Anniversary Series

Voices from Family Medicine: Nikitas Zervanos

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

The training of residents in community-based hospitals has been an important task for clinician-educators in family medicine. Community programs have produced more than 75% of family practice residents. The development of these programs has been a major mission for the discipline and has required strong vocal support. Nikitas Zervanos, MD, founder and current director of the residency program at Lancaster General Hospital in Lancaster, Pa., has long provided that support. In this discussion, an edited version of interviews conducted in May 1991 and March 1992, Dr. Zervanos recounts his early and lasting involvement with the residency in Lancaster. He has served as the director of Temple University's family practice review course, as a longstanding consultant to the Residency Assistance Program, and in various capacities on the boards of the Society of Teachers of Family Medicine and the STFM Foundation. In 1987, he received STFM's Certificate of Excellence; in 1990 the Pennsylvania Academy of Family Physicians honored him with their Leadership Award. Dr. Zervanos is a clinical professor in the Department of Family Practice and Community Health at Temple University in Philadelphia.

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I remember it well. I decided I was going to become a physician in my third year at Albright College in Reading, Pa. When I went to college, I wanted to be a chemist because I was good at chemistry. I had never considered the medical field because it would have been a financial problem for me. Even then, I wasn't quite sure how I was going to do it. But I got a state senatorial scholarship to attend Penn, and with that stimulus I was able to proceed.

When I made the decision to go to medical school, I always thought it was to become a general practitioner. I had only recently rediscovered that I had an uncle back in Greece who was a GP. His name was Hippocrates, believe it or not. My father's brother. We really hadn't talked much about him because he died early in his life. But that wasn't what did it. As I read about medicine and what it meant to be a physician, it occurred to me that the generalist made the most sense. I began to envision having a relationship with patients over a lifetime, taking care of people in the context of their families.

The physician who took care of us back in my home town of Reading was a general practitioner. He was somebody who took care of all of us. I grew up in a neighborhood where a third of the families were immigrants from Greece. They were part of my extended family. We all related to our physician, Dr. Levan. My family held him in the highest esteem. How I viewed the physician's role developed from this modeling inside my family.

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).

I had a wonderful class at Penn. I look back at those days with such great fondness. One of the best groups of human beings I have ever worked with were my classmates in medical school. We had many discussions about medical practice in general.

Those were the days of the debates between Kennedy and Nixon. Listening to the debates in the fall of 1960, you could sense we were in an era of change. You could feel the change coming. America was feeling its oats at the time. We were doing well economically; we had a good sense of ourselves. And when Kennedy started talking about some of the social ills in our society and how we were going to have to deal with them, it was exciting for me.

When I entered medical school, at least half of my classmates were interested in general practice. Unfortunately, only five of us survived the socialization process of medical education. I was annoyed with that. I was annoyed that the number of my classmates who still considered entering general practice had dwindled away. I realized that this needed to change.

Dr. Zervanos graduated from the University of Pennsylvania Medical School in 1962. He went to Lancaster General Hospital for his internship, with the notion that he and his wife Diana would settle nearby.

While I was in my internship, a number of things happened. I met Ed Kowaleski, a physician from the little borough of Akron, Pa., who was later to become the president of the American Academy of Family Physicians. That year, Ed was president of the local chapter of the Academy of General Practice. I heard him discuss his concerns about the future of general practice. That got me particularly interested in my own future and also in some of the political aspects of the field.

During my internship, I decided that I needed some more training before I set up practice. I looked at general practice residencies, but they seemed nothing more than another year of internship, and besides, there were none in any of the medical schools around our area. I decided I wasn't going to do that. Therefore, I decided to go back to Philadelphia, do a year of medicine, and then come back to Lancaster.

I got drafted and went into the US Army. I wanted to go to southern Europe so I could visit my relatives in Greece. There was one Army position there, and I got it. While I was stationed in Greece, I started a letter-writing campaign back to some friends and expressed my concern about what was happening to the future of general practice. When I wrote back to Dean Gurin, my dean at Penn, and told him what I was up against when looking at general practice residencies, he was sympathetic. He thought I had a legitimate concern and told me I should write to Joel Alpert up at Harvard.

Joel Alpert at the time was an associate professor of pediatrics, in charge of the Family Health Care program. This program was founded to prepare pediatricians coming out of Boston Children's Hospital for community practice, since many of them didn't feel adequately prepared outside of academia. When I got out of the Army, I went and visited with him. He offered me a fellowship following the year of medicine that I had planned at the Philadelphia V.A.

I ended up spending a second year in Philadelphia at the hospital of the University of Pennsylvania. I shared some of my career goals with Dr. Jim Wynnegarden, then chair of the Department of Medicine at Penn. He was rather encouraging and suggested I stay on to participate in some of the ambulatory care experiences that would help prepare me for future family practice. During that year, I also participated in a Balint seminar offered to both residents and practicing community physicians. I learned a great deal from that experience. I then went up to Boston in 1968.

What Joel Alpert offered me in the Family Health Care program was an opportunity to acquire some administrative skills in graduate medical education, to understand how a curriculum is designed and implemented, to utilize the resources of an academic medical community, and to be exposed to research. It was an exciting, invigorating year.

I also had the opportunity to observe some of the difficulties we were going to be experiencing in academic family medicine because of the way a university like Harvard felt about general practitioners and family doctors. Joel tried to demonstrate to the Harvard community that the Family Health Care program was worth preserving and developing and that they ought to support it. Oddly, it was considered one of the first 15 pilot programs when the American Board of Family Practice was established in 1969. There was hope it might really take off, but it didn't. Unfortunately, it never really did get much support from the university. Soon after Joel left to go to Boston University, around 1972, the Family Health Care program folded.

While I was in Boston, I got a call from John Esbenshade, the director of medical education at Lancaster General Hospital, and he said that they were thinking about establishing a residency program in family practice. Would I consider the opportunity to develop it? Obviously I was quite interested. I was excited about being a part of it early on.

I was anxious about it, too, because at the time there were few residency programs in place. Just the idea of starting a new residency program was scary. But I remember what Joel told me; I'll never forget it. It helped me make the decision to go to Lancaster. He said, "Nik, don't let your anxieties drive you to inaction. Go with it." That was something I needed to hear.

The anxieties I was experiencing were entirely appropriate and also helped create the kind of energy source I needed inside me to be able to weather the storms—because there were some storms. When I got to Lancaster, there was a lot of mistrust; people didn't know what I was up to. One senior member in our department of general practice said, "Look, we never needed you, we don't want you here, and don't expect any support from us." He thought I was going to do something radical and that it was going to change the face of medical practice inside the hospital.

Dr. Zervanos began by converting Lancaster General Hospital's outpatient department, a collection of clinics that provided services on a voluntary basis to indigent patients, into a family practice office. The residency recruited and brought in its first three residents in July 1970.

We decided the Lancaster program would direct its philosophy in the care of people who were socially and economically disadvantaged. Yet we learned that such a family practice unit, solely dedicated to the indigent community, did not meet the requirements of the Residency Review Committee at the time. So in addition to the hospital-based office, we came up with something unique. We developed our own family practice center in rural Lancaster County. We recognized that the most underserved area of the entire county at the time was in the little borough of Quarryville, 15 miles south of Lancaster City. That community of 1,800 people was the hub of the 300 square-mile southern Lancaster County. It had, at one point, six or seven general practitioners. Then a couple retired, and another one had just died. It was a serious situation.

To help us get started, a medical student from Harvard agreed to come to work for me that first summer of 1969. His name was Ed Benz. We did something very interesting with Ed. I told him, "Ed, I want you to go out and meet with every agency director in Lancaster: Heart Association, Lung Association, Cancer Society, the Children's Bureau, the Community Action Program, the whole bunch of agencies. You go out there just like you were a journalist, and you interview them. You find out what they do, what they expect from hospitals like ours, and what they expect from a specialty like ours. And you tell them what this specialty of family practice is. You tell them that this is a brand new specialty, committed to providing continuing and comprehensive health care. Then you find out how they feel about that, how they might want to interact with us, and how we might be able to work together for the future benefit of our community." He did it. It was a nice way for us to establish a foundation in the community at large.

The next summer, another student, Roy Lehman from Temple, did a remarkable thing. He recruited 30 citizens of the southern Lancaster community, primarily from the Farm Bureau, and met with them. He told them what we were going to try to do in Quarryville and that we wanted to be assured of their support. This student managed to set up a house-to-house survey, to get these people to go out and visit 10 homes each for a total of 300 households. The feedback we got was overwhelmingly supportive of our endeavors to establish this family practice center.

The way we envisioned our program, none of our interns were going to be participating in the center in Quarryville. They would all be second- and third-year residents. Our residents would spend a half a day a week in the family health service, which was what we called the unit at the hospital. Beginning in their second year, they would spend two to four half days a week down in Quarryville. We thought that was a really exciting model. It is still the same way to this day. In the unit in Quarryville, that first year of operation, we were handling several thousand patient visits. Now we're up to almost 30,000 patient visits. It's turned out to be a very successful model for us. Being in a rural setting, I think, has helped prepare people for overall practice; it turns out that two thirds of our graduates are practicing in communities of fewer than 30,000 people.

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Our focus in 1969 was the creation of a discipline. General practice before 1969 was not a discipline. It was a way of practicing general medicine, but it wasn't a discipline. General practitioners were not practicing the same throughout the country, and they weren't practicing the same in any one community. You got out of your hospital-based internship and maybe you did a hospital-oriented general practice residency, and then you went into practice. What you did was learn on the job. The graduate level training available wasn't the kind of training that prepared you for what you were actually going to be doing in the office setting. It wasn't relevant to our needs. The family practice residency programs were established to prepare somebody to enter the specialty of family practice.

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Family practice was conceived as a reaction. If you look at the history of medical education, if you go back to the 19th century, we had an apprenticeship system for the most part. Medical students spent a lot of time with their mentors; much of their training took place in the office setting. But when we created the new model of medical education, evolving out of the 1880s experience at Johns Hopkins, things really changed.

The new educational model was great for training people to learn about disease and about patients who get very sick. It was an invaluable improvement and continues to be a very important part of our education. But what we also needed along the way was more opportunity to acquire expertise in the care of people with common problems over time. When family practice was conceived, the graduate medical education system was going so far away from looking at patients as people that something had to happen. It should have been part of the way physicians were trained 50 years ago.

For 23 years, Dr. Zervanos has continued in his role as residency director at Lancaster General Hospital. His reasons for staying? Many center on his strong connections to the surrounding community.

When I think of the word community, I am reminded of the Greek word *kinonea*. This word comes to mind because when, in 1985, they were establishing a department in a new medical school on Crete, they were going to call it the department of community practice. Well, they used the word *kinonea*, which has to do with communion, as opposed to community.

The word *kinonea* has a very special meaning in Greek Orthodoxy. The word has to do with a spiritual bonding that takes place at the deepest levels in a relationship. It involves a special feeling of closeness with your fellow man but extends beyond that to the people in your own family and to your relationship with God.

What does community mean to me? It has to do with these very close connections I have with my roots in the Reading-Lancaster area. I can easily count all the Zervanoses who live in America—that's how close we are. There are about 28 of us. My extended family refers to not only my relatives on both sides of my family and my wife's family but also includes almost the entire Greek Orthodox community where we live.

When I came to Lancaster, I knew I was going to have a small practice in view of my position as the residency director. I chose to adopt as my patients those people who were Greek-speaking immigrants. Since I knew the language, I would be able to do them added service. Not only did I get to know those people through my connections in the extended family and the church, I got to know them intimately through my practice. It's been fascinating. Living here, developing a practice, and getting to know these people as I have has been an experience that underscores the words communion and community.

From his perspective as a longtime family medicine teacher and residency administrator in rural Pennsylvania, Dr. Zervanos brings insight into the current concerns of medical education and medical practice.

Two of the big issues back in the 1960s, when our specialty was being developed, were the problems of the poor and the elderly. Interestingly enough, when we talk about health care issues today, again it's the elderly and the poor. The difference is that, then, the country was flush with money. We felt confident allocating resources and money to help solve some of those problems. We created Medicare and Medicaid, the Comprehensive Health Planning Act and the Community Mental Health Act, the Regional Medical Programs, the Housing and Urban Development Health Care Initiatives, the Office for Economic Opportunity programs, the neighborhood health centers, and the health systems agencies. We created all kinds of programs to respond to the needs of the people in this country, particularly the underserved. We were doing a tremendous job in reaching out.

Now, while the same population groups get our attention, we're not flush. We don't have the same kinds of resources available.

We're going to have to deal with it at some point. My prediction is that we're going to have some kind of universal health plan within the next few years. I think the next administration will have to tackle it. That's obviously going to alter to a large extent the way we deliver health care services in this country. Regardless of what system we adopt, whether it's government run or a partnership between government and the insurance industry or some other kind of corporate structure, as family physicians we are going to play a very important and primary role in the development and implementation of that system. The demand for family physicians is going to intensify.

We've got to do a better job of getting medical students interested in our specialty. I realize it's a multifactorial issue that involves the medical schools, the payment system, and the medical-political structure in our communities, but all of us are going to have to work together to improve the pipeline of students because we have the capacity and the capability to train and educate family physicians.

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I know we are dealing with other forces that are working against what we're trying to achieve. Clearly. It might sound trite, but we'll have to get back to why people really go into medicine, and I still think people go into medicine for the right reasons. People go into medicine because they care a lot about people and they want to do something meaningful and worthwhile for other human beings. Family medicine creates one of the best opportunities society offers to do good for others.

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There is this notion that not every medical school needs to produce a generalist. I think that's hogwash. When you go to medical school, you don't go to become a specialist. You go to become a doctor. When you come out of the system as a doctor, you should be broadly educated, trained, and oriented toward the whole patient with a good understanding of all areas of medical knowledge as they relate to the care of that patient.

We will have, obviously, a good number of students who will choose specialty and subspecialty careers, and that's fine. But I would like to see the Liaison Council of Medical Education and the Association of American Medical Colleges make it a requirement that every medical school, to be accredited, has to have a department of family practice and that family practice curriculum time has to be incorporated in all four years of medical school. Every medical school should be developing physicians who are well trained as generalists first.

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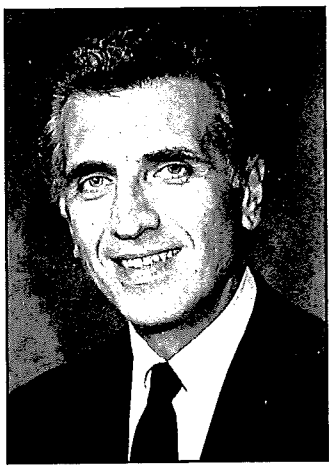
Our efforts in Lancaster felt radical to some people; they didn't feel radical to me. It was like motherhood to me.



Because how could what we stood for do anything but a lot of good? The philosophy of family medicine was the philosophy of medicine. When we used the philosophy of family medicine and talked to medical students, . . . well, that's really what I think medical students went to medical school for. Anybody who would come in our door and hear what we had to say about family medicine couldn't help but get turned on by our discipline. This was the late 1960s and early 1970s, remember. It was the language of the times. It was what people needed to hear. We were part of something very, very good, and we got a lot of support from the students.

To me it's still the same vision. I still think we're moving in the right direction. When I look at Lancaster County, I see the good that is coming from the care and the practices of our graduates. That is extremely heartwarming. When I hear the feedback from patients and organizations in our community, it's all positive.

It's all exactly the way we said it was going to happen. We are meeting their goals. When I see the good that's happened in Lancaster County, I think it can happen throughout the state of Pennsylvania and throughout the United States.

We're going to see a lot of things happen over the next 10 years. The bottom line is that I feel very confident about where family practice is going to be. The leadership we're looking for in medicine is going to come from our specialty. I'm excited about the future of our discipline.

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