Anniversary Series

Voices From Family Medicine: Theodore Phillips

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

Ted Phillips has had a remarkable career in medicine. He practiced in a rural Alaskan town, helped build the University of Washington's Department of Family Medicine as its founding chair, labored as an associate and acting dean at the university, and, more recently, returned to clinical practice part time on a small island in Washington state and travels to the University of Washington to direct the course on introduction to clinical medicine. Dr. Phillips was president of the Society of Teachers of Family Medicine in 1978-1979 and received the Society's Certificate of Excellence in 1981. He currently serves as the only community-based physician on the National Advisory Council of the Agency for Health Care Policy and Research. This transcript is an abridged version of interviews conducted in April and June 1992.

(Fam Med 1992; 24:469-73)

I grew up in a medical family. My dad was a surgeon who did general practice for a number of years, until the war was over and he could restrict himself to surgery. I particularly admired one of his colleagues: a small-town GP who worked about 12 miles from our home in southern Ohio. With this background in clinical medicine, I formed a notion of going to a rural town to be a general practitioner.

In college I became interested in field biology and worked summers with the Fish and Wildlife Service in Alaska's Prince William Sound. One summer a research vessel came in by my stream guard station. On this vessel were two epidemiologists from the Johns Hopkins' School of Hygiene. They were traveling all around the world tracing down epidemics; in my area they were digging clams. I spent a lot of time talking with them, and I thought maybe that's what I would do. So I went to Hopkins for medical school. I never got back to epidemiology, but I did get back to a small town as a GP.

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There was not a lot of support for being a general practitioner at that time—not where I went to school. Absolutely none. In 1958, when it was time to get recommendations for internships, the student affairs dean refused to write a letter for me because I wanted to do a rotating internship so that I could go into general practice. Finally he wrote it, but only after insisting that I look at some straight internal medicine programs, which I never did.

I'd ask faculty for letters of recommendation and would have to sit through the same lecture on how I was throwing away my Hopkins education. Then I went to Jim Cantrell in the surgery department and told him what I wanted to do. He pushed his chair back, put his hands behind his head, and said, "You know, I've often thought that's what I should have done." You could have knocked me off my chair.

I interned at Western Reserve University Hospital in Cleveland and ran into more support. Dr. Roger

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

Ebert was chair of medicine there before he went to Harvard as dean. He and I figured out a way for me to put a couple of years of medicine and one of pediatrics together and still become board certified in medicine. I tried to put some obstetrics in, too, but couldn't work that out. When I got on my inpatient medicine rotation and didn't enjoy what I was doing, I went back to tell him, "No, I don't want to do this. I want to go to Colorado for its GP residency."

Interestingly enough, Dr. Ebert's father was a generalist physician and happened to be a patient on my ward in the hospital several times. He loved to watch "Gunsmoke" on television. Doc Adams was one of his favorite characters. I'd drop by and watch "Gunsmoke" with him and talk about what it was like to be a general practitioner in a small town.

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The University of Colorado's general practice residency was a hospital-based program, with 2 years of rotating at what would now be called the R2 level. It was predominately inpatient with some outpatient work in the hospital's medicine, pediatrics, obstetrics, and gynecology clinics. One facet of the program was a rotation in one of two or three small community hospitals. You functioned as the only house officer in the hospital and ran the county clinic. I went to Fort Collins and spent the last 6 months of my residency there. It was a great way to fill in gaps I had in my education. I hadn't had much orthopedic training, and there was a new orthopedist, the first one ever, in town. I attached myself to him, and he called me for anything. Same thing with an obstetrician. That was my model family practice unit, if you will, out in Fort Collins.

After his general practice residency, Dr. Phillips went to work in Mount Edgecumbe, an island just off Sitka, Alaska. He stayed there, first with the Indian Health Service and later in solo practice, from 1962 to 1969.

I was in Sitka when the early developments in family practice were taking place. I'm not sure when I first became aware of the changes; I was busy just getting things started. I do remember all the ferment going on in the American Academy of General Practice about whether there should be a board of family practice. I was firmly against the idea. How could you have a specially board for general practitioners?

In 1968, I was an alternate delegate to the Academy meeting in Las Vegas. I was committed to vote against the notion of a board. It turned out that as an alternate delegate, I wasn't seated, so I can't claim to have voted against it. But that's where I was. It didn't make any sense.

One other thing was happening at that time. I kept trying to find somebody to practice with me. I didn't want to be solo. Whenever I had a vacation, I'd go down to Denver and visit Dr. Wes Eisele, the head of my GP residency. He tried to interest residents and put me in touch with people he thought might be good. But nothing ever went anywhere.

In 1967, I was program chair for the State Medical Association that met in Sitka. I invited Wes to come up and speak. He came and spent 2 weeks telling me all the things that were happening. He was the one responsible for starting me thinking about doing something else. He'd say, "There isn't going to be anyone coming out to join you in practice unless people like you pick up the challenge to start some of these new programs being talked about."

He sensed I was vulnerable and tired of being in solo practice. He kept it up for 2 more years before I finally said, "All right, I'll come look." He was going to be retiring as director of the GP program and had thoughts that it might be convertible to a family practice residency. I went down to Denver to visit him. Clearly, nothing was going to happen right away when I was there.

I had seen Gene Farley's ad in *GP* for faculty in Rochester. Wes knew Gene, and he said, "Why don't you go talk to this guy? He used to be a resident here." So I went on to Rochester and met with Gene. It was intriguing. I went there in February of 1969, came home, and said, "Let's go." We were in New York by July.

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I was in Rochester just 1 year. Along about Christmastime, Gus Swanson called me from Seattle. Gus was a neurologist on the faculty at the University of Washington; I'd known him from practicing in Alaska and sending patients there. He was acting dean. He called me and said, "How did you get away from us? How did you get from Alaska all the way to Rochester? We're looking for somebody." The curriculum had changed, and they were looking to start a family physician pathway. I said, "Absolutely not. There's no way I can move my family again right now. We haven't even gotten the furniture we ordered. There's been a big enough upheaval." Gus persisted but understood.

He called me later in January. "I know you're not interested in a job, but we're inviting people to come through to advise us on how to develop the program. Would you come as a consultant?" I said, "Sure, I'd like to go back and see friends." But I got hooked. It was -4° in Rochester when I left, and the snow had been up around my ears since late October. I flew into Seattle on a Sunday afternoon in February. It was 60°, the sun was out, and there were sailboats all over the lake. Everybody says, "I remember the year it did that

in February," but it might have had something to do with why I went to Seattle.

Dr. Phillips became chair of the newly formed Division of Family Medicine in September 1970. Two years earlier, the University of Washington Medical School had undergone a major restructuring of its curriculum, which paved the way for the establishment of the division. This restructuring followed the publication of a report that addressed the school's long-term mission.

The report was couched in terms of looking ahead 25 years and deciding what kind of doctor the university ought to be turning out for the community. It was a blueprint of what would now be called community-oriented primary care and called for family physicians to function in community-based units. Predicting what the future of health care was going to look like, this report said it was going to be much more highly organized, rather than the individual entrepreneurial activity it had been. Therefore, there were going to be varying roles for physicians and a need for diversity that would drive the curriculum.

Out of that report came a 3-year curriculum planning process, which concluded that the MD degree didn't mean just one thing. It meant a wide variety of things, like a PhD degree. Any individual student's curriculum ought to be planned in accordance with his or her goals. This was operationalized with a system of five pathways: medical specialist, surgical specialist, behavioral specialist, research scientist, and family physician.

When I went out for that first consultation visit, I found that family practice was central in the new curriculum. Construction was to start on a family practice center right at the front door of the university hospital. At the same time, the school was starting the WAMI program, a wild idea about teaming up with Alaska, Montana, and Idaho to send students out to rural areas for clerkships. Big things were falling together—the four state governments, the governors of the four states, the state university systems, and the family practice/general practice communities. These were all positive start-up ideas. They needed somebody to help develop that. Coming in as an unreconstructed GP, that was what I set out to do: to train physicians for rural areas.

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When I first came to the University of Washington, we never used the terms "family practice" or "family physician" out in the state. Nobody would have understood what we were talking about. It was not uncommon for people to talk about creating the department of general practice. If we tried to tell somebody we were creating a department of family medicine, then we'd have to stop and explain it, and the only way we could explain it was to say, "Well, we're trying to train more general practitioners for the community."

There were always mixed messages in the term "family medicine." I can remember the chair of the pediatrics department was very much interested in the word family and hoped our department would stress family studies and family therapy. Others, particularly those in surgical specialties, were more interested in creating docs for small towns, generally trained as long as they didn't do too much surgery. To the legislators and the people in communities that were lacking doctors, the words family medicine meant nothing. What they were looking for was more general practitioners.

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It was after 4 or 5 years as chair that conflicts escalated between internal medicine and family practice on the national scene. That meant tough times.

The setting was this. Remember that in 1965 and 1966, when the Millis Commission and the Willard Committee were writing their reports,[1,2] they identified early on a need to formally train people for the role of primary physician. They set out to talk to academic leaders, primarily in internal medicine, saying, "We see a need for reorienting training. Are you interested in doing that?" They were resoundingly told, "No. Primary care is not what we're about. We're about training specialists."

So then the commissions responded by suggesting something new. The general practitioner of the past was as close as they could come to what they were envisioning, but there needed to be changes in training. Out of that came everything we've done in family medicine.

Of course, it caught fire. The American Board of Family Practice was created in 1969, residency programs rapidly increased, and students began flocking to the specialty. Undoubtedly, some people in pediatrics and internal medicine wanted to do this all along. But as a reaction to family practice's success, others who were initially indifferent suddenly became concerned with primary care.

All the subsequent conflict between specialties was born in that era. There was just too much need for individual specialty identities in primary care to merge and work together. The fighting was over which type was best suited to do the job, over who was to train the best primary care physician.

After 6 years as chair, Dr. Phillips resigned his position to coordinate the department's nascent research operations.

When I went to Seattle, I told the dean that it would take a different kind of person to start the department

than to run it after it was up and going. We formally acknowledged that start-up things had to be done and that the department initially wouldn't be able to do much in the way of scholarly work. I had the notion that I would step down as chair and try to get the research efforts going. I went on sabbatical, took 3 months of coursework in the School of Public Health, and went to England to work in a GP research unit at the University of Nottingham. It was presumptuous of me, as I look back on it now, to think that I could develop a research program. I had no research record. But I didn't know enough to think I couldn't do it.

At the end of about 3 years, the associate dean for academic affairs left. The dean, Bob VanCitters, called me one day and said, "Have you had enough of that research business? You know you're not an investigator, don't you? You're an administrator. I want you to be associate dean." So I did that. Two years later the dean quit. Three months later, the incoming dean had a heart attack. I was suddenly acting dean for 6 months. Then a new dean was appointed, and I went back to my associate job. Four years later, the president fired that dean, and I was, once again, acting dean. That went on for a year and a half.

I stayed around for 3 months after the new dean came, wrote a history of the department, and tied up some loose ends. Then I got out. I took a leave, got some clinical retraining, and went up to Anacortes to fill in for a friend who was taking time off. By the end of September 1988, I had to declare whether I was coming back. I surprised everybody, probably even myself, when I decided I was just going to stay up there.

Ever since Wes Eisele talked me into going to Rochester, I always had the sense that I was going to be in academics temporarily, then I'd get back to being a country doc.

Dr. Phillips' clinical career has come full circle. So too, as he predicted in 1984, has our society's need to recreate "generalists and generalizers."[3]

The switch from general practice to family practice was in some ways an unfortunate one. It had to happen, at least in academia, because the word "general" had lost its status. The whole concept of creating a new specialty had more credibility than talking about training general practitioners. Also, family practice brought together several different groups of people under one rubric. Unreconstructed GPs like me, pediatricians like Bob Haggerty and Joel Alpert, family counselors, and people interested in family systems theory joined to create the academic movement. It had to have a new name to do what was needed at the time.

It disturbs me to watch the current resurgence of generalism and see people in family practice, some of our former residents resist being called generalists. They've come up through a time when they thought they were going into a specialty, not becoming generalists. I fear that family practice may go on fighting an identity battle rather than grabbing this new opportunity to lead.

We have never been able to stop arguing about which specialty is best equipped to train primary care physicians or gatekeepers or general practitioners, whatever terms we're going to use. We need to quit thinking about who is the best primary care physician and instead need to picture how we can best put the various specialty pieces together to provide population-based health care for a group of people. As academicians, we need to develop complementary relations between specialties and departments.

I always wanted to create an educational program that trained family physicians, pediatricians, general obstetricians, gynecologists, and surgeons in one group-practice setting. It would train them as a unit so they could function together in the community. It's not a new thing outside of universities. A couple of general practitioners get together, create a group, and decide they need to bring in somebody else. It might be a surgeon or an internist or an obstetrician. As the group grows, these people play different roles than the family physicians who were there first. The general internists in those naturally occurring groups become diagnostic specialists. They take on the historically important role of consultant, a role clearly different from that expected of family physicians.

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Whatever goes on inside academic medicine right now will have a very marginal influence on the health care system. The creation of family medicine in the 1960s didn't just come about because people in academic settings sat down and designed a new mousetrap. There were lots of outside pressures, just as there are now. Now is the time for family physicians to become politically active and design a better health care system.

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In the late 1960s, family medicine was part of a revolutionary trend. It fit right in with the back-to-earth movement and all the things that stressed community and environment. Those interests were all people and community oriented. The dominant theme in our society today is high technology, which is hard for me to plug into family practice. It is the major influence on the shift away from primary care toward surgical subspecialties, orthopedics, and radiology in student career choice. It's not the money gods that our culture worships. Yet, everywhere I look, I see a renewed interest in generalism.

Industry, for example, has created the need for generalists at top levels of management to coordinate,

understand, and put pieces together. I'd like to see family practice embrace its generalist heritage and fill the same need in medicine. We need to think in terms of the unit of health care for a small community of people, how we put the various kinds of professionals together in complementary relationships and then create models that train those people together. We haven't been able to overcome the specialty identity.

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It was true before and even more now—the fun of practicing medicine for me is that I enjoy the role I play in the community, living among the same people for whom I care. Sure, my mistakes and omissions greet me on the street every day, as do my successes, but that's what medical practice means to me. I get a kick out of running into people on the street, hearing follow-up on them, and getting the opportunity to ask them something rather than waiting and wondering why they didn't come back to clinic. It's been fun.

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I came to academics thinking of myself as a general practitioner, and I still do. When I left practice in Sitka in 1969, I kept the plaque off my office door. Just as it did all the time I was chair and in the dean's office, it's hanging in my office now, down at the university. It says, "T.J. Phillips, M.D., General Practice."

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