

Voices From Family Medicine: Cooperation Across Disciplines

William B. Ventres, MD, MA; John J. Frey, MD; Alfred O. Berg, MD, MPH

A variety of individuals lent their efforts to the establishment of family medicine as an academic discipline. Many had careers outside general or family practice, yet because of their interests and active involvement, they helped forge the way toward a rational and comprehensive education for family physicians in this country. In this transcript, edited from interviews conducted in 1992, four contributors from other disciplines discuss their perspectives on the history of family medicine.

(Fam Med 1992; 24:618-22)

Richard Magraw, MD

*Dr. Magraw has had various professional identities. He has had postgraduate training in surgery, psychiatry, neurology, and internal medicine. Although Dr. Magraw's eclectic professional background distanced him from the traditional academic mainstream, it also enabled him to grasp, early in the 1950s, the need for refocusing medical education toward the development of primary care. His subsequent work culminated in the 1966 publication *Ferment in Medicine*,¹ a book many consider the blueprint for the establishment of family practice. Dr. Magraw recently retired as the chief of psychiatry at the Minneapolis Veterans Administration Hospital.*

After finishing two years of a surgical internship and residency in 1944, I went to northern Minnesota to join what was then a unique, co-op medical practice, the kind that's described in the book *The Citadel*.² I became immediately involved in a busy general practice with a surgical orientation. I was highly committed to this.

I remember explaining to my wife what the practice was like. I would come home and say, "I've been acting all day." This was my best way of describing how I strove to play an appropriate role with each of the patients who came in. I didn't know very much,

explicitly, about the psychological dimensions of practice, yet they loomed large. It was a relief to have somebody come in with a laceration or something that was quite explicit. But the issue of communicating with patients, of understanding what patients were saying, was an arduous task and not entirely satisfactory. George Engel coined an epigram one time; he said that disease seldom fully defined illness. That was what I was discovering and what many doctors had discovered before me.

In 1947, I returned to the University of Minnesota. I came back to take a year of psychiatry but became immersed in it and ended up taking the full training. Still, I didn't want to commit myself to psychiatry because I had seen the real medicine—as the Africans say, I had seen the elephant—and that was rural general practice. Because of my psychiatric training, I was increasingly less able to see surgery as the be-all and end-all of things. Although removing a hot appendix is satisfying, for every patient like that you tend to have a waiting room full of people with more ambiguous kinds of things.

Medicine became enormously more fulfilling. The satisfaction I had formerly reserved for a "little Jack Horner" process of putting in your thumb and pulling out a plum of pathology now was available to me for almost every patient. I became quite a missionary about this. After the Korean War, I became the director of the medical clinics at the university and entered that position with the conviction that we needed to equip medical students with an awareness of the system and with the capacity to fill the role of primary physician.

From the Department of Family and Community Medicine, University of Arizona (Dr. Ventres), the Department of Family Medicine, University of North Carolina at Chapel Hill (Dr. Frey), and the Department of Family Medicine, University of Washington (Dr. Berg).

The university was seeking to reform its curriculum for medicine around 1958, and the new curriculum divided the senior year into two six-month segments. For six months, students were assigned to the comprehensive clinic program; we would now call it a model primary care clinic.

We put the students in the position of being primary doctors. We backed them up with a whole cadre of primary care staff and specialty consultants. The students followed their patients all the way through and were responsible for formulating treatment plans, communicating with the referring doctor, and tidying up the whole thing. The whole exercise was much more coherent and ongoing than the one-shot cameos on which students had previously based their educations. We were providing students with something they had never gotten: the capacity to deal with patients in their offices. We were inoculating them in ways that would enable them to tolerate ambiguity, to meet their patients' needs. I had a fervent belief in this because I'd seen lots of people go into practice and simply become mired in the human interactions of practice as opposed to the more mechanistic interactions of hospital medicine.

We also had sessions in which we helped the students understand what they were doing. When we attempted to find sources for the students' guidance, however, it became quickly apparent that there was no systematic presentation of the nature and purpose of medical practice. The academic staff was ill prepared to do this; many had never practiced in the community and didn't have a concept of it. Our best teachers were doctors who came back from practice for a refresher. We had special funding to pay them, and usually they'd come for a month. It was duck soup for them to pick up these patients and to articulate the principles of general practice. They would have truths to tell students that carried the ring of authenticity. When some obviously knowledgeable community practitioner talked with medical students, it was very, very reassuring and convinced many that general practice was really a professional job.

Retrospectively, the comprehensive clinic program was clearly part of a reform movement. With it, we were seeking to rehumanize medical education and medical care at a time when academics and third-party payers were going in the opposite direction, dealing with episodes of disease, fitting things into boxes that did harm to the actual facts. It was a successful experiment and went on for 10 years. The book *Ferment in Medicine* grew out of my experience with the program.

I was quite careful not to make the book an argument for family practice in a naked kind of way. But it was not just happenstance that it served as a basis for many people's ideas. I took great pains to point out that medical specialization was an inevitability and medical coordination a necessity. I identified family

practice as the first of the system-defined specialties. As opposed to the technology that undergirded radiology, or the anatomical special characteristics that undergirded ophthalmology, or what have you, the system needed family practice. I think that is still true.

Charles Odegaard, PhD

Dr. Odegaard, a historian by education, has been an important figure in the history of primary care medicine, beginning with his membership in the Citizens' Commission on Graduate Medical Education,³ better known as the Millis Commission. At the time, he was president of the University of Washington. Since serving on the Millis Commission, Dr. Odegaard has strongly championed generalist training, emphasizing a compassionate humanistic approach to working with patients. His recent book, Dear Doctor, has enjoyed wide readership in family medicine.⁴

The Millis Commission was appointed by the American Medical Association in 1963. I never discovered the inside details regarding how the Commission came about. I've always assumed that Jack Millis had an important role, as well as Dr. Leonard Larsen, the former president of the AMA. There were four physicians and seven nonphysicians. Jack Millis had a substantial interest in medicine, owing to his background at Case Western Reserve University, and proved to be an excellent chair. I especially enjoyed Ed Levi, provost at the University of Chicago, who had a dry wit about him, and the former head of the American Association for the Advancement of Science, Dael Wolfle. The lawyer on the committee was a former justice of the US Supreme Court, Charles Whittaker. They were all very competent people.

Between 1963 and 1966, we met six or eight times a year for two days in Chicago, generally at the Drake Hotel. All of us came from somewhat different positions, but we grew to a level of firm consistency with regard to the major issue that we wanted pushed: the shrinking number of general physicians. There were areas that we elected to set aside as secondary to this main problem. Ultimately, we wanted to be constructive.

The Millis Commission came into existence because of the friction between two generations of physicians. There was a generational shift that explained much of the problem. Most of those in the pre-World War II generation had merely a Flexnerian undergraduate medical education. They were less involved in postgraduate residency education than those in the post-World War II generation. With this intensification of specialization in the younger crowd, the older generalist physician felt that inadequate attention was being paid to some important things in practice that weren't taught in medical school.

It was the nonphysicians on the Commission who recognized how many aspects of practice were in-

creasingly neglected by the high-tech, specialized post-war versions of biomedicine that had developed in medical schools. It was this lay element that permitted the issue of primary medicine to develop. I don't know whether we invented the term "primary medicine." I've heard that Kerr White may have used it early on. I do know that general practice had become a dirty word. The Commission affirmed that we needed to see more medical school graduates interested in a general kind of practice, whatever you called it.

What did it take to develop the kind of primary medical care we were conceptualizing? We began by remembering what it was like to be patients. We couldn't help but stumble on the fact that there were important dimensions involved in primary practice that the medical curriculum of the time and the available graduate programs didn't deal with because they were fixed in the biomedical mode. It was one thing to say that we needed primary physicians, but we also needed a curriculum that prepared physicians to deal with people.

The report said two things. First, we needed a redistribution of energy on the part of all doctors to cover neglected aspects of patient problems, particularly regarding continuous comprehensive care. Second, we needed to train certain doctors in all they needed to know about patients and to help them develop the skills necessary for them to care for the ailments patients presented.

I don't think we have yet seen the result we hoped for. Doctors continue to live in ivory towers, indifferent to the growing public recognition of high costs and less-than-perfect results of the current medical system. I still think, however, that what the Millis Commission presented as primary care is a good definition of something that should characterize about 50% or 60% of the doctors in this country.

C.H. William Ruhe, MD

Dr. Ruhe was on the faculty of the University of Pittsburgh School of Medicine for 20 years, teaching physiology and pharmacology and serving as an associate dean. In 1960, he joined the staff of the American Medical Association. In his positions as secretary to the Ad Hoc Committee on Education for Family Practice⁵ and, later, as secretary of the Council of Medical Education, he played key roles in the development of family practice residencies. After subsequently serving the AMA in many professional capacities, Dr. Ruhe retired in 1982 as senior vice president for Educational and Scientific Affairs.

The state of general practice was a hot subject in the early 1960s. The Millis Commission was established in 1963 and, at about that same time, the National Health Council and American Public Health Association convened to report on the status of community physicians.⁶ The AMA's Council on Medical Educa-

tion was under a lot of pressure from the House of Delegates to push things along as rapidly as it could. Since there was no clear delineation of the content of family practice residency programs that could lead to eligibility for board certification, the council created the Ad Hoc Committee on Education for Family Practice, chaired by Bill Willard.

I was assigned the responsibility of being secretary to that Committee, and that's when I got right in on the discussions about starting up family practice. I lived with it daily, and it was a long and sometimes painful process.

It was often hard to tell who was your friend and who was your enemy. There were people beating on us from all sides. The traditional specialties were not at all favorable to the creation of a family practice specialty. Particularly opposed were the surgical disciplines, which questioned whether surgery was going to be included in approved family practice residency programs. And within the American Academy of General Practice, there was practically a knock-down drag-out fight at every meeting. Some general practitioners were adamantly opposed to having a specialty board because they felt the strength of general practice was that it wasn't a specialty. Others felt they could only reach parity with other groups through the definition of family practice as a specialty. It took a number of years for the tide to gradually turn internally within the AAGP and the AMA toward support of family practice.

I doubt that it could have been done any faster. There was a social change going on—the enormous growth of medical knowledge and its natural consequence, specialization—and that social change had to occur before family practice could emerge. As the knowledge base became great enough, people divided the practice of medicine into subdivisions. But this fragmentation, based on biomedical criteria, was leaving patients out in the cold.

I happened to be present when the representatives of internal medicine met with the Millis Commission and Jack Millis presented the concept of the primary physician. There were people from the American College of Physicians and the Society of Teachers of Internal Medicine, among other groups. All were distinguished faculty members from prestigious medical schools, people who by spirit, by instinct, saw themselves as prototype family physicians in the care of their own patients.

After Jack Millis made his presentation, he asked for their reactions. They were quite negative and said, "These are the things that every internist worthy of the name already does. We don't need another specialty." This was the first and only time I ever saw Jack Millis get really angry. He exploded; he blew his stack. "You people are hiding your heads in the sand. You don't realize what's going on in the world," he said. "You may take care of your own patients that way, but that

is not the way most new internists are practicing medicine these days. They're going immediately into subspecialties and sub-subspecialties. They're not functioning as family physicians. Something is going to have to be done to fill this void. If you people are not going to do it, then there's going to have to be another specialty."

The internists left angry and chastened but unconvinced. Yet some told me a few years later that it was time there was such a thing as family practice. They recognized that internal medicine was not the same discipline it had been and were reassured when the new family practice programs turned out to be well-conducted residencies in reputable institutions.

I recall with some pride the role I had in the development of the specialty. I was responsible for preparing the minutes of the Ad Hoc Willard Committee. These minutes formed the basis for the Committee report, which sought to form the template for the future of education for family practice. Later, after becoming secretary to the AMA's Council on Medical Education, I had the good fortune to hire Lee Blanchard and Lynn Carmichael as "ministers plenipotentiary," traveling missionaries for family medicine. They preached the gospel of family medicine every place they went and worked with directors of developing residency programs to help them meet the stated essentials of the Residency Review Committee.

The timing was quite precarious because so many things had to fall into place to make it work. We had to make sure that the right things would happen at the right time, that the right people would get on the program of the Congress of Medical Education and deliver the right speeches on the right occasions. We had to work on the people who were causing us problems. There was a lot of back-room persuasion and pounding on the table. I chose to grease the gears of family medicine because I believed in the whole movement. I still do. But there's a lot of work to be done yet.

Family practice ought to be an important part of the delivery of care in this country or any other country. We're vastly overspecialized and overfragmented. That is one of the big reasons I believe in family practice; we need a specialty in breadth that covers most of the major disciplines in which contact of physicians with family members occurs. A medical school cannot consider itself to be a modern medical school if it does not have a program in family medicine that is comparable in quality to those of all the other disciplines.

Donald Fink, MD

Dr. Fink was a founding member of the Society of Teachers of Family Medicine and played an important role in bridging the fields of pediatrics and family medicine. He was the director of pediatric clinics at

the University of California, San Francisco, in 1963. In 1971, he served as president of the Ambulatory Pediatric Association, one of the largest organizations of general and community pediatricians. He has been a member of the Society of Teachers of Family Medicine's Board and currently serves as its representative to the Council of Academic Societies.

In the book American Medicine and the Public Interest,⁷ historian Rosemary Stevens characterizes pediatrics as a specialty that originated as a social movement concerned with the well-being of children in society. In that sense, Dr. Fink's career models that of many other pediatricians who found an intellectual and philosophical home in family medicine during its founding period.

My father was in general practice in a neighborhood of Chicago for 57 years. I literally lived with a model of family practice because he had his office in part of the building where we lived. He got very good at the family dimensions of illness care and was the defender and coordinator of his patients' care.

Needless to say, general practice was not highly regarded at the University of Chicago, where I went to medical school. I chose pediatrics as the closest field that dealt with health and illness and the family. That type of practice seemed to me an enriching kind of medical practice. The chair at Chicago, F. Howell Wright, was an absolute generalist. He required that all of the faculty, even the subspecialists, have a well-baby clinic. He had one himself. As pediatric residents, we too had a continuity clinic of our own in our senior year. Wright said, "This is important stuff. We are interested in science and subspecialties, but let's keep our eye on the whole child." It was an incredible learning experience.

In 1962, I was invited to head the ambulatory care program at the University of California. I set about establishing a curriculum that included taking residents and students out to see normal kids in normal settings, helping them work with other people concerned about child and family health: teachers, social workers, and so on. I became involved as a consultant for Head Start, which got me out into the community, working with community groups. I became convinced that you can't just deal with a patient in the examining room, you've got to deal with the child in the context of the family and community. If I wanted to influence child health positively, I was going to have to work within a larger context.

We all knew from our own practices that this was needed and that it wasn't being provided in medical education, including pediatrics. Although pediatrics gave lip service to behavioral science, including psych rotations and psychological testing, there weren't many family systems views. There were other subspecialties, developmental pediatrics and child psychiatry, but these weren't in the mainstream.

In 1966, I helped develop a 12-week required ambulatory clerkship. It was called the family clinic. We had bright students who had been influenced by the free speech movement and did incredible case presentations. We didn't know it and they didn't know it, but we were teaching contextual medicine. The faculty was learning as much as the students were. It drew students interested in change. They were unhappy with how things had been and wanted to make them better. They were willing to make it up as they went along.

I began to meet other pediatricians, like Marc Hansen and Ken Reeb from Wisconsin, who were medical educators by design, into real-life experiences for students. By the time Lynn Carmichael organized the original STFM membership, a group of us pediatricians were strongly interested in the domain of family life. I have always felt that there was a greater congruence between pediatrics and family medicine than between family medicine and other disciplines.

In 1970, I made the decision to leave pediatrics and become director of the Division of Family Practice at UCSF. Our program was conceived originally as a program to train family physicians for urban underserved areas. We said family practice had just as much a place in urban as in rural areas. People have just as much uncoordinated and duplicative care in urban areas, where the need to care for low-income families is even greater.

When I came to the charter meeting of STFM, I didn't think family medicine was just for general

practitioners or family practitioners or pediatricians. I felt that anybody who wanted to care for people should understand family medicine. One of my greatest disappointments was when the Society became the academic organization for family practice residencies. I understand why this needed to be, but I hope that STFM will one day open its doors as an organization and say to others, "Come in and share in some family-oriented skills." I have preached that the contribution family practice will make to all of medicine is its way of looking at families. While other disciplines manage to avoid it, family medicine was and is something for all of medicine, not just for family practice.

Corresponding Author: Address correspondence to Dr. Ventres, Arizona Health Sciences Center, 1501 North Campbell Ave., Tucson, AZ 85724.

REFERENCES

1. Magraw RM. *Ferment in medicine: a study of the essence of medical practice and of its new dilemmas*. Philadelphia: Saunders, 1966.
2. Cronin AJ. *The citadel*. New York: Bantam Books, 1956.
3. Citizens Commission on Graduate Medical Education. *The graduate education of physicians*. Chicago: American Medical Association, 1966.
4. Odegaard CE. *Dear doctor: a personal letter to a physician*. Menlo Park, Calif.: Henry J. Kaiser Family Foundation, 1986.
5. AMA Ad Hoc Committee on Education for Family Practice. *Meeting the challenge of family practice*. Chicago: American Medical Association, 1966.
6. National Commission on Community Health Services. *Health is a community affair*. Cambridge, Mass.: Harvard University Press, 1967.
7. Stevens R. *American medicine and the public interest*. New Haven, Conn.: Yale University Press, 1971:219-20.