

Anniversary Series

Voices from Family Medicine: Eugene Farley

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This transcript is an abridged and edited version of interviews conducted with Eugene Farley, MD, MPH, in May 1991. It is the second in a series that looks into both the founding history of family medicine and the lives of those people who helped create the discipline. Dr. Farley is professor and chair of the Department of Family Medicine and Practice at the University of Wisconsin. In 1989, he received the STFM Recognition Award.

(Fam Med 1992; 24:152-5)

I always wanted to be a GP. I pictured myself being a rural practitioner in the mountains of Pennsylvania. Being a GP meant serving. Service was always what I wanted, in a rural area surrounded by mountains and country. All my image about medicine was in that role. I wanted to be needed. I wanted to go to an area where there weren't enough doctors and serve.

These were the values I grew up with. My father and mother were very community oriented and very much service oriented. There was the sense of helping people develop, get educated, and be able to go out and do.

In 1954, after finishing a rotating internship at Philadelphia General Hospital and the first year of a two-year general practice residency at the University of Colorado, Dr. Farley and his wife, also a general practitioner, became field medical officers in charge of the Navajo-Cornell Clinic, a research project and model clinic in Many Farms, Ariz.

Lindy and I had two fantastic years with the Navajo. It made us realize that we were not just taking care of a patient, we were taking care of a whole community, and that our job was prevention as well. We made a lot of hogan visits so we got used to carrying "medicine into the home." We had a community advisory committee. We worked with the medicine men. We did no hospital work but came to realize that only a very small percentage of the medical problems we saw in the population, in our 800-square-mile territory, required hospitalization. Our world opened up to possibilities for practicing community-oriented primary care.

Dr. Farley left Arizona for a year of residency in internal medicine at the University of Vermont. He and Linda then sought out a location to set up practice.

We specifically wanted to practice in an area where we could define the population so that we could do a longitudinal study like we were doing with the Navajo. We had great dreams of following a population for 20 or 30 years and looking at the evolution of their health and disease. Now when I make that statement, you realize, I didn't know beans about how to do it. But I was naive in those days and didn't know any better.

We entered a rural practice in Trumansburg, N.Y., a town of 1,300 in a one-hospital county. It was between two 40-mile-long lakes, so there was limited access. We were going to settle for life. Well, things happened while we were there, and six of the 11 doctors serving this big rural area died. They died because they were old, including my next-door neighbor who was 98 and still seeing probably five to 10 patients a day when he died. You couldn't retire



in those days; you just died. The need was so great. When Lindy and I were handling 12,000 patient visits a year our last couple of years, we realized we couldn't keep it up. So finally we decided we had to get out. We loved it, it was a beautiful place, it was nice for the kids and nice for us, but we couldn't stand the pace. You couldn't say, "Well, go down to the hospital," because we didn't have emergency room people, we didn't have ambulance services, we didn't have EMTs. We were it.

We tried for seven years to get more doctors to come into the area and could attract nobody. I blame our failure to recruit doctors on the medical education system. It didn't give a damn about the health care system in those days. Being a general practitioner was suspect to begin with, and it was considered un-American and probably communistic if you wanted rural general practice.

The fun thing about practice there was you felt you knew the whole community. You really could see epidemiologic patterns. You could tell from the measles epidemics where the school boundaries were. As clear as punch, measles never crossed the boundaries of the school districts. You could trace a local outbreak of hepatitis. You could see where it was and how it related to the creek going through town. As a result, we could work for a new sewage system. It was just fascinating to be able to sit on top of a real epidemiologic study all the time because you were handling such a huge percentage of the population. It was an experience I will never forget.

I very quickly found in practice that I saw more "disease" among patients caused by psychosocial problems than disease caused by organic problems. I had been trained to take care of organic problems. George Engel had been one of my teachers in medical school at Rochester, so I knew better. But the teaching in those days was that you didn't take care of families, you talked with the individual. Quickly, I found out that I needed to learn how to handle the family and work with it as a unit. To relieve my workload, I had to take care of emotional problems.

After a couple of years in practice, two teen-age boys who were our patients came down with what was then called juvenile diabetes. They had essentially the same level of disease education and the same level of disease biochemically. One was from a very stable family and never even went into the hospital. The other one was always in the hospital, in and out of diabetic ketoacidosis or having insulin shock. One you could help regulate easily, and the other one you couldn't. I finally found out that the father of the second boy was having an affair and that this kid was aware of it. I had never paid attention to the family—I thought that I was taking care of diabetes and that it was causing the distress. Well, it was the family problem that was causing the stress, and until you could handle that, you couldn't handle his diabetes.

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I was not one who felt we should change the name "general practice" to "family practice" because I was a general practitioner with pride. However, I felt that once we changed the name, then we had better change the educational programs to really do what was needed. I think the unit of care is the patient, but I can do that as a pediatrician or as an internist or as an obstetrician or

something else. The context in which that patient lives is also something I have to respond to, and because I care for people of all ages, I realize I care for families. By the seat of my pants, I had to learn that. Nobody ever taught me.

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If you look at the social context from which family practice developed, it was the time when finally black Americans were saying "no more." It was a very exciting time because there was both fantastic need for change and major resistance to change. We watch the things going on in South Africa and realize we were watching much of that in this country with the sit-ins, with the protests, with the hoses and bombings. It was a situation where we realized our Constitution had to work for everybody or it might not work for anybody.

There were things we noticed in our own community. In our practice, I was doing about 100 deliveries a year, and about 10% of my deliveries were out of wedlock. We didn't have abortion in those days, and the Pill wasn't in yet. So Lindy and I started a sex education program in the Episcopal church and the American Legion hall. And then, because we were seeing so many problems with teenagers—every year we would lose a couple of them who were drunk in auto accidents on the road down to Ithaca—Lindy got involved developing a program to help teenagers have something to do. She decided to run for Village Board. She won the election on the issue of developing these youth programs, but by then we needed new water and sewage systems, and she was made water commissioner. So she became responsible for helping get a new water system in town.

I too had some very strong feelings about things. Even before Kennedy was killed, I had begun working actively in the local Democratic Party. Several years later, I decided to run for US Congress. In a Republican community where Democrats usually don't win, it wasn't hard to get the nomination. I even had a platform: "You need a hundred years' peace because one minute of nuclear war guarantees the end of democracy." But I withdrew.

What happened was that I had a partner that year, and Lindy and I had four kids by then. Lindy thought she could take over part of the practice and run it together with my partner. But he decided we were already too busy, and he wanted to go into dermatology where he'd have more regular hours. This was rational for his life, but it was suicidal for the practice and the campaign. So I decided just before they distributed the posters; I had to call and back out. It bugged the heck out of me because I really would love to have done it.

I see us having gotten into the "Reaganoid" years, the turns that society seems to have taken, and . . . I keep thinking, would I have made a difference? I would like to think I could have. But I don't know. Goodness knows. I'm sure we all want to make a difference.

Dr. Farley left Trumansburg after seven years to enter a master's degree program in public health at Johns Hopkins University in Baltimore. He concentrated in international health because he "wanted to know how medicine was practiced in other countries where there were not enough doctors."

Hopkins gave me a year when I wasn't on call every other night, every other weekend, handling 12,000 patient visits a year. I met people from all over the world training there. Some were in education, some were in nursing, some were in medicine, some were in administration. All had an interest in how we get and maintain health. It was the first place I'd been where people were speaking to the issues that even in practice I was aware of: that you had to worry about the health care of the whole population, not just of individuals. The private practitioners only saw the individual issues. The public health personnel only saw the global issues. My frustration in practice was that I felt the practitioners and the planners needed to relate to each other so that they could work together.

As a clinician, I had watched what I considered to be the absolute political stupidity and conservatism of our medical profession. I liked the individuals; I hated the politics. I often still object to our politics as a group because we don't look at what the needs of society are. We too often look at how to continue doing what we're doing because what we're doing is all right—just ask our patients. But we never ask our patients, and we don't ask who are the patients who may not be able to get to us. Even if we're committed to serving the underserved, only so many can get to us. I entered my MPH already very aware that we as a profession weren't really responding to the health care needs of our society.

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As I was leaving my MPH program in 1967, Colorado asked if I would be willing to come back and start a family practice program there. I went and looked, and I thought probably this was the place where I would go because it was the oldest university GP residency program in the country. But the people in preventive medicine saw family medicine as preventive medicine. The people in pediatrics saw it more as a pediatric thing. The people in internal medicine didn't see it at all.

Before I made my decision, Jake Holler from Highland Hospital at Rochester called up and asked if I would consider coming there. I looked it over. I thought with Bob Haggerty there—he had set up the family practice program at Harvard, the one Lynn Carmichael and Nik Zervanos had taken—with Bob there, he's probably going to say it should be this way and this way. But he said, "You know, we don't know what family medicine is. Why don't you come and try to develop it?" I can't imagine having started at a better place because there was this one great advantage. It was fantastic. The hospital and the university were supportive, and though they didn't understand family medicine, they gave us a free hand to go ahead and develop it. I was naive enough to think that I could do just that.

There were some things we needed to do. I felt the practice should organize its data so we could give better patient care and really identify patient problems, essentially use patients' charts as laboratory notebooks for research. So we filed our charts by census tracts, and all household members were filed in the same folder. With the Navajo, my bosses, Kurt Deuschle and Walsh McDermott, had wanted me to file by camps, and I had resisted. They said, "Well, if you want the job, you're going to do it." I did it and became absolutely sold. The practice from its

inception could identify the patient population by age, by sex, by disease, by where people lived.

We quickly grew, thanks to the medical school, which had successfully helped create a great shortage of primary care physicians. Very nicely the newspapers were interested in us, and soon people in Rochester became supportive. We wrote a Health Demonstration and Research Grant, the first one ever offered in the country, and it was awarded to us. By getting two other doctors to join, we became the first program in the country that had three full-time family physicians. And in 1969, we got our first group of four residents who came for the whole three years.

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When I finished my MPH, I read the Willard Report¹ and the Millis Report.² They were fascinating. But I was a reader of these, not a participant in developing either. While others were looking at the whole broad concept of family practice, I was looking at educational issues. I wanted to start a program that would have a community advisory board with input, a program that would have structured, organized charts to collect data and pull it back, a program that would really become a way to study the community, work on the social issues, and develop the resources to respond.

Richard Magraw's *Ferment in Medicine* was the one book that spoke most to my condition.³ I considered that a powerful book. It's not one that was used in the political process but was written by a practicing physician in Minnesota. It was the first book I read that really spoke to what my condition was in practice, and I still use one of its diagrams in all my thinking and writing. I felt it matched my needs. It was fairly concrete, just as I was and I guess I still am. As you look back historically, that was my strength. I was focused on a specific way of training residents.

Subsequent to his 11-year tenure at Rochester, Dr. Farley served as department chair at the University of Colorado before moving to his present position in Wisconsin. He plans to step down as chair in July 1992, taking a wealth of perspective with him to Meharry Medical College in Nashville, Tenn., where he will help develop a new faculty development program in medicine for underserved populations.



We as a specialty have always been able to serve people regardless of age, sex, or disease. As a result we can work with families. I am convinced that families, however you define them, play a major role in how you handle, prevent, or acquire diseases. The role of family as a disease determinant can be cultural, it can be genetic, and it can also be functional.

You see these things in family practice. You watch with wonder. I've always said that as a family doctor, you're a participating observer or an observing participant. It may just be advice that you give; it may be time, or medication, or just long-term support. It is a role where you can have a tremendous impact, and it's an exciting role because of the degree of observation and participation demanded.

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As an academic discipline developing new knowledge and research, family medicine needs to do a lot more focusing on the care and study of the family. To date, we have often focused our research in areas that are important but that could be done by an internist or a pediatrician or a gynecologist or anybody in health care systems. There are very few places focusing on those aspects of research and care that we can do best. I'd love to see more community-oriented primary care approaches where you're looking not just at the population that's in your practice but at the population out there in the community—to integrate it so that your practice is responsive to the needs of the community, to develop with the community the resources needed to make sure that a population gets care.

I'd love to see family medicine playing a role in looking at how we get universal health care for Americans at an affordable cost. Right now, we're piecemealing it. Could we develop an ideal model system? I don't know, but I think we should be focusing on how we make sure all people get care. Working as a profession, we should take some stands as a group to say, "We'll work for this," and try our best to accomplish the change. I would love to see us take leadership. That's the challenge.

I would like our training programs to help residents have a better understanding of what the family physician's responsibility to a population of patients is. We're good at taking care of patients with heart attacks in the CCU, but as a practice group, we have not really taken responsibility

for making sure our population is immunized or getting needed preventive care. I would rather not graduate a resident because the population of families for whom he or she is the responsible physician isn't properly immunized than because he or she didn't get CCU privileges. I'm exaggerating, but I feel very strongly about it. I think we should be doing preventive care, and I think we should be leaders.

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When family medicine is threatened by decline, like now, it's when society is going toward selfish extremes. It's when you'll pay anything to build up the military and any war is all right, but you don't want to do social services, and you don't want to give to the social good. When it's get what you can get, keep what you can get, to hell with the other guy—as long as that is the popular social wisdom, which it is at the moment—then family medicine can't thrive because it's not a specialty that is going to give all its members a Mercedes and a Corvette and a high, high standard of living. We do well—there's no family doctor who's suffering—but while we're high, other doctors are much higher.

You hear a lot of pessimism in me, but I must admit I'm fantastically optimistic. I would love to see family medicine really be able to do the things it says it does. I know it can do these things. I can give you outstanding examples of people doing it. We're getting good graduates, good clinicians, and good physicians in family medicine. I have nothing but delight about what's going on in family medicine and am confident in its future.

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