some offices, and a tiny waiting room, but it was a focal point. The dean told me later that he never thought the specialty of family practice was going to get board certification, only that we would remain an important demonstration project.

I was really green. I had no idea about curriculum or anything. Early on, we had a curriculum committee meeting up at the farmhouse. There was no hospital yet. It was just the basic science people and me. They asked how many curriculum hours I needed. I had no idea. I said 17, and they said that sounded reasonable and put it down. Later, I realized I didn't know if that meant 17 a week, a month, or a term.

If continuity of care over time is a central theme in family medicine, essential to the teaching and work of family practice, then Dr. Leaman's care of the patients in Hershey is a model of what can be done with perseverance, support from family and patients, and



a sense of responsibility to community. Here he reflects on the issues of practicing and teaching in the same community for 40 years.

I have never felt uneasy about the choice for me personally or about the right-ness of what we were trying to teach. I have been enormously pleased with the people who have come out the other side. There are exceptions, people who are well-trained technically but who are money focused and production oriented.

My commitment is service to people. To me, it is a Christian commitment. Medicine is one of the ways to do that. My church is very important to me—not the formal church, but the spiritual belief behind it. That provided me with a sense of direction. Still, being in church renews me. It's not free of medicine in the sense that most of the people in the parish are my patients, but it is a place where I can go and feel great nourishment. I have come to love the people in that group.

I am a serving person first and a physician second. I care deeply about people. I've learned that there are patients I literally don't like, though that is unusual. I've also discovered that I can learn to love the people I dislike the most—if I get to know them well enough. Family practice is a wonderful way to get to know people better, ask them anything, be with them during all kinds of moments.

The joy of practice, to me, has been the ongoing relationships, some of which have taken a long time to ripen. I am fascinated by what has gone on with families during the span of my lifetime, the changes I have been part of. As I look back, there were times I made a significant difference. There were times when I should have made a difference and didn't. But that's what makes this type of practice, family practice, a fascinating way to live and work. It's made for a very interesting life.

Corresponding Author: Address correspondence to Dr. Ventres, Department of Family and Community Medicine, Arizona Health Sciences Center, 1501 N. Campbell Ave., Tucson, AZ 85724.

REFERENCES

1. Balint M. The doctor, his patient, and the illness. New York: International Universities Press, 1957.