Roundtable

The Intellectual Basis of Family Medicine Revisited

(From the proceedings of the Advanced Forum in Family Medicine, Keystone Resort, Colo., September 23-28, 1984, sponsored by the Society of Teachers of Family Medicine Foundation.)

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Stephens: Thank you all for coming to try to recreate the first roundtable from Monday which we didn't get recorded. There is a certain amount of historical information that I think we are all interested in, if we can pursue this in somewhat the same order that we did the first time. The title of this roundtable is "The Intellectual Basis of Family Practice Revisited" and the question that each person is being asked to address at the beginning is: "What were you doing in 1966 in relation to family practice education?" We'll begin with Ned Burket.

Burket: In 1966, I was chairman of the board of the American Academy of General Practice. The next year I was president-elect and the third year I was president of the academy, so I was around when all three applications for the permission to form the board (ABFP) were written. The idea of a board wasn't new to the academy at that time. There had been a group of academy members a number of years before who had organized (privately) what was called the American Board of General Practice, and attempted to get a (legitimate) board established then. However, the Council on Medical Education of the AMA, when they went before them, promptly told them that anything that was general couldn't be special. So they were immediately rejected. The same group about two years later then changed its name to the American Board of Family Practice.

Well, a (certifying) board was quite a controversy in the House of Delegates of the American Academy of General Practice, and it was for this reason that it took so long for them to officially apply for permission to form an American Board of Family Practice.

I remember so well because when I ran for the board of directors (AAGP) originally, I ran on the idea that I was for the (certifying) board. I was elected by one vote. So you can see how close the division was on the idea of boards. But by 1965, the House of Delegates did vote in favor of forming an American Board of Family Practice so it was up to us to start things in motion for an application. But

*Recording of First Roundtable, Sept. 24, 1984, was faulty. Recreation of discussion Sept. 27 with three original participants missing (Pisacano, Stelmach, Curry)

we had a lot of difficulty because we had to apply to the Liaison Committee for Medical Specialities which was a liaison committee between a loosely organized group of all existing boards and the Council on Medical Education of the AMA-and they had not approved a (new) board for 15 years (actually, 1949). So they really didn't know quite how to do it, and we couldn't find anybody who was responsible for (authorizing) a new board or

where we could get an application.

Finally we did find a man by the name of Gus Buie, a proctologist at the Mayo Clinic who was the secretary to the (organization of existing) boards. So one day Mac Cahal and Amos Johnson and I flew to Rochester to see Gus Buie, and we were ushered into his consultation room. Gus wrestled around and through his filing cases and finally came up with one sheet of paper and said, "Oh here it is," and he looked at it and read it. "Well I don't think this is up to date enough, we'll have to send you an application and also we'll have to decide what the procedures would be." Gus was true to his wordand incidentally we spent about an hour in Gus' office telling him what family practice was - and I think that he was probably one of the first allies that we really obtained in getting board certification, as far as the other specialities were concerned.

He sent us the procedures and we did the best we could the first year when we presented it the following April, at the meeting of the Council on Medical Education. We not only had to present to the council the application but we also had to go before representatives of all the (existing) boards. That group didn't have any official name then; it was just part of the Liaison Committee and all the boards had representatives. I'm sure that they didn't quite realize what they were doing because all the boards were pretty independent. They didn't have any tight organization. They all ran their own shop and that was it.

But our application that year was rejected. They found a number of things wrong with it. So the next year we tried again and we went through the same procedure and there were additional things that we had to do. One of the things they demanded the third year was that we have 15 programs in operation. Well you can imagine what that was like,

when we hadn't had board certification and there was no way we could certify programs and yet we had to produce 15 of them. Of course we did have some men with a great deal of foresight like Gayle Stephens, who had a program going at Wesley Hospital, and I think there was one going at Santa Rosa at that time. It was general practice but we claimed it as family practice at that time. Also there was one at Broadlawns (Iowa) and there was one at Rochester and also Oklahoma. Anyway, we managed to get the 15 programs and through a lot of political manipulations - visiting with the individual boards between applications, and talking to members of the Council on Medical Education—our boards were approved in 1969 and we became the twentieth (primary) specialty board.

There were a number of things going on at that time, such as the three major reports - the Willard Committee Report, the Folsom Committee Report, and the Millis Committee Report-all of which really favored the formation of the board. I would like to mention specifically the Willard Committee Report because the Willard Committee was really created by the Council on Medical Education to help us get the board, and this was a real turnaround on the part of the council. Before, they had been sort of lukewarm, but when they set up the Willard Committee, this was an indication to us that they were going to do everything they could to help us get the board. Of course they then, through their connections with each of the individual boards, made it possible for us to get approved in 1969.

Stephens: Who was the president of the academy in 1969?

Burket: In 1969, Maynard Shapiro was. I was in 1968, but Maynard became president in October 1968, so he was president when they approved the boards in March 1969 (actually February). Bill Lotterhos was chairman of the (AAGP) board at that time. He did in 1969 what I had been doing in 1967 and 1968.

Stephens: Neil Chisholm, what were you doing in 1966?

Chisholm: Well, in 1966 I had a very busy general practice, but also I was serving a six-year term on the Commission on Education (AAGP), the first three years as a member, the second three years as chairman. Those were extremely busy years for the commission because we were developing and maintaining our CME program, which was already the most outstanding CME program of all the disciplines of medicine. We had a subcommittee on graduate education, another on undergraduate education, and a third subcommittee on CME. We had developed directional brochures on those, but when the "boards" began to be talked about, and were soon to become a reality, then it was the duty of the Commission on Education to study the four reports that came out-the Willard Report, the Millis Report, the Folsum Report, and the Coggeshell Report. We were very busy people. I had four commission meetings a year; in addition we had subcommittee meetings. So many of us on the commission were gone about half the time from our practices.

Establishing Essentials

It was very interesting and we were up-to-date on what was going on in all branches of medicine at that time because we were given the duty of establishing the "essentials" for accreditation of the (new) family practice residencies. That was no easy task. We assembled a group of people from all of the other major specialties, two representatives each from surgery, OB, pediatrics, psychiatry, and so forth. We met for two-day sessions on several occasions just to iron out and fight out the contents of the "essentials" that would then govern the training programs in the new specialty of family practice. We purposely left those "essentials" very broad so that they could be interpreted in many ways to develop programs in family practice. Those first "essentials" lasted for a number of years because we did broadly orient them and the different programs were able to interpret them in different ways and to establish programs that were viable family practice programs. Of course later on, new sets of essentials were much more specific but still very broad.

So we were very, very busy; Ed Ciriacy was on the commission, and Lynn Carmichael (and I) became very close friends since he and Lee Blanchard travelled throughout the country to help the 15 programs that we needed to develop to be eligible for approval as a board of family practice. We also served on the "CORC" Committee, which was a large committee that met for many hours to establish a core curriculum for family practice training. I remember Carroll Witten was chairman of that, and by the time we finished we were criticized strongly because we had so much content in the core curriculum that it was almost allinclusive. But we really studied it very carefully and tried to include everything in there that we thought family physicians should learn; it was a very comprehensive document.

Stephens: Wasn't that also used as the basis for the first certifying exam? That committee's work was translated into the examination, the very first one.

Chisholm: The same CORC Committee did create the first examination. This was done in anticipation that we would get permission to form the board, and when the American Board (of Family Practice) was formed, they purchased that examination from the academy. Of course the board didn't have the money at that time to pay them for it, but it did pay for it in about three or four years.

Stephens: The interesting thing to me is that there was a lot of anticipatory "stuff" going on. There were programs in existence and an examination was being prepared, yet the political hurdles hadn't all been jumped over, and that in fact didn't happen until 1969. There was a great deal of groundwork being laid. Who was the chairman of the CORC Committee?

Chisholm: Carroll Witten.

Stephens: And then the first examination committee, wasn't Vernon Wilson the chairman?

Burket: Ray Feldman, representative of the board of psychiatry, myself, and Vernon were the three

members. Vernon insisted on going over the examination himself and we changed it a little-I mean the original examination that the CORC Committee created. The next year after that we created the panel concept with the National Board of Medical Examiners, in which we had the pictorial panel, the multiple choice panel, and the patient management panels. That was all created under the supervision of the NBME.

Stephens: I remember a very hot confrontation between Vernon Wilson and John Hubbard of the NBME...that must have been for the second exam .. about how John Hubbard was rather adamant that there wasn't enough time to produce the exam in a way that he wanted it and Vernon Wilson was equally adamant that the time table could be met. I was there as a very young member of one of the examination committees looking at these two titans fighting in the front of the room.

Burket: That was because of personal feelings you know. We kind of got caught in the middle for awhile. We spent one weekend a month for 12 months in Philadelphia at the NBME building writing that exam and I mean ten hours a day on Saturday and Sunday once a month for 12 months.

Stephens: Lynn Carmichael, what were you doing

in 1966 in relation to family practice?

Carmichael: In 1966, I was in Miami and directing what we called the Division of Family Medicine at the University of Miami School of Medicine. A little background on how I got there. I had been in general medical practice in Miami and left in 1963 to take a fellowship at the Family Health Care Program in Boston under the direction of Bob Haggerty. People who were fellows at that time with me were Evan Charney and Joel Alpert. That was one of the most stimulating years I ever spent, and while I was there I really devoted myself to trying to develop a curriculum for teaching family medicine in the medical school. When I returned to Miami, we started our program there in March of 1965, and I think that was really the first teaching of family medicine in a medical school in the Western hemisphere. In 1966 we added an internship; we essentially took over the rotating internship program at Jackson Memorial Hospital. There were six (positions) there and this developed into our residency, first approved as a general practice residency in 1966 and later as a family practice residency in December 1968.

A "Voice" for Family Medicine

During this time I became aware of the other activity around the country and one of the people that I ran into very early was "R2" (R.R) Hannas who was AAGP staff on their medical education division and was secretary to the commission on education of the academy. Neil (Chisholm), at that time was chairman. We had a number of activities that the academy sponsored. One of these was in early 1967, it was in Denver and Ward Darley was there. Ward had been one of the people who originated the term, family medicine. He was at that time with the AAMC, and at that meeting he talked about the Coggeshell Report. This was a report that changed (the) AAMC from being a "dean's club" that would

meet once a year at the Broadmoor in Colorado Springs into a real political force within American medicine. One of the things they recommended was moving from Evanston, Illinois to the center of the world, which was Washington, (D.C.), and another was to create representative bodies within the AAMC, one of these being the Council of Academic Societies. He said to the people there that if you really want to get this thing moving, you're going to have to have a voice in medical education, and a way of having a voice would be to become a member of the Council of Academic Societies. Well this was the spark that lit the fire under the Society of Teachers of Family Medicine, and later that year, in the fall of 1967, (when) the AAMC was meeting in New York City we had the first meeting of people involved in family medicine education that evolved into the STFM.

My duties at that time were at the medical school, but with these things happening, the AMA was taking an increasingly positive view. I don't remember when the AMA officially adopted the Willard Report or the part of the Millis Report that dealt with family practice. I think it was sometime in 1967. Bill Ruhe, who at that time was secretary to the Council on Medical Education and had been staff to the Willard Committee, was able to put together some dollars and he was very helpful in supporting the movement at that time. They wanted to find a full time staffer for the AMA who would work with them in developing family practice but weren't able to identify anyone. Lee Blanchard then offered to do so on a half-time basis and said that he would work in the western part of the U.S. and suggested that I might do so in the eastern part of the U.S. For the next three years on my part, and I think for about four or five years on Lee's part, we were half-time with the AMA, running all over the country looking at programs, going to meetings and talking about family medicine.

One of the assignments we had was to try to identify those graduate education programs that could be incorporated into the application for the board. Lee and I finally came up with 16 programs and these were approved in December of 1968, when the AMA was having its clinical session in Miami. That was the first meeting of the Residency Review Committee for Family Practice. These 16 programs were approved, including Syracuse, Rochester, Miami, Oklahoma City, Hunterdon, Brooklyn, Wichita, Newport Beach, Santa Rosa, Buffalo, I'm not sure if we had Boston in that group or not, Ross Egger in Muncie, Indiana, and I believe Akron, Ohio. There were sixteen that were in existence and had residents in them. Since I was functioning as staff, I made certain that Miami was the first program approved. Anyway this prepared the application for its subsequent approval in February of 1969.

Early Residencies

Stephens: Maybe you could comment about the two-year internships in family practice that preceded this development. A good deal earlier there was some kind of experimental program sponsored by the AMA.

Carmichael: If I recall there were actually two different ones. One in the '40s that was a two-year internship designed for people who wanted to go into general practice. Those went along for awhile and didn't really flourish. At some time in the '50s they then developed two-year general practice residencies. I don't think they used the term family practice; they were called general practice. There was a Residency Review Committee for General Practice; I remember Maynard Shapiro, and I think Vernon Wilson, were on that. Most of these programs approved as GP residencies said that they wanted to change to the family practice, but there were some, interestingly, that did not. I remember that there was a program in Fort Worth that had a long history of doing really good teaching and they said, "No, we're going to stay general practice."

Bishop: If you want to digress like you did Monday, I brought with me this special communication, "The Challenge of Family Practice Reconsidered," which Bill Willard wrote in JAMA in 1978, and it was from that I got the accurate list of the Willard Committee. But in the introduction it makes this point that a strong effort had been made by the AMA in the 1950s to bolster general and family practice and by the end of the decade, that would be 1950, there were four recognized pathways of graduate medical education into the field: one-year rotating internship, two-year rotating internship, two-year residency in general practice, and a twoyear pilot residency in family practice. He makes a point that none of these proved attractive to medical graduates and through the 1960s the number and percentage of medical graduates entering general and family practice continued to decline.

Burket: I wonder if I may add something about the formation of ABFP? The sponsoring organization for the American Board of Family Practice had to be the academy (AAGP); that was the rule, the major national (professional) organization or society sponsored the (corresponding) board, so the Academy was selected and named the (first) members of the board. However, in order to get the name, "American Board of Family Practice," we had to negotiate with the group that owned the name and was incorporated under it. So we came to an agreement with them that on the new board we would place two members of the "old board." It's important to point out the two members who went to the new board - one was Phil Frohman and the other was Nick Pisacano of Lexington, Kentucky. Although the first secretary of the new board was Mac Cahal, when it came to getting a permanent secretary, it was Nick Pisacano who served parttime for a year or two and then became the first fulltime secretary to the board.

Stephens: That refers to the transition of the first board which was organized by a small group of physicians and incorporated in the state of Maryland, but did not yet have the backing of the national academy.

Frank Snope, what were you doing in 1966?

Snope: I was general practicing in Lebanon, New Jersey, a little town of about 900 people in a part of

New Jersey that most people don't see, rural New Jersey. I was practicing in the long shadow of Ed Pellegrino who had left Hunterdon Medical Center, my hospital, in 1959, to go to Kentucky. I had chosen to go to Hunterdon Medical Center to do my one-year general practice residency because Ed Pellegrino was there, and everyone said what a superb teacher he was, what a magnificent program that was, and I went in the front door and he went out the back. But his shadow persisted for many, many years. I mention Hunterdon because that was really the "Hunterdon system" and no particular person that I can point to. I don't think Ed Pellegrino developed the Hunterdon system; in fact I think in looking back that it came rather serendipitously. I practiced in a framework of practice that was a model for what I subsequently did, and it was a framework in which specialists were doing their thing in a hospital setting and acting as consultants on a salary basis, and the general practitioners were practicing in the community, seeing all of the primary care. To design a system that would use both types of medical specialties, that's probably the system that you would design. So that system influenced my practice and my academic life, I think probably even more than I could even imagine. In 1966 I was probably beginning to have some stirrings of discontent with what I was doing based mainly on two things. One was the fact that my medical education, even my GP residency at Hunterdon, had not prepared me for (what) I found in the real world of medical practice. And the other was that I felt an idealistic need to teach what I knew and what I had been given at Hunterdon, so that when Tom Leaman called in 1969, with his twoyear program in operation for two years, I was ready to go and I joined him at Hershey in 1969. (Penn State University).

Stephens: Jack Stelmach, who was here Monday, indicated that he was in private general practice in Kansas City and had been given a clinical appointment at Kansas University School of Medicine. He also recalled that Chancellor Franklin Murphy of Kansas had a mandate from the legislature in the 1940s and '50s to establish required preceptorships for Kansas University medical students, particularly in rural areas, and Jack had that sort of experience as a medical student. Ed Ciriacy, what were you

doing in 1966?

Ciriacy: As I have already indicated, my ability to memorize and recall exactly what I was doing in 1966 is somewhat limited, having difficulty recalling what I had to eat last night. I think in 1966 I was a member of the Commission on Education with Neil Chisholm; I spent six years with that group and it was one of the most fascinating periods of time that I have had the opportunity to participate. The major activity of the commission was the development of "essentials" which the trustees (AAGP) had delegated to the Commission on Education the responsibility to review and modify. Every time the application was turned down, the "essentials" came back for correction and regeneration of new ideas and rewriting. The people on that commission then were people that many of us continued to have contact with and were most enjoyable to work

with—Lynn Carmichael, Jerry Wildgen, Charlie Strong, Si Grant.

"Another Piece of Paper"

The other thing I was doing then was that I was very active in the state academy. I was president of the state academy in Minnesota at that time. We had some ongoing activities with the University of Minnesota in looking at the options of developing programs that would produce general practitioners. Even more important, and also as a consequence of that activity, I happened to be a delegate to the (AMA) House of Delegates nationally. Most of us at that time didn't really see what a "board of family practice" would do to accommodate the goals that we had in mind. So most of us were rather opposed and the basic comment—one of mine and many, many people - was: "I don't need another piece of paper on my wall." It was some time before we recognized, as a mechanism of obtaining credibility in the eyes of our students, that such a board and such a piece of paper were indeed a very important aspect of growth and development of general or family practice. When I went into practice, the practice milieu was characterized by an increasing explosion of knowledge, if you will, an increasing emphasis on high technology with its resultant fragmentation of care into specialties and subspecialties. Those of us, particularly in rural communities, had experienced growth of our own knowledge base through the reality of practice. I recall, for instance, that it must have been five years before I had a case of alcoholism in my practice, and perhaps the same length of time before I recognized that there were any such things as marital problems in my practice. A general practice background really didn't include those kinds of training, but having had experience with some of the additional problems of people, and learning to work with them in the context of their families, their community, and their individual value systems, was a very rewarding experience. We also found that our patients reacted in a very positive fashion to our kind of care. And we became concerned that we weren't going to have any replacements to fulfill those same kinds of responsibilities in the future, and as we talked to our medical schools we found that there was little interest and no organization established to carry out that kind of a goal. So I think at the same time that patients were becoming disenchanted with medicine and what it had to offer, that attitude was becoming reflected in the Millis, Willard, and Folsum reports. There was also a ground swell of people in practice who were recognizing that there was something important that we were doing that wasn't going to be replicated or continued unless we did something, and that's the impetus that got so many of us involved in terms of local institutions and with the academy both at state and national levels.

Stephens: Gene Farley, you were one of the people whose name I became aware of in the mid-1960s. What were you doing in 1966?

Farley: 1967 was a transition year for me. We had been in active rural practice in upstate New York. Lindy (my spouse) and I had gone there following a

GP residency at University of Colorado where Ward Darley had some influence on our thinking. In medical school at Rochester we had been exposed to John Romano. We had almost taken the two-year internship developed by him which was to prepare you for "family medicine." We did not take the internship but John and his two-year internship program did influence our thinking. During my GP residency, the general medical clinic run by Fred Kern, which was considered a "model" at that time, influenced my conceptualizing how you might educate physicians appropriately for practice. For two years after residency we worked with the Navajo with Kurt Deuschle at the Navajo Cornell Clinic at Many Farms, Arizona. This experience oriented us to the community and to "whole family" concepts and showed us how you integrate these into practice. We entered practice in Trumansburg in upstate New York with plans to serve a population over a period of time, develop a group practice, and study the evolution of health and disease in that population. We very quickly found that the issue was not how do you do studies or research in practice, but how do you survive the load when doctors are not being replaced when they die (the average age of doctors in our community was well into the '70s' and the population is increasing. This overload made us very concerned about the need to educate people properly so they would "dare" to go out into general practice where needed. We found that our residency education had prepared us well for hospital oriented practice. We had learned to do many things well, but had not been prepared to handle the bulk of primary care problems optimally. Many of the major primary care problems we had to learn to handle by the seat of our pants. We believed appropriate education for primary care could markedly improve the physician's ability to serve a population of patients.

"Pushing" Family Medicine

In 1966, after trying for seven years to recruit doctors into rural practice, we accepted the fact that the medical education system was not concerned with, or responsive to, the needs of the medical care system. Lindy and I decided we needed to push people into general practice because we sure couldn't pull them into it. Six of the 11 doctors serving our area had died and nobody came to replace them. In 1966 I went to get an M.P.H. (degree), not because I wanted to be in preventive medicine, but because as I looked at clinical departments around the country, I found nobody was interested in "how do you get health care to people or what do you do when the doctor is not there." Even the general practice residencies had no particular interest in that. I majored in international health to see how other countries handled the problem of inadequate numbers or maldistribution of doctors. While at Hopkins, I was asked by both Colorado and Rochester if I would be interested in starting a program in family medicine.

I knew some of the things you others have been telling us at this meeting were going on. I was peripheral to most of them but knew of some of the personalities involved, but not the depth of their involvement. I knew things were happening and had to happen. If we were going to survive, not just as general practice but as any kind of rational health care system for the nation, we had to have appropriate providers. Bob Haggerty's, Ian McWhinney's, and Richard McGraw's writings, (plus) the three already mentioned reports, were all having an effect on what we and the medical education

system were going to do.

I went to Rochester in July 1967 and was very lucky in that we were given the freedom to develop a program and practice systems that hopefully would prepare people for practice. We were able to recruit among our first faculty David Reed, now at Pittsburgh, Ted Phillips, now at Seattle, David Metcalf, now chairman at the University of Manchester, Jack Froom, now at Stony Brook, Don Treat, and a succession of very strong people who helped us develop a teaching system. We were also able to recruit some outstanding residents. This narrative covers parts of 1966-1969 but it was '66-'67 that was the transition year. The basic decision in 1966 was: "Do you stay in and plug it out, recognizing that people from the education system don't seem to give a damn about the medical care system, or do you make a drastic change and go and do something about it?'

Transition Period

Stephens: Ted Phillips?

Phillips: In '66, I was in practice in Alaska as a general practitioner. I'd like to pick up on the comments a little bit ago about what went on in the 1950s. I think the year was '58, about the time I was finishing medical school. There was an AMA report called the "Final Report on Preparation for General Practice." It always interests me that someone thinks that they can write a final report on that subject. But I was aware of that (report) as I finished medical school and had an interest in basically living in a small rural or isolated community, so I chose general practice. After an internship, I went to Colorado to the GP residency program that I believe Ward Darley had actually started back in the '40s. I went into general practice very purposely and proudly. Also in '66 and '67 I was active in the American Academy of General Practice as a member of the Alaska Academy, a "big" organization of about 35 members in those days. As Ed Ciriacy mentioned earlier, I was one of those who agreed that in order to be a general practitioner we had no particular interest in specialty boards. I was actually alternate delegate to AAGP in that meeting in Las Vegas and was instructed to vote against all these new developments that were happening. But a couple of years later I had changed and I am trying to remember why. I was successful in practice, busy, but increasingly dissatisfied with the way I was meeting the responsibilities that the community and patients seemed to expect of me, which were different than what I had been trained for, particularly the kind of community responsibilities they expected me to have. I was managing patients on a continuing basis who were also my neighbors and friends and who had problems that I was not going to cure but was going to care for. I knew nothing about that whole (clinical) world. I became increasingly dissatisfied with how I was handling that. And Wes Eisele, who was the director of CME at Colorado and also the director of the GP residency at that time, came up to visit and spent two weeks, filled my head full of Millis and Willard Commissions and all those kinds of things, and challenged me to get involved. He put me in touch with Gene Farley and I went to Rochester in '69. That's the transition during those years for me.

Stephens: Marian Bishop, what were you doing in 1966?

Bishop: In 1966, I was on faculty at the University of Missouri, Columbia, with the rank of associate professor. I was in a department that was called Community Health and Medical Practice. The reason it was called Community Health and Medical Practice was that the dean of that medical school was on the Willard Committee, was committed to family practice, but didn't feel that the medical school was quite ready for a department of family practice or family medicine; so, he slipped it in under the rubric of "medical practice" and it was a divsion in that department, chaired by a GP, Dr. Sherwood Baker. He had been recruited by Dr. Wilson directly out of practice in 1963 to come and start this new thing.

The question came up about the Willard Committee and I was fortunate to have a little opportunity to watch it function from behind the scenes. The Willard Committee was appointed by the AMA in September 1964; they worked on their report for two years and it was accepted at the (AMA) meeting in 1966. The dean of my school, Dr. Vernon Wilson, was a member of that committee. The other members were William Willard, chair, John Gaughev, William Lotterhos, Julius Michaelson, Vernon Wilson, and William Ruhe was secretary. Other members included Tom Hunter, Frank Land, William Longmeyer, and Amos Johnson. During the time the report was in progress, Vernon Wilson, who many of you know flew his own plane, would hop into his plane at 5 a.m., head for Chicago taking drafts of materials with him, spend two days, and then fly back

I was a very lowly person down on the bottom of that totem pole but I had a lot of contact and respect for Dr. Carl Marienfeld, who was a pediatrician heading the Department of Community Health and Medical Practice. Via Carl Marienfeld I was given the behavioral science section draft to make some suggestions. Well, I didn't know what I was writing for I must say that in 1963-64 the fight about general practice/family practice was over my head. I had been recruited to teach a behavioral science course for first- and second-year medical students, not to do anything with the discipline of family practice.

The other reason I was recruited was that Dr. Wilson wanted a behavioral scientist on the medical school faculty. My husband, who is a psychiatrist, was actually the one recruited to go to Missouri University—I was a tag-a-long. But as Dean Wilson

interviewed Bob, he turned to me and said, "What do you do?" I replied, "I have a PhD in sociology with a thesis in the medical area," and his ears perked up and he said, "I want to talk to you; I want 'one of those' on my faculty." It didn't matter that we weren't quite sure what to do with me, but that is how I got started in medicine.

One of the other things I would like to comment on is that I did have a conversion to family medicine. I was converted to family medicine something like Saul was on the road to Damascus. Partly because of the juxtaposition to Kansas City, and through Sherwood Baker and Vernon Wilson, I was invited to go to Kansas City around 1967 to meet with the Commission on Education, then chaired by Jerry Wildgen. That was a two-day meeting and I have that report with me. I found it in my files when I was cleaning out and looking back. It is sort of interesting. At that meeting I met about 40 or 50 family physicians, some in practice, some already in teaching positions; Paul Young was at that meeting and Gayle; Lynn Carmichael was there and Ed Ciriacy. Ned, I'm not sure if you were.

Ned: I probably was.

Nik Zervanos was also at that meeting. I guess that's the time I decided that I had found a group of people that I really felt comfortable with, and for better or worse I was going to hitch my wagon to that star. I had never met a group of people who were more enthusiastic, more excited about what they were doing, with sort of a missionary zeal. Here was this young group of thin, trim, lean-and-mean fighting (physicians) who were really going to change the world.

"Success Story"

I've gone on record as saying when the history of medical education is written for the decade of the '60s and '70s, I have no doubt that this development of family practice and the impact it has made in medical education and in the academic health science centers is going to be written up as the success story of the decade. I liken it to a civil war in medicine because it seemed to me like medicine was sort of a little closed universe and here came family medicine and they were either going to secede or succeed. I think that they succeeded. You remember on Monday, Nick Pisacano said that he likened it to the American Revolution; the Royalists were sort of the old guard in medical education and the family medicine movement were the rebellious kids, the revolutionaries. He thought the right guys won and I think the right guys won.

I do have just a little bit of trivia to add. In researching materials for the STFM-ATPM joint project, which is now in publication, I discovered that there were four chairmen who founded a department of family practice or family medicine still at that same department today. The oldest tenured chairman is Tom Leaman at Penn State University at Hershey. He was the first faculty member that was appointed at that medical school by Dean Harrell. The others are Fitzhugh Mayo at the Medical College of Virginia, Hiram Curry at South Carolina, and Laurel Case at the University of Oregon, though he's no longer there. Lynn Carmi-

chael has as long tenure as the others but his was a division rather than an independent department founded as a department of family practice.

Stephens: I want to clarify a couple of dates. You were working on the drafts of the Willard Report sometime between 1963 and 1966. It was accepted in September of 1966 at the AMA. What I am wondering is whether anybody remembers what the factors were that went into setting up the Willard Committee, which must have happened in 1963.

Bishop: Would you like for me to read from the review here? The Ad Hoc Committee on Education for Family Practice was established by the AMA Council on Medical Education in September 1964 with their representatives, and there is some background here about the '50s and the fact that the general and family practice numbers were declining.

Burket: One thing we have to acknowledge is that at that time there was a Section on General Practice of the AMA that was really very active and they probably were responsible for getting that type of motion through the House of Delegates. They

worked very closely with the academy.

Stephens: I have often wondered where the term "behavioral science" came from in the Willard Report. I had occasion a few years ago to review minutes of the Mental Health Committee of the Academy as it existed throughout the 1950s; there was strong liaison with the American Psychiatric Association with a lot of continuing education programs, but behavioral science didn't appear in that. It seems as though it sprang full-born in the Willard Report.

John Geyman, what were you doing in 1966?

Meanings

Geyman: In 1966, I was practicing as a general practitioner in a town of 2,500 in northern California. I'd like to go back just a few years and draw some observations about the terminology of family practice and general practice. It interested me that over the years, the '60s and '70s and up to now, we've had quite a bit of overlap and at times confusion, and often tension and ambiguity as to what we mean by general practice, family practice, family medicine, and the like. It's of interest that personally, as a young student entering medical school in 1956 in San Francisco, I was not aware of too much of these various meanings; but I wanted to be a family doctor. I was in a class of 84 and only five of us went into general practice to become family physicians. The pressures, as in many medical schools now, were from the other departments to go into other specialties. As we all remember, it was against the tide at that time. There weren't any role models on the faculty for being a family doctor and there was no literature. You would go to the bookstore and find nothing. I ended up half-way through medical school in 1958 going down to the offices of the California Academy of General Practice, where I was quite excited to find that they had an excellent general practice preceptorship which was virtually identical to family practice preceptorships today. I took two of those. They confirmed what I wanted to

do. Upon graduating and looking at how to train, I figured out that three years of graduate training was the way to go, which is about what we do today. After a rotating internship which is very similar to our family practice R-1 year, I looked around and saw not very many general practice residencies. In the West we had three or four in California that were quite strong. There was an excellent one in Colorado. I didn't know what was east of the Mississippi. I gathered there was one in Akron and perhaps some others. I went to Santa Rosa and had excellent training. I then went out into practice.

In '66 I was doing some things I suppose that are what we would like to see today as a result of a family practice residency, and some things that I am sure would be considered deviant behavior today. At that time I was in a rural county; solo practice was the norm. I hadn't had any training to be a group physician in residency nor did any of my peers. The mystique was how broad your practice could be. The emphasis was on breadth and variety of practice including surgery and anesthesia, treatment of fractures, etc. I developed a fairly uncontrolled practice, huge numbers of patient visits, and hospital practice. As many others in practice at that time, I suppose, I was doing much of what we talk about as family physicians today, but was untrained for it. For instance, in community medicine we talk about the family doctor's role in the community and I was attracted to doing such things as developing a coronary care unit in a small hospital, training the nurses, looking at the problems of an ambulance system and trying to develop a better system, etc. That seemed to come naturally. I'd had no training for that in residency, however. I had zero training in behavioral science and I saw the need for such as that and read a book or two—for instance about marital therapy or marital counseling-and tried to do some. But in my culture, a rural logging town, I usually couldn't get husbands of patients with marital problems in for joint counseling. I also found myself, I think, being attracted to teaching, and had medical students from the nearest medical school on general practice preceptorships with me. I was attracted to the regional medical programs and some of their efforts to bridge the university medical centers into the community. That involved some postgraduate teaching activities and actually led to my going out of practice into full-time teaching. An RMP grant was developed in '68 to change the Santa Rosa general practice program into a family practice residency and establish an affiliation with UC-San Francisco. A few months later I left practice to direct that program, and it's of interest to comment in a word or two of some of the changes that went into that transition from general practice to family practice residency. We're aware of these. Just to summarize them:

Two-year program to a three-year program, emphasis from episodic care to continuity of care. That was a big problem. You have to reorganize the clinics, and that was a major effort and only partially completed.

• Shift of emphasis from solo to group norm, and that was an uphill effort as well.

 Shift of emphasis from zero to some emphasis on behavioral science and increased emphasis on comprehensiveness of care such as preventive approaches which generally were rather lacking in a GP residency.

 The initiation of a university affiliation and the development of family practice clerkships and the development of full-time faculties in a place that previously had mostly volunteer teaching.

Those are some of the things that went into that transition. That kind of covers in profile some of the things that I was involved with.

Stephens: Loren Amundson?

Precepting in Rural Areas

Amundson: I think I was also in transition in the mid-'60s, perhaps a grass roots, flatlander approach, a product of preceptorship programs which had been present since 1947 early on in my two-year school in South Dakota. During that time I was exposed to family practice or general practice through having some practitioner come to the medical school and give a general practice lectureof-the-year. Also in reference to the general practice residencies mentioned here today, there was one at the time in Yankton, South Dakota, where Chester McVay, of hernia repair fame, and Brooks Ranney, recently president of ACOG, were fairly young practitioners at that time. One of Paul Young's former faculty members, Margaret Faithe, still at Nebraska, took that general practice residency at that time.

Then I went on to Wisconsin where again I was exposed to a strong preceptorship program, which had been present since the mid '20s when Wisconsin went from a two- to a four-year program, and there I saw that practitioners were able to practice medicine. I saw people actively attend a National Rural Health Conference and thought that rural health was still alive and that's what I wanted to do. After military time, with the equivalency of residency, I believe, in OB and pediatrics, one of John Geyman's current neighbors in Seattle being one of my mentors, I returned to where I had had my sophomore preceptorship to practice medicine.

Having preceptees from the medical school, starting in 1960, was an enjoyable experience and I think that led me to some of my future endeavors. During that time (I talked with Marian Bishop about this) Vern Wilson spent sometime every October in Webster, South Dakota, a 2,500-population, county seat town in northeastern South Dakota. He spent time hunting pheasant, as he had a sister who was married to a farmer there. So I knew Vern Wilson from the late '50s through pheasant hunting.

Some local problems led me then in the mid-'60s to make a change and move into "metropolitan South Dakota," Sioux Falls, and there I ran into a couple of factors which I think led me to become involved. One was the second-class citizenry I saw as a general practitioner in a multiple specialty group, which I had not seen in a community where general practitioners were much loved. And I saw some apathy in the specialty society that I had

joined several years previosuly. It was the general practitioners' resistance and apathy to what we have discussed here in changing into the specialty of family practice, and the second-class citizenship, that led me to get involved with the academy to try to create change and help people develop some new ideas. I joined, became an officer and executive, and am still an executive for the South Dakota academy.

I didn't realize at the time how strong the feeling against becoming a specialty was among my colleagues in the academy. I think it's important to realize that some never took the boards and are still wondering why the whole thing ever happened. This continues to haunt some of them. We have had to fight another battle in that our criteria for "Family Doctor of the Year" in South Dakota includes board certification. We're being challenged as to how come good 'ole Art can't be named the "Family Doctor of the Year."

I want to mention one other name from the mid-'60s which has come to light recently in the sports world, a friend I had known earlier in high school days — Bob Voy — who was just named medical director of the Olympic training center in Colorado Springs. He's a South Dakota native who I think all through his career has maintained a strong feeling for general and family practice.

Stephens: Paul Young?

Developing a Residency

Young: In 1966, I was in general practice in a mixed group in Raytown, Missouri. It was at that time that a great deal was going on in the academy, of course, and I was active in the local academy. I became acquainted with "R2" Hannas who introduced me to others including Carroll Witten. Their enthusiasm and evangelistic attitude I think seduced me into giving up the practice and going into Research Hospital as an employee with the idea of developing a residency training program there. Some at the academy felt it would be an advantage to have a residency program locally so that the academy could use it to demonstrate what they were talking about. Unfortunately the program that I tried to start never really developed. My interest then was strong enough that I stayed in that business and was subsequently recruited at the University of Missouri, Columbia. Vernon Wilson also had something to do with that. At that time he was the head of ADAMHA in the federal government and tried to recruit me to Washington...until I discovered that he really wanted a hatchet man, and that really wasn't what I wanted to do. I ended up at the University of Missouri, Columbia, with Sherwood Baker. Marian, you had just left when I came there. I think what this represents is the enthusiasm that was developed among many generalists of my age, stimulated by the enthusiasm of the people in the leadership in the academy. That drew in many people who otherwise might never have become involved, and I think I was just a representative of that kind of individual who was caught up in that wave of enthusiasm.

Stephens: Tennyson Williams?

Williams: Things I was doing in 1966 were

significantly influenced by events described around this table. I was a 1951 graduate of Western Reserve University where Millis was president and Jack Caughey, a member of the Willard Committee, was the dean of admissions. I can't help but give you a small anecdote about Dr. Millis. I stopped in to see him, having been back to one of the five-year reunions that I attended, and I made it a point to stop to talk to him about the Millis Commission. We ran out of time and he was due downtown. That's where I was going anyway, so he drove me downtown. One of the things I remember was his saying that it would certainly be nice if all the other specialties looked upon the issue that the commission was discussing the same as the Academy of General Practice did. It was an opportunity for general practitioners because they were the only people who were talking about "what's best for the patient." The radiologists were talking about what's best for the radiologist and so forth and so on. I remembered that.

A Catalyst

To a significant degree what I was doing in 1966 was a legacy of Tom Reardon. Tom hasn't been mentioned before, but Tom was one of this original group of pioneers who sought boards for us. I think he was one of the architects of the resolution that was sent to the AAFP in Chicago in 1962, which failed in a very hot meeting. As a matter of fact, some other people from Ohio went purposely to speak against the boards. Tom also was strong for departments in the medical schools and he wrote two white papers, either one of which could be adopted today without too much change. One was a description for a departmental structure for a department of family practice. The other was a medical student curriculum in family practice. I think these were done in about 1960. Tom did research and had a paper on screening for risk factors published in JAMA. He was a significant influence in my life in terms of my curiosity and my practice. I think the major role that Tom played in the whole movement was that of catalyst. He wrote to a lot of people; he stimulated a lot of people, I think he excited a lot of people; and many of the people he excited and stimulated did more actual work than Tom.

Tom started the first menopause clinic in the U.S. at Ohio State, among other things. I really didn't see myself as not being prepared for what I was doing because I think my parents prepared me to be curious and my medical school prepared me with basics and with concepts and taught me to be flexible to the situations facing me. Practicing in a community with a small liberal arts college, I had patients who were teaching me things, too. So we were doing things with patient groups, premarital counseling, screening, involving patients in decisions, purposely differentiating the office staff into a team which was recognized as such by patients, and other fun things like that. As I said in the first session, I was happy as a bunny in a pea patch. I was not really all that uncomfortable with it. I was happy to have the opportunity to innovate and not 228

having to follow a whole bunch of protocols like everyone else was doing. I was impressed that what people were defining as the difference between general practice and family practice was really what I thought that I was doing—so maybe I ought to be thinking about doing something in academia. It wasn't until '74 that I finally did.

In the Ohio Academy of Family Practice I was chairman of the Medical School Family Practice Committee, which had been handed on from Tom Reardon. It had a goal to see departments in all the state medical schools. One of the things that we did was organize a symposium or seminar after the fashion of the Williamsburg conference that Dr. Haggerty had conducted in '64 or '65. The purpose was really to get members of the dean's staff, members of the major departments, members of the academy, medical students, and even laymen together to hear somebody with academic credentials make a presentation, and to break into small groups and discuss. This resulted, I think, in some very positive things happening in Ohio. It was the next spring that Ohio State used the \$100,000 that had been given for a "chair" in family medicine to fund a family medicine clinic precepted by family doctors and general internists. That ultimately led to the success in the legislative efforts to mandate departments in medical schools.

There was another report that came out at this time and that was the so-called Fort Lauderdale Report. This seminar was organized by Dr. Cope at Harvard, and looked at how medical education should be changed. Many of the things that were talked about in the Cope report were also concerns

of these later reports.

Other things I was reading and doing and getting involved in I think changed my life. I attended two of the teaching skills workshops that Lynn Carmichael put on at the University of Miami, and I think the first of those was in 1966. Someplace along the line someone told me about the *Journal of the Royal College of General Practitioners*, and I was reading it on a regular basis.

Let me just give you some of the participants in that 1968 conference. E. Grey Dimond was the keynote speaker, Vern Wilson and Art Nelson were very helpful and influential in organizing that meeting. Lynn was there and Ned was there. Ann Somers represented the lay point of view. Also, Joel Alpert, Whitney Brown, Nick Pisacano, and Dr. Bauer from Hershey attended. I'm sure there were a few others that I can't remember; the names mentioned were presenters or moderators of the group session.

Naming Names

Stephens: Tenny, I'll just note in conclusion that Hiram Curry was a member of this original roundtable and not able to be present for this reconstruction; Jack Stelmach was also at the original panel.

Bishop: There was a name that came up Monday that hasn't come up at all that I don't think we should overlook—that's Tom Johnson, who was the first permanent secretary of the Division of Education. He was mentioned Monday but I don't believe he came up today.

Burket: Chuck Nyberg was the first executive secretary of the Commission on Education and then came " R^2 " Hannas. I remember he was the first MD that we hired for that position. Then came Tom.

?: Last Monday in the audience they mentioned that we didn't answer where the society was in 1966. I think we can underestimate the impact that that has on us because civil rights had come in, we were aware of health care shortage areas, we were aware of huge populations that didn't have it, and I think most of us around this table felt we could never resolve those issues if we had inappropriately trained doctors to do inappropriate things who wouldn't go where needed. We felt we could train doctors appropriately who would go where needed.

Stephens: There is another person who was not named Monday that I would like to mention today, and that's Roger Lienke, who came from Minnesota to establish a residency at the University of Oklahoma in 1967. He also represents something that Lynn might have a further comment on, which was the role of pediatricians in the development of training programs. You did mention Bob Haggerty and Joel Alpert.

Burket: One group which we mustn't forget which had a profound effect and was a major force in our forming a specialty and that's the students. The student body noticed this big gap in health care and the students became very, very active in promoting family pretice, and I think they had a great effect on the House of Delegates of the AMA approving our boards, and also the Council on Medical Education. I'm not sure how much effect they had on the individual boards but they certainly had a big effect on organized medicine. So let's don't forget the student body.

Carmichael: Gayle mentioned the pediatricians. I think Bob Haggerty was really the focus for this. Bob had started what he called the Family Health Care Program at Harvard Medical School and Children's Medical Center in 1961 or '62, and he established a fellowship for physicians. I was the first GP to go into that fellowship and that was in 1963, Ian McWhinney came in 1964; Jim Burdette, Whit Brown, Nik Zervanos, Mary Elizabeth Roth, Richard Feinbloom, a number of the other people early on. That program provided a stipend; at that time it was \$7,500 a year. I know that was the most fruitful year I've spent in my life.

Bishop: Gayle, I think there is unanimous support to hear where Gayle Stephens was in 1966.

Stephens: In 1966 I was in Wichita, Kansas, and had been in a two-man partnership doing broad spectrum general practice in a northwest section of Wichita. Interestingly enough, and I don't know exactly why this came about, but we, my partner and I, called ourselves "family physicians and surgeons" in 1955, and we put that on the sign out front, and on our stationery. I had completed 11 years of practice in 1966 and was very happy in the practice, but I had become progressively more involved in the hospital medical staff at Wesley Hospital. The chief administrative officer, Roy House, and I had been carrying on a series of conversations about a possible role for me in

connection with the hospital. At that time the "sore toe" of the hospital was the emergency room, which we had traditionally staffed with interns, but since the recruiting of interns was progressively more unpredictable, the staffing of the emergency room from year to year was becoming a problem. So the deal that I was able to make with the hospital was that I would attempt to do something about the emergency room problem if the hospital would fund a family practice residency. We had a general practice residency at Wesley for some time under Jack Tiller, who was growing a little weary with it. I was largely unaware of the political things that Ned and Neil and some of the rest of you have described were going on in the academy. I had been an academy member since 1959, but really was not much involved. Somebody gave me a copy of the Willard Report in the fall of 1966 and that was like a light going on in my head. I didn't know where it came from but I knew immediately that I wanted to do something about that. So essentially I negotiated a deal with Wesley that allowed me to transfer my practice across town into a remodeled house and we started with our first resident, who was Conrad Osborne, in the fall of 1967. I also formed an emergency room corporation according to something called the Pontiac Plan, which was a separate coproration that contracted with the hospital to staff the emergency room. So that's what I was doing in 1966.

Addendum

William L. Stewart, M.D.: In 1966 I had been in private practice for 14 years, except for a hitch with the U.S. Army. My practice was in a rural community of 10,000 in western Maryland. At that time my only real connection with medical education was through a summer elective preceptorship with the University of Maryland. I had been taking one or two junior medical students in my practice for a month or two each summer for several years and really enjoyed the experience.

I had been partly responsible for the governor of Maryland appointing a committee of the state legislature to study the shortage of general practitioners in Maryland. One of the recommendations of that committee was that the University of Maryland should develop a program to expose students to general practice.

At that time the chairman of the Department of Medicine at the University of Maryland was Dr. Theordore Woodward. His father had been a devoted and loved general practitioner in the same town in which I practiced. He (the older Dr. Woodward) had died several years earlier but his widow still lived there. I was very surprised to receive a telephone call from Dr. Woodward on Thanksgiving Day, 1966 asking me to come to his mother's house for a chat. At that time I did not have the faintest idea of why he wanted to see me. It turned out that he wanted to start a division of general practice in the department of medicine and asked me to head it. After a great deal of soul searching, I finally decided to give up my practice and started in my new position July 1, 1967. Incidentally, we compromised and named the new

academic unit the division of family medicine.

In a nutshell, Gayle, that is what I was doing in 1966 and 1967. It has been the highlight of my professional life to be involved in a very small way in the birth of our now not-so-new specialty.

Hiram Curry, M.D.: I must begin before 1966 if my comments are to make any sense. After my internship at Philadelphia General Hospital (1950-51) I returned to my childhood hometown where I was a general practitioner until the end of 1957. Then I began to prepare for a teaching career by training in internal medicine and neurology. After five years in Baltimore, Charleston, Sweden, and Boston, I joined the Department of Neurology at the Medical College of South Carolina in 1963 to teach neurology.

I should add that I joined the AAGP in 1951. During the above years of additional training I maintained my membership in the academy. During those years my broad view of medicine was often mentioned, and to my pleasure. I believe it was this orientation which in 1969 attracted the attention of the vice president for academic affairs, Dr. James Colbert, as he sought to meet the medical university's responsibility to train primary care physicians for South Carolina.

In our first meeting to discuss this problem he asked three questions: (1) "Do you believe a generalist worth a damn can be trained?" (2) "Can a generalist be produced who can stand as tall as an internist, pediatrician, or neurologist?" (3) "Can a generalist be produced which the medical university will be proud of?"

For busy practitioners these questions may seem out-of-bounds, but those working within academe at that time were well aware of the disdain directed toward general practitioners, the LMD. I do not believe that those in general practice at that time knew how lowly they were regarded by those in academe.

I expressed my opinion that an excellent generalist could be trained. I favored the training of a specialist in family medicine. Dr. Colbert requested that I describe in detail how this could be accomplished. A lengthly proposal was written. It was accepted by the administration of the medical university and its board of trustees. And I was urged to implement the plan.

The questions posed by the academic vice-president became charges as implementation began. To favor the development of high standards a policy of open competition for residency appointments was announced. There would be no quotas, no discrimination on the basis of race and sex, and local graduates would not be given preference. This policy has resulted in high standards; and these standards are the reason family medicine has been accepted by the faculty of this medical university as a legitimate specialty.

What did I believe when we began? I believed most general practitioners were inadequately trained physicians. I have thought about this many times over the years; I believe I was correct. I was an inadequate physician for my responsibilities in Jasper, Florida. Later between 1963 and 1970, I served as a consultant for many general practitioners.

That experience reinforces this opinion. I wish to point out that a few of the general practitioners I knew were outstanding physicians.

Out of the above belief came a determined effort to train an adequately prepared family physician.

My self-image as a general practitioner was poor, and that of most of the general practitioners I knew was poor. I believed that there had to be professional pride if there was to be professional happiness. Pride in being a professional ordinarily issues from recognition by colleagues and those you serve that you are a professional. I believed then, and I continue to believe, that family medicine must be a genuine specialty, and family physicians must be specialists if family medicine is to survive in America.

To be accepted as a useful and important part of the medical profession in America, I believed family physicians had to prove the value of family medicine to other specialists and to their patients. I regarded the heretofore neglected areas of psychosomatic complaints and psychosocial problems as tailor-made challenges for this specialty. Relationships, and family relationships in particular, often predominate in these problems. This was the area where medicine needed a new specialist, an expert, the family physician.

I was confident that the first requirement for any physician is that he know that part of medical science which is the foundation for the medicine he or she practices. This requirement is no less important for the family physician.

The second requirement for a primary care physician is to understand the person of the patient, how he reacts to stress, how he copes. I believed those insights are best gained by understanding the development of a person; and that brings us back to the family. This understanding sets the stage for accepting a patient where he is and remaining nonjudgmental. This information and attitude serves one well in helping patients solve their psychosomatic and psychosocial problems.

Lastly, it is the person, or self, or personhood of the primary care physician that interacts with the patient, that communicates concern and understanding, that establishes a trusting and tenured doctor-patient relationship. Without this relationship patients are unlikely to provide a full and accurate history complete with their feelings (which are often even more important). This relationship is likewise essential if the patient is to accept the suggestions and advice of the family physician. I believe young physicians need to gain insight into their motivations, to learn how and when to use their personhood in behalf of their patients. To me this is the essence of being a physician rather than a mere doctor of medicine.

I continue to believe and to stress that these three foundation items, and self-knowledge, are essential if one is to be a happy and productive family physician.

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