

## Voices From Family Medicine: Lynn Carmichael

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

*Now that the 25th anniversary of the Society of Teachers of Family Medicine is upon us, educators are likely to look back at the history, which set the stage for family medicine. This is a history replete with reports, politics, and ultimately, the development of family practice training programs. It is a history, as well, made through the labors of individuals. The vantage points we have chosen to examine in this series are those of some of the people who lent their efforts to the founding of family medicine.*

*Common personal needs prompted us to explore these vantage points. Although we are at different points in our professional trajectories—one of us is a recent graduate from residency and fellowship training, the other has many years of experience as a teacher and journal editor—the same themes emerged in our self-explorations. Where do we fit into the family medicine movement? What satisfaction do we get out of our day-to-day routines of practice, teaching, and research? What meaning sustains our activities in the discipline?*

*To help answer these questions, we looked to some of the leaders of family medicine. In this transcript, an abridged and edited version of interviews conducted in April and May of 1991, Lynn Carmichael, MD, discusses his involvement with the founding of family medicine, his perspectives on the importance of family practice, and his thoughts and concerns about the future. Dr. Carmichael is professor and founding chair of the Department of Family Medicine at the University of Miami School of Medicine. He was the first president of the Society of Teachers of Family Medicine, the founding editor of Family Medicine (then Family Medicine Teacher), and the initial recipient of the STFM Certificate of Excellence in 1978.*

(Fam Med 1992; 24:53-7)

My involvement with family practice goes back to my childhood in the 1930s. I was raised in Mooresville, Indiana, a small town of roughly 2,000 people. We had a family doctor there, Dr. Kenneth Comer. Some of my earliest remembrances, my first really positive feelings, were about this family doctor. He made a pet out of me and was always available whenever I had a problem.

I wanted to be like this man. I wanted to be a family doctor. I knew there were specialists because I remember my sister had an appendectomy. But specialists were different. They weren't your doctor. To be a doctor was to be a family doctor.

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I went to the University of Louisville Medical School. The University of Louisville had a tradition of turning out doctors who worked in Kentucky, particularly in the hills of Appalachia. My desire to be a family doctor was reinforced by this and the fact that most of my friends

shared the goal of becoming generalists. Since the Korean War was on when I graduated, I went into an army internship at Brooke Army Hospital in San Antonio, Texas. After a year, I was sent to the Far East and was a battalion surgeon in an infantry regiment. This was toward the end of the Korean hostilities, around the time of Pork Chop Hill. I caught the tail end of the war and ended up staying for a while. I came back to the States in 1954.



From the Department of Family and Community Medicine, University of Arizona (Dr. Ventres), and the Department of Family Medicine, University of North Carolina (Dr. Frey).

*Upon returning to the States, Dr. Carmichael married his wife, Joan, and moved to Miami, Fla. He sought out a location to gain the skills of general practice. What he found was Kendall Hospital.*

I realized that my experience in Korea really hadn't done much to prepare me to be a doctor of any kind in the civilian sense. At that time, there were no training programs for family doctors, so I looked for other options. Kendall Hospital was operated under county management, principally for the benefit of the indigent people who lived in southern Dade County. There was a fairly large indigent population down there, largely because of agriculture. Most were farmworkers. Most were black. They were very poor. And there was this little 125-bed hospital, really out in the country. I went there.

At Kendall there was no full-time staff other than the house officers. There were five of us. We delivered the babies; we kept a clinic going 24 hours a day; we took care of the patients in the hospital. For specialty care we were dependent on voluntary physicians who drove the hour down from Miami. It was like being back in a war situation again. It was a frontline activity, and you never knew what was coming through the door. We really learned by doing. We had some incredible experiences.

*Kendall Hospital was eventually closed in the late 1960s and was absorbed into the South Dade Community Health Center, one of the teaching sites for the University of Miami Family Practice Residency Program in the 1970s and 1980s.*

In 1955, I took over the practice of a physician who had been drafted and entered into solo practice in Coconut Grove, an urban area of Miami. That practice continues now. It's moved a few times, but it's within a mile or so of where it's always been. For 10 years, I was in full-time family practice. Looking back, I probably did more for more people there than any other time in my life.

One of the first things I found out in practice was that nobody really knew what family practice was. When I took over the practice, I didn't know quite what to expect. I thought it would be kind of like an emergency room. People would come in; I'd take care of them, and that would be it. Over time I realized that there were whole other dimensions to family practice. First of all, people didn't usually come in alone. Usually somebody came with them. Most often it was a family member: a daughter with her elderly mother, a child with his parents, a couple. It could be a whole group of people. I learned very quickly that I could focus on the person but that the individual's family and social relationships were very important, and I had to include them as well. At first I thought, "This is a small examining room and I don't want these people in here." What I found out was not only couldn't I keep them out, I didn't want to keep them out. They were too valuable a source of information, too valuable a resource for whatever plans we would work out.

The next thing I learned was that people came back to see me. I was developing a continuing relationship with them. This continuing relationship wasn't focused on diseases or problems because my patients kept coming in

with different kinds of problems. My patients were what I was taking care of, not their particular illnesses. This was a revelation to me. I had, like most people in medicine, been raised with the idea that diseases existed and that our job was to treat diseases. I found out that diseases don't exist. What exist are people who have different kinds of health problems. We don't treat diseases; we take care of people. We label them with a disease name as a way of simplifying it. It always bothers me to read an article about, say, the recent advances in the treatment of hypertension. How can you treat hypertension when hypertension is an abstraction? It's no more than a label. What you treat are people who have hypertension. And because people are very different from each other, the treatments are never the same. So I began to look at the person and not at the disease.

The development of a personal relationship with these people was the next step. I came to know each of my patients as a person. I became close to them. I found that I didn't want them to be sick. Where in medical school we were looking around for people with various kinds of diseases to get excited about, I was now finding I didn't want to see these things. I didn't want to see these kinds of problems arise in people I really liked. Disease was no longer an interesting detective story; it was a tragedy. As this became apparent, I remember shifting my clinical emphasis, trying to do things that might prevent problems. I became much more aggressive in doing Pap tests, for example.

This personal relationship I developed with patients was based on familiarity. Later on I defined that family relationship as having four components: affinity, intimacy, reciprocity, and continuity.<sup>1</sup> Affinity meant that there was some sort of bonding between the patient and the doctor. This bonding led to a degree of intimacy, of openness between the doctor and the patient. In many ways, the intimacy was actually mediated through physical touch. Reciprocity signified a sense of trust between the doctor and the patient. The patient trusts the doctor, and the doctor trusts the patient. That reciprocity led to a certain amount of continuity, built on the expectation that each person was going to be there in the future.

These four components characterize the relationship of a family. When I talk about family medicine or family practice or whatever it might be, I'm not talking about the family as a unit. I certainly see that we're very social animals and the family's involved in that. But the meaning of family in family medicine, to me, is not that the family is the unit of care as much as it is the process of care. It characterizes that type of relationship that you have with a person, a family-type relationship. What a family physician does is attempt to establish that kind of relationship with a person. As I looked around at the world in the '50s and '60s, it seemed to me that there was a great need for this kind of doctor. But there were practically no new people coming into it. General practice was going to disappear and with it the opportunities to practice this type of medicine.

*Dr. Carmichael decided to become involved with the medical community and was appointed to the board of the local teaching hospital, Jackson Memorial Hospital. He*

*approached the dean of the University of Miami School of Medicine, Hayden Nicholson, and encouraged him to begin a venture in training physicians for general medical practice. Nicholson responded: He couldn't do much about it.*

I began to correspond with others around the country. There were some stirrings in the literature, not so much in the articles but in letters to the editor: "Who's going to take care of the people?" "Why don't we get training programs going?" I recall reading Bob Haggerty's editorial in the *New England Journal of Medicine* about the Family Health Care Program at the Harvard Medical School.<sup>2</sup> I'd read about their fellowship program. So in 1962, I went up to Boston to take a one-week course in adolescent medicine and met with Dr. Haggerty, a pediatrician. We really hit it off. I said, "I'd like to come spend a year with you." He said, "Fine, we can pay you \$7,500." I had three kids, two cars, a house, a dog, a practice, and I didn't see how I could manage it. But somehow I did it.

I went there and spent the year. It was really glorious. While in Boston, I attempted to develop a program for teaching family medicine. That led to my first publication in the discipline, "Teaching Family Medicine," in *JAMA* in 1965.<sup>3</sup> I also had the opportunity to travel around the country. I went to the University of Kentucky and met Ed Pellegrino and Nick Pisacano. I went to the first WONCA meeting in Montreal and met Reg Perkin, now the executive director of the Canadian College of Family Physicians. I went to the University of Vermont and met Kerr White. And George Silver in the Bronx. He had written a book called *Family Health Care* based on his experience with a demonstration health maintenance organization at Montefiore Hospital.<sup>4</sup> It was a heady time for me.

I came back to Miami in the middle of 1964 knowing what I wanted to do, but I still had to find some way of doing it. I met with the dean again. Again he was very encouraging but said, "We have no money for this kind of thing." We wrote a grant to the Kellogg Foundation, and they weren't able to support it. Then a patient of mine who had been active in the Woman's Cancer Association at the University of Miami offered to help with some extra money. They gave us a grant for \$37,500, which was to last us for two-and-a-half years. With that we were taken into the medical school.

I joined the faculty of the medical school and became the first family doctor who went into a medical school to teach about family practice. On March 1, 1965, we started our student program. In the spring of 1966, Jackson Memorial Hospital decided to eliminate its rotating internships and link incoming interns to various medical specialties. Six interns were left with no place to assign them. So we designed a program for them that was a rotating internship plus a half a day a week in our model family practice unit, where they would learn what it was to be a family physician under the supervision of family doctors.

*Concomitant to Dr. Carmichael's work in south Florida, events promoting the establishment of family practice were occurring nationwide. In 1966, two committees of the American Medical Association issued reports endorsing the idea of specialized training for family physicians.*

*The Willard Committee discussed the preparation of training programs in family practice;<sup>5</sup> the Millis Commission focused on graduate medical education but discussed the preparation of a personal physician to provide general medical care.<sup>6</sup>*

It's probably good to see these reports in the context of the times. If you look back on the early '60s, it was a time of ferment. The country was affluent, and it looked like nothing was impossible. People believed in social progress. The civil rights movement was gaining momentum; there was the very beginning of the women's movement with a book called *The Potential of Woman*;<sup>7</sup> there was attention being paid to disadvantaged groups like migrant workers. It was a very optimistic time. It was a time in which people were discouraged with the way things had been in the past, willing to take chances about the future. The changes in medical education were simply part of changes that were occurring throughout our society.

With these two reports, the AMA's Council on Medical Education was empowered to go out and develop family practice. Bill Ruhe, the vice president for education within the AMA, was given the charge to recruit an individual who would publicize this mission around the country. I was interviewed for this job, as was Leland Blanchard. We were both hired half-time. Lee Blanchard had been moving in the same direction as I but in California. He had worked mainly trying to modernize the American Academy of General Practice. Lee took the western part of the country, and I took the eastern part of the country. Our job was to go out and develop family practice residency training programs so that there could be a critical mass that we could then take to the American Board of Medical Specialties to see if we couldn't get specialty and board status developed.

Lee and I ran all over the place. We went to AAGP meetings. We went to AMA meetings. At one of these meetings, we became acquainted with Ward Darley, who had been the dean of the University of Colorado School of Medicine and more recently was the president of the Association of American Medical Colleges. When we all met, the AAMC was in the process of restructuring its organization, adding a Council of Academic Societies. Ward said, "You know, for family practice really to go, you're going to have to have an academic society. You need to be in the existing power structure." That to me made an incredible amount of sense. I decided I was going to form an academic society. I decided on a name for it. We would call this the Society of Teachers of Family Medicine.

With the AMA's financial support, we sent off letters saying that we were going to start a society and wanted participation in it. We began to get letters back. Gradually the interest list grew and grew and grew until there were several hundred names in it. We set up a meeting to be held in New York City at the time of the American Medical Association meeting there. Everybody got together in a room--a number of people who are now very senior in family medicine were involved--and we talked about forming the Society of Teachers of Family Medicine. All the people there were going to be members; all they needed to join was five bucks.

That was the inception of the Society. The impetus was political. It was to create an academic society for placement on the Council of Academic Societies. This would give family practice academic representation, like the Academy was giving it professional representation and the American Board of Family Practice, to be developed, would give it a certifying mechanism.

Lee Blanchard and I continued to work with the AMA and the Council on Medical Education. We drew up the first special requirements for training in family medicine, then a pretty loose and permissive kind of document. We set up a residency review committee and brought people onto this committee. In December of 1968, at the AMA's winter meeting in Miami, this committee approved the initial 16 residency programs. We then went to the American Board of Medical Specialties and petitioned for representation as the American Board of Family Practice. That happened the next year, in February of 1969.

*Dr. Carmichael's work to lay the foundations of family medicine has encouraged him to think about its place within a larger social and professional context.*

Family medicine developed as a social movement, a reform movement within medical education and the delivery of care. Just like other reform movements or revolutions, at first people opposed it. When they found they couldn't destroy it, they then attempted to co-opt it. Family medicine and family practice, in all its dimensions, have been co-opted by a lot of the developments that have occurred within medicine. We are now seeing some of the fallout from that.

Physicians have become more and more interested in their own personal welfare and their own elitism, and the integrity of the profession has been compromised—it's become a commercial endeavor, a business. Medicine is no longer a profession; it's a trade. Whether we acknowledge it or not, we work for the medical-industrial complex. We're employed by them, directly or indirectly, and we become almost like a purchasing agent for them. We have an interest in the success of the company. You don't make money by holding somebody's hand. You make money by doing tests and putting them in the hospital.

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We practice medicine like we make war. Our country is so infatuated with technology and scientific discovery that we can spend any amount of money, incredible amounts of dollars, to get a 10% increase in performance. The consequences of our actions are just immense. Our technological triumphs can engender horrible outcomes. We make patients pay exorbitant amounts; we waste terrible dollars, all to satisfy the avarice and ego of a fairly small group of people, most of whom are either physicians or medical administrators.

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In dealing with medical students and residents, I find that they already share so many values with contemporary medical care that they're not about to change anything. They don't want to change it; they want to join it. It's been

very difficult for me to accept that. I keep saying, "Don't you want to make it better? Don't you want to change things?" But medical students or residents don't really want to be challenged. They want to find out how to conform.

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I have stopped using the term family medicine because that now characterizes a discipline within medicine, not a way of caring for people. My own interest has switched around to how we provide that care, rather than how we educate people for it. The basis for this is a conceptual framework that identifies a constituency-based, person-centered health care system.

The constituency base goes back to the very beginnings of my own practice when I found out that I cared for a constituency. As a physician, you identify the people you serve and look at the needs and interests of that constituency. You then are going to have continuity of care between that constituency and the deliverers of the care. This continuity needs to extend throughout the patient's involvement with the system; we don't have this now. We talk about primary, secondary, and tertiary care sectors, but these are bad descriptions. There's no flow of information among these sectors. There's no coordination of the patient's needs. So you start with a constituency. What flows from it is continuity. What flows from continuity is the generalist, promoting prevention and health maintenance.

The second part is person-centered. Living things have an innate ability to repair themselves up to a certain point, and then at a certain point they don't work any more, and they die. There's a momentum to life that wants to keep it living. We do know that many things affect individuals' abilities to heal themselves: for example, nutrition, other problems, the weather, and relationships with other human beings. We also acknowledge that there is an ultimate limitation to self-healing, that death really is inevitable.



We, in error, often refer to physicians as being healers. Physicians have never healed anyone but themselves. The only person who does any healing is the individual; the real healers are the patients. The goal of the physician should be to do whatever is necessary to enhance individuals' abilities to heal themselves. As a final task, a physician can give people permission to turn off their healing powers and die. That's what I mean by person-centered medicine. It's not dependent on a particular type of physician. It's dependent on interaction between human beings.

I see family practice or family medicine as simply a means to this end. As long as we're achieving constituency-based, person-centered health care, that's fine. If we're not, then let's move on to other places.

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I've been identified as an outsider or maybe a nonconformist. I don't see myself that way but just see myself as being different. I get impatient, and I sometimes get too vocal when I see things that don't fit with the way I think they ought to be done. Many times I'm not correct and find out that it was a good thing they didn't do it my way. While I don't see myself as an outsider, I can't quite give up and compromise what I think should be done.

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Remember the book *The Joy of Sex*? I would like to write a book, *The Joy of Family Practice*. There is a tremendous amount of gratification and satisfaction that can come from this kind of medical practice. We as physicians have the opportunity to develop the doctor-patient relationship to an incredible degree. It's really an incredibly fulfilling undertaking, and it makes it worthwhile to get up in the middle of the night to go out and see somebody or to spend the time necessary and do whatever

you can to help people. It gets back to the family--it's a way of becoming part of that person's family. That to me is more important than the salary, the benefits, and the prestige of being a doctor, and I think it's much more sustaining.

You can find this gratification anywhere there are people, in whatever setting, whether it's in a community health center or a golden ghetto, wherever. While we talk about a doctor glut, of having too many of this or too many of that, physicians who are seriously interested in doing family practice are inevitably successful and enjoy their work, and the people they serve benefit from it. I think the most important things I ever did, both for others and for myself, were when I was in my original family practice situation. Looking back on it with almost 30 years' perspective, I'm not sure I did the right thing. Maybe I should have stayed there.

*Corresponding Author:* Address correspondence to Dr. Ventres, Department of Family and Community Medicine, Arizona Health Sciences Center, 1450 N. Cherry St., Tucson, AZ 85724.

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