

Voices from Family Medicine: Donald Ransom

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

Family medicine is a discipline of inclusion. It has welcomed, from its inception, a diversity of professionals and educational approaches. In this transcript, the third in a series of oral histories focusing on the creation of the field, clinical psychologist Donald C. Ransom, PhD, discusses his early and continuing involvement with family medicine. Interviews forming the basis for this abridged version were conducted with Dr. Ransom in May and November 1991.

Dr. Ransom is professor of family and community medicine in the Department of Family and Community Medicine at the University of California School of Medicine, San Francisco, and the behavioral science coordinator in the family practice residency program at Community Hospital in Santa Rosa, Calif. In 1986, he received the STFM Certificate of Excellence; in 1989, NAPCRG and STFM jointly honored him with their Weatherby Award for outstanding clinical research in primary care.

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I entered family medicine by accident. In 1969, I was in graduate school working for Henry Lennard, a family sociologist. He was at a party and ran into my first boss at UCSF, Herb Vandervoort. They talked, and one thing led to another. Vandervoort needed somebody to be a recording secretary for the newly formed Pathway in Family Medicine. But they had no courses, and they didn't know the first thing about family medicine. I was brought on to do that job, to go to the library, look things up, and find out what others were doing in the field. I really got interested and helped them design and teach an introductory course for first- and second-year medical students. So at the same time I was finishing graduate school, in 1970, I taught what I think was the first course on family health, illness, and care in the country.

The course has always been an extension of my values and purposes. I always taught it with a family doctor. We invited all students and tried to tell them that whatever specialty they went into, they would be well served by having an imagination stimulated by an interest in who people are and what affects them. We asked them to go out into homes and interview family members about their health history and their doctors and their health plan—just basic stuff. The students loved it!

This year I was preparing to teach that course for the 22nd consecutive year only to find that we had too few students enroll. There are now lots of other opportunities in the department to do preceptorships in community clinics

and family doctors' offices and to get some of the same ideas, so the course is not nearly as unique as it used to be, which is good. I feel sad that it's canceled, but the best aspects of it will be integrated into "Introduction to Clinical Medicine," a required course for all first-year students that is now the responsibility of our department. My course is history.

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In those days, I was taken intellectually with general systems theory, family systems, and the ideas of Gregory Bateson. As an undergraduate at Harvard, I was influenced by psychoanalytic anthropology and by interdisciplinary approaches to social relations. I developed an interest in Robert White's biographical approach to psychoanalytic theory, looking at how a person evolves over a lifetime. When I got to Berkeley in the mid-sixties, I became absorbed in the mutual influence of personality and social environment and how each shaped the other. I moved away from the narrow focus of psychoanalytic theory, which seemed to blame the victim. I don't accept the one-sided view that people are the cause of their own misfortune because of their internal hangups or that they need analysis to get insight and to mature.

Even though my graduate training as a clinical psychologist was traditional, the research I was doing was on family systems and the psychology of health and illness. Family therapy was just starting to happen, and I had a chance to work with one of the pioneers in the field, Chuck Fulweiler. So I was part of the first generation of graduate students who could be trained in individual approaches and family approaches at the same time. When I took the job at UCSF, I thought, if the insights transforming the individual approach to a family approach were good for psychology and

mental health, they were going to be even more important for general medicine. That was what I figured was going to happen, but I was wrong. Family medicine didn't have those revolutionary ideas yet, except in the rhetoric of some of its founding documents and the minds of a handful of its early leaders.

I was concerned that a historical opportunity was going to be missed. A lot of what I thought of as unreconstructed GPs had taken over department chairs and were leading their new specialty in the wrong direction. One part of me said, "Well, this isn't my business. I'm not a physician, why am I bothering?" But the other part of me said, "This is too important to be left entirely in the hands of physicians. They're family doctors, it's their specialty, but this also is health, the public interest, and federal dollars." I had something to say about this, too.

At UCSF, Dr. Ransom met John Geyman, one of the members of the committee convened to form the Family Medicine Pathway. At the time, Dr. Geyman had just taken the position as the first family practice residency program director in Santa Rosa.

John Geyman invited me to come up to Santa Rosa and teach one day a week. Every Thursday I'd get up early, drive up there, work with the residents all day, and come home. John and I struck up a friendship and ended up driving down to the Mental Research Institute in Palo Alto a couple of times. We'd sit behind the one-way mirror and watch Watzlawick and Fish and Weakland work, then we'd talk all the way home in the car about what was going on and what this could bring to family practice. John was skeptical but intrigued, and his heart was in the right place. He wanted to find out as much as he could and get his family practice program set up right.

I had a clear sense of what I thought was important, and that was to train a new kind of physician. There was something about the biomedical model that was abstract and removed; it was both an idealization and an exceedingly narrow view of what was really going on with people's health and illness. A new kind of physician would look at the context, look at personal and family history, look at the meaning of symptoms, and really connect with people. This would lead to a more effective kind of practice. Bringing in the family ideas and behavioral science was almost secondary; it just made sense. The family was a kind of icon reminding everyone that the personal context of people's lives was important.

In 1973, I published the paper that got me into the field in a big way. It was entitled "The Development of Family Medicine: Problematic Trends," but it could have been called "Where Is the Family in Family Medicine?"¹ When this paper came out in *JAMA*, many doctors were really upset. They thought I was undermining the young specialty and trying to turn family doctors into social workers. John Geyman ended up arranging a debate about this between Ed Neal, a family physician from nearby Healdsburg, and me in front of the residents and faculty. I told Ed I would be happy if family doctors were more like social workers but that I wasn't trying to take anything away. I thought family physicians should be doing procedures and delivering babies and anything else they wanted and were qualified to do, but I insisted that they were incomplete physicians until

they brought the social environment into their doctor-patient relationships. They needed to think of themselves not just as purveyors of procedural skills but as a new kind of physician. Ed and I became allies at that point.

Dr. Ransom first attended an STFM annual meeting in Washington, D.C., in 1971. The meeting, and his own observations of the development of family medicine there, became the stimulus for that 1973 JAMA article.

I was naive and went to the meeting with great expectations. I assumed that family practice incorporated my goals of training a new kind of physician, putting the family in the center. I thought I was going to find a bunch of comrades, but the people there were all going around and boasting about how many new medical school departments had just been approved. They were talking about physician maldistribution and addressing the bureaucratic and economic dimensions of the problem. They were being self-congratulatory about the progress they'd made politically, not uttering one word about the family. I was very upset by it. I thought, "Wait a minute, what's going on here? These people don't have the first idea about what family practice is about or could be about." So I rented a typewriter, and I went up to my hotel room and banged out a draft of that *JAMA* article.

In that article I tried to do two things. One, I argued that the thrust the new specialty was taking wasn't going to succeed in the long run and that it wasn't different enough or ambitious enough. The situation was this: Biologically reductionist medicine had made great progress into smaller and smaller spaces, and public health had carved out its scope in the larger arena. In between was the person and relationships in the immediate social environment. There was this gap between medicine and public health, and I used the infelicitous term "microecological medicine" to describe it. I was trying to identify where family doctors should be looking and working: in that unclaimed space between what the specialist does and what the public health officer does—the personal physician, integrating biology on the one side and the community on the other. The other thing I said was that the real answer here was not filling the primary care gap—that could be done any number of ways. What was more important was a new imagination, a new kind of practice, a new kind of physician.

The article was a bit strident and clumsy, and it polarized people. They either thought it was destructive or it was great. The turning point for me came when Roy Gerard, who for years was the chair at Michigan State, grabbed me at a meeting a couple of years later and said, "I've got to tell



From left: Norman Livermore, Don Ransom, John Michael Wise

you something. I was in private practice, thinking about getting involved in this academic movement. When I read your article in *JAMA*, I said, "This is it, this is what I've been looking for, here is a blueprint for a department. I'm going to take that department chair at Michigan State." I couldn't believe it. That gave me the hope to keep doing this stuff, a real sense of being okay.

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I don't think I invented the phrase about a family being "any group of intimates with a history and a future." For a long time it got traced back and ascribed to me, but that was just the way the family was thought of by many people in the early family therapy movement. In any case, the definition stuck and made a lasting impression. It wasn't taken literally but emphasized that the social environment was essential to the conception for family and that the middle-sized set of influences between what goes on inside the body and what goes on in the community makes a big difference in people's health and illness.

These issues, Dr. Ransom believed, were relevant to the scope of family practice. Through his work as an editor of Family Systems Medicine, he helped forge bonds between the disciplines of family therapy and family medicine.

If we want to understand why people in our practices behave the way they do, we need to find out who they are, where they fit in society, what roles they play in their families. We need to learn something about their history. If we tell them to take this test, or take that medicine, or change their diet, what is this going to mean to them, and what effect might it have on someone else? It was this conceptual framework that I wanted to convey to family doctors in training.

Families are different from other kinds of primary groups. Blood is thicker than water; there's something different about family ties. Even with the variety of arrangements, including the fantasy of the nuclear family, there's lots of juice. One person who influenced my thinking a lot was R.D. Laing. He noted that people will commit great crimes to control their family members and keep them from acting a certain way. They will go to any lengths at times because it feels like their own survival, their own lives, and their own value depend on it. In more recent years, I have come to appreciate the transgenerational approaches. I use the genogram to get people thinking about their own families of origin and what difference those make in the kind of physicians they are, to bring a personal, human, historical element into practice.

Family has become a metaphor for me. I've written that the myth of the biomedical model is that all doctors and all patients are interchangeable: If you are a well-trained doctor, you can examine a patient anywhere in the world, take the history, do the lab work, make the diagnosis, prescribe the treatment, and cure the patient. In "The Patient is Not a Dirty Window,"² I wrote that the biomedical model, in its crude form, tried to look through the patient to see the disease. There's certainly some usefulness in that oversimplification, but it's an idealization. By emphasizing the family, I used a little different kind of language to say that the central subject of practice is the person. If we

want to understand the patient, we need to know about the family, present and past. The idea of the family was a good hook on which to hang the valuable parts of family medicine that were being left out of medical education and practice. It became a rallying point.

I remember the first Family in Family Medicine Task Force meeting in Kansas City in 1980. In the keynote address, I discussed the history of the major projects that had looked at the family and health care. I talked about the Peckham experiment in England³ and the Macy-funded Richardson study that came out in the book *Patients Have Families*⁴ and the Greater Health Plan of New York,^{5,6} where George Silver worked on developing the first family-focused HMO in the United States. I tried to show that there was an intellectual basis to family studies and that it was not just family therapy. Let's think about the family and health, let's think about the social environment. It worked, setting a good tone from the outset. That task force has stayed together and grown for 12 years now.

From his vantage point as a clinical psychologist in family medicine, Dr. Ransom has witnessed the growth of the specialty from a perspective different from those of his physician colleagues. He uses this perspective to reflect on the evolution for the discipline.

From the beginning, there were two main streams of influence in the modern family practice movement. It wasn't really one versus the other, although sometimes it appeared like that. They were both important; they were complementary. The majority stream was made up of those who came in to fill the primary care gap and saw the discipline as one of synthesis: You needed specialists to help you learn each particular specialty up to a certain point, then you put it all together and became a jack of all trades. That tradition emphasized procedural competence and the ability to be all things to all people. The minority stream is the one that Lynn Carmichael represented and that I really tried to strengthen. The family doctor is the point of entry to medical care, and anyone can come in the door for any reason. The idea is not that I can treat all your problems but that I'll be with you whatever is wrong with you. I want to understand you; I want to help you be a healthy person.

That second stream of folks was soul searching all the time, asking penetrating questions, wanting to know about patients and the symbolic meaning of symptom presentations. They realized that this inquiry was intellectually and personally challenging and made it a main part of the agenda of becoming a family physician. As time has passed, it seems like this stream has widened. The result is that even people who were the "superdoc" types have come to reflect more about what they're doing. All kinds of people have become interested in resident stress and well-being, learning to talk with people instead of using cookbook approaches, attending Balint demonstration groups at regional and national meetings, and becoming aware of themselves. It's helped to develop the whole personality of the specialty.

I'm encouraged by this increasing awareness of the potential of the personal physician and of the importance of meaning in the doctor-patient relationship. I'm really encouraged by the growing interest in Balint training. Balint groups have come to be seen as a kind of procedure; you can

almost draw an analogy to doing a flexible sigmoidoscope exam. The Balint process provides an approach to thinking about a problem and coming up with alternatives that are extremely practical. It's the best method we have to help family doctors deal with problem patients and difficult situations, to increase their sense of satisfaction and reduce the risk of burnout from day-to-day practice. Balint training is a technique to get a handle on a lot of the things in practice that used to drive people crazy, to help family doctors realize that they're doing the best they can in a very difficult and personally demanding job.

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I think we're at a critical juncture in the brief history of family practice in the United States. On the one side, we have made great progress toward fulfilling the hopes put forward in the best rhetoric and plans of the 1960s and 1970s. On the other side is the terrible larger matter of the economics of health care. This is an alien force that is real and has to be reckoned with. It is a force that has no concern for the doctor-patient relationship, or what's the best way to practice, or what's good for patients. It turns the doctor's skill into a commodity and patients into consumers. The current economic environment makes it very difficult for some of the more helpful developments in family medicine to continue to evolve.

There is a tension between being the kind of family physician we set out to be and the economic pressures to see more patients, connect with managed care systems, and survive in today's practice environment. There is also a continuing tension between family physicians and specialists. There is a third tension, too, something that's worried me for a long time. There is more of an intellectual and research basis to family practice than has been allowed to grow. One reason it hasn't grown is because departments are short handed. It's a very labor-intensive venture to see patients and to teach, and there's not much time or money left over to invest in scholarly activity.

There has also been a lack of imagination about what constitutes good research and good research questions. There are tremendously interesting questions out there waiting to be studied. It's vitally important to look at the natural history of a doctor-patient relationship and to recognize and describe turning points in the course of illness and care. The interplay of mind and body and social environment and treatment approaches are waiting to be explored.



It's a challenge to look into these areas systematically. The state of the art is so primitive in studying this. There's not much being done in the field; it's wide open.

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Were I empowered to improve resident training in family practice, my suggestions would be modest. I'm certainly aware of what an incredibly difficult job it is to train family doctors. I'd try to create opportunities for the faculty and the residents to practice together more in outpatient settings and for residents to spend time observing experienced family doctors at work. Many residents are initially not interested in watching; they want to do things themselves. But when they see somebody who's achieved a sense of identity and self-regard as a family doctor working with patients, their issues about "What is a family doctor, anyway?" come together for them.

The other thing I'd encourage is making family practice training more like graduate school, with more time for seminars and more time to reflect, and less like a continuous rotating internship. An ideal model to learn is intensive case presentation and longitudinal case supervision, where a small group of residents and faculty periodically present and discuss the medical and emotional aspects of difficult cases and follow them together over months. But this is hard to do. Given the pressures of time and scheduling, it's tough to train this new kind of physician.

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I have always believed that family practice was, in an elegant sense, a good cause. I'm not a physician and sometimes have felt like a visitor in the house of medicine. This is a constant issue for behavioral scientists in family medicine. But I've never worried too much about that. I've always believed my work was useful and complementary, and if I've helped to train some people and shape some ideas, I'm happy about it. Things have come a long way since the early days. Behavioral scientists are now more accepted; they are valued and have become part of the family of family medicine. There is a lot of satisfaction in that for me, in seeing it all succeed, in seeing family practice flourish. It's been rewarding.

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

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