

Voices From Family Medicine: Toward the 21st Century

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Throughout STFM's 25th anniversary year, we illustrated the dynamic history of family medicine using the personal narratives of some of the discipline's founders and early leaders. We have attempted to take the energy of their spoken words and put it on paper for clinician educators to learn from and lead by. For us, as authors, this process has been enriching and has caused us to reexamine and confirm the meanings of our roles as teachers in family medicine.

In this final installment, we present five new voices: individuals from succeeding generations of academic family physicians. Like the many others we interviewed but have not included here, these five individuals were identified by colleagues for their demonstrated leadership in the discipline. They and others will help mold the future of family medicine well into the 21st century.

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Ramoncita Maestas, MD

Dr. Maestas, an assistant clinical professor at the University of Washington, is coordinator of the behavioral science curriculum and adviser for second-year residents at the Providence Medical Center Family Practice Residency in Seattle. In 1991, she received a New Faculty Orientation Award from the STFM Foundation.

The reason I went into family medicine was because my childhood experiences. I grew up in rural New Mexico, in a small community called La Loma, about 120 miles east of Albuquerque. My parents were farmer-ranchers, and whenever we had any injuries or illnesses with the livestock at the ranch, they took care of them. They vaccinated, gave antibiotics, tended to sores, and nursed the livestock. They were always responding to animals in need.

There was my maternal grandmother, a very strong woman who practiced indigenous healing and a little bit of midwifery. I think about her making house calls: Somebody would come for her in a buggy and off she would go. She would lay her hands on, give massage, and offer herbs. Foremost, she would listen. She

wouldn't speak very much; she would just listen a lot. I have now come to realize that she had great healing powers.

I began to perceive that in the community in which I grew up there was relatively little access to medical care. Those who had transportation, most likely a truck—cars were almost unheard of—could take their ill relative or child or spouse into town, 40 miles away. But many people didn't have transportation. I remember my father loaning out the truck when someone was gravely ill. I remember, in particular, a 40-year-old aunt dying of a heart attack out there. Imagine her dropping dead of a first heart attack at age 40. She left very young children, and I thought this was not right. I wondered whether this really had to happen.

Then there was the language barrier. I remember going with my parents to see the physician. My parents spoke only Spanish, and here I was, a child



Dr. Maestas (right)

awkwardly trying to interpret, realizing that the transfer of communication was suboptimal. I hoped that whatever needed to take place in terms of understanding and treatment was going to take place, but I didn't have complete confidence that this was happening.

I remember a woman being pregnant. One day she wasn't pregnant any longer. You could see her out about the community, but you couldn't see the baby. There was no baby. I must have been 10 or 11 years old, and I asked my mother, "Where's the baby? Is the baby always kept in the house? How come we never see it? It's very different from other babies." Mom told me that the baby had died during childbirth and had been buried in the back yard. I thought that was really bizarre. I didn't have the framework in which to put it. I couldn't think, "Oh, if only she had had prenatal care. If only she had had access to a doctor. . . ." I didn't have any of those things in mind because none of us saw doctors. But it just struck me as something that shouldn't happen. Access to appropriate health care was very much an issue.

I almost dropped out of medical school over this very same issue. People would say I came to medical school naively idealistic, wanting to make access to health care a reality. I think I was realistic. I went to medical school thinking that becoming a physician meant becoming a family physician. But I was subjected to a lot of talk that you can't become a good family physician; you won't know enough. That was a big blow. When all the friends who I thought were altruistic and saw the world as I did dropped off into anesthesiology or radiology, I began to question whether mine was an unrealistic dream.

I left for a year to study in the school of public health. It took awhile for me to get beyond the socialization of medical school and gain a firm grasp on my roots, but that brought my goals back to me. I again realized that there were people without care. No matter what anybody said about family practice, it was the specialty that had been addressing and would continue to address health care as a right and not a privilege.

I'm quite happy that I grew through all that and persisted in pursuing family practice. It has made me more committed to being a family physician and placing myself in a position to continue to provide care to the disadvantaged and underserved.

My memories give me special energy. There's loss and pain in my childhood, but also joy and richness. All of this helps me rededicate myself to my family practice; it helps me participate intimately in other people's lives. It's the same with the residents I teach. Keeping in touch with what their needs are and contributing what I can to help them stay the course is very gratifying.

Joe Ferguson, MD

Dr. Ferguson is director of the family practice residency program in Greeley, Colo. He is on the board of directors of the Association of Family Practice Residency Directors.

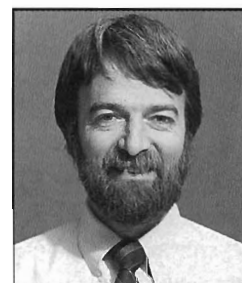
My dad was a pediatrician in the house-call era of pediatrics. He was always in the homes of his patients, dealing with sick kids there rather than seeing them only in the office. I was often a tagalong in that process and got to see him in action. He was a strong role model for me in caring for people. From a very young age I wanted to be a doctor, a generalist, and emulate my dad.

I went to an "orphan" medical school or what is now more correctly called a "target" school: Tulane. It has no department of family medicine. I had no family physician role models, zero, in the whole four years I went there. I still wanted to be a generalist. So like many people, I looked elsewhere for training. I took a flex internship in Spokane, Wash., and then finished my second and third years of residency in Salinas, Calif.

The more I saw what family practice was, the more I understood it and became excited about it. Because I trained in a public hospital in Salinas, I took on indigent care as an area I wanted to pursue. I started practice in a community health center here in Greeley.

Circumstances led me into my current position as residency director. Like many other directors, I came to the position with virtually no management skills and few leadership skills. All the things that are critical to being a manager and leader I had not yet developed. The last eight years have been a process of looking at the areas that I need to improve and working on them one by one.

I began to see the larger picture of health care delivery for our region. The shortage of rural family docs became apparent. As I learned more, it became obvious that the shortage was not only a local problem for Colorado, or even for rural areas, but also a universal problem. There are not adequate numbers of generalists to meet the needs of our country under any system of health care. Each year my enthusiasm and energy have grown because I've realized that, in the absence of family doctors, there is no appropriate answer for rational health care delivery.



Dr. Ferguson

We in family medicine are essential in terms of providing entry-level health care. Everyone else has to ping-pong patients because they don't offer the full breadth of care. No matter how many general internists and general pediatricians are produced, they still won't provide the cost-effectiveness that family physicians can. This isn't a primary care game, and it's not even a generalists' game. It's a family doc game. It's politically unwise and may appear self-serving to promote family practice as the sole answer, but it is the answer, and a constituency broader than academic medicine will ultimately come to recognize this.

No one is quite sure whether the ultimate delivery system will come and what it will look like if it does. But there's tremendous comfort in knowing that no matter what, it will be driven by family physicians who treat across age and sex barriers. That's unquestionable.

In training our residents to fill this role, we need to emphasize caring. I believe that this is a matter of exposure to family doctors. We need to continue to move toward mentoring by family docs, accessing real-world practices, putting residents in the hands of family physician groups in the community. To the extent that we teach our residents obstetrics using obstetricians who view their role largely from a technical perspective, we've missed the boat. To the extent that we teach our residents obstetrics in the hands of family physicians, we've moved ourselves much further down the road toward effectively training around issues of caring.

The other piece of caring that's critically important is our strong emphasis on the behavioral sciences. A big part of the behavioral sciences is care of oneself: making sure that you have a balanced life, that you approach your obligations with a balanced perspective, and that you include your family as a part of your daily life, not just as an add-on. If you're not caring for yourself, you can't care for other people in a way that best serves their needs either.

If family practice had been around when my dad chose his specialty, he'd be a family doc. It makes him feel really good to see that I've tried to follow in his footsteps and broaden what he endeavored to deliver. It means a lot to him. It means a lot to me.

Elizabeth Naumburg, MD

Dr. Naumburg is an associate professor at the University of Rochester School of Medicine and Dentistry and director of the Highland Hospital Family Medicine Residency Program. She is chair of STFM's Group on Women in Family Medicine.

My family has a strong history of social activism and political involvement. My maternal grandmother, for example, was extremely active in women's rights. In 1914, she was the valedictorian of her high school class, and her graduation speech was about suffrage.



Dr. Naumburg

From there she went on to become active in the League of Women Voters and in a variety of other social causes. I was very impressed by her and her husband, my grandfather, who was also involved in community activities. They were wonderful people.

Within my own nuclear family, I got support for looking at things critically and trying to change things if I didn't think they were right. It was a good thing to go out and get involved in demonstrations or political campaigns. When I consciously started thinking about careers in my sophomore year of college, medicine seemed a way to become a social activist.

I went off to medical school with no clear image of what kind of doctor I wanted to be. I only became aware of the existence of family medicine as a second-year medical student. It's amazing that I even heard of it because I went to the Mount Sinai School of Medicine in New York City, which was on record for wanting to train specialists.

During medical school, my desire to be a change agent was stifled. I had an opportunity to rediscover it in residency. In Rochester, there was a sense that family practice had a lot to do with a social commitment and making people's lives better—not just curing or caring but helping to change the entire context of people's lives at the individual as well as the community level and all the levels in between.

The program pushed me to redefine what being a doctor is about. The definition of a physician was much more expansive than I had previously known. Where a physician got his or her rewards was not simply in intellectual pursuits but in a whole series of things involving relationships and producing change. The faculty members were clear about the need to train people to go into areas where patients were underserved. They understood that medicine is a social force, a manifestation of our cultural trends.

Now, as a residency director, I've had to ask what motivates other individuals to enter family practice, especially when the dominant force in medical school pays homage to the gods of subspecialization and technology. Most medical schools continue to value cognitive, research-oriented skills over intuitive and relational skills. Some people, still, are driven by social activism. A lot of people who want to be agents of societal change go into family practice.

Some people go into family practice because they

like the diversity of subject areas. Some are interested in international medicine. Instead of the infectious disease route, family practice has now become an acceptable path to working in a Third World country. Some people have a mission of some kind: They go into family practice because it is the way they can most easily express their ethical principles.

There are also people for whom the most substantial aspect of being a doctor is their relationships with their patients. These people come through medical school without any particular political or social or religious framework. They just want to be connected with their patients and see family practice as a way of doing that.

The myth that family practice is just another cold, just another headache, just another sore throat, just another depression misses the boat. Family practice goes well beyond simply understanding the micromolecular basis for disease. Family practice is one human being, a physician, working with another human being, a patient, and devising new ways to put the patient's story together and help that person.

Family practice is really all about the human connection. Though there is a lot of intellectual stimulation and challenge in figuring out how to help people with whatever problems they bring you, there's also a wealth of intimacy and sharing. Through the human connection, family physicians, patients, and families alike can move their relationships to a new place and begin to fulfill the promise of social change.

Thomas Schwenk, MD

Dr. Schwenk is an associate professor and chair of the Department of Family Practice at the University of Michigan Medical School. He has served as a Residency Assistance Program consultant and was the Association of Departments of Family Medicine's representative to the STFM Working Committee on Curricular Guidelines for a Third-year Family Medicine Clerkship.

As an undergrad at the University of Michigan, I started on a track in chemical engineering, very involved in math and science. Suddenly in 1970, the summer after my junior year, I decided that engineering was so rigid and cut and dried that it just wasn't interesting any more. I started looking for other career directions, and medicine was one of those.

When I got to medical school, the same issues applied. The hard sciences were too constrained, too limited. Everything was so carefully described; it seemed sterile and spartan. I rapidly moved toward the richness of behavioral sciences and family practice. I wanted an area where I could work with art along with science and was captivated by the newness and by the uncertainty of family practice.

At the time, it was valuable to be on the margin. It

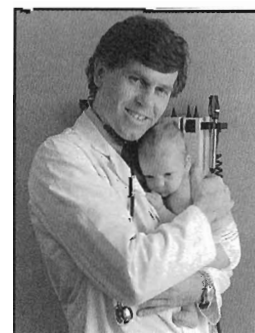
was an exciting place to be. Professionally and educationally, it was an honored place to be. Everybody was radicalized in a variety of ways: socially, politically, and otherwise.

Now, the critical need is to be at the center of both medical education and medical care so that we retain the innovation and the excitement at the margin, that we retain the original radicalizing value systems while understanding how those fit into traditional power structures and the academic medical establishment. There is a danger that we in family practice will be a temporary phenomenon if we derive most of our energy from that early socially active, socially conscious time without moving into a more established position.

My job as a department chair is to figure out how a department that is fundamentally different from all the other departments in the medical school, one that has radically different values and ways of going about its day-to-day business, can fit into a traditional system so that the traditional system begins to change as well. There's this long-term process, longer than any of our work lives, in which the system ends up looking different in small, incremental ways. In the short term, it's not apparent that anything's happening, but in the long term, we might begin to see things we hold dear become mainstream.

I have been in academic family medicine long enough to see that happen. I truly believe that the educational systems are different, that academic medical centers are different than they were 10 to 20 years ago. Family medicine is responsible for that to some extent. Sometimes we were there at the right time. Sometimes we actually made changes happen.

The management of conflict is inevitable in this process: conflict in one's personal growth, conflict in departmental growth, conflict in organizational growth. I see family medicine struggling with the excitement and the strength of a deeply felt value system. There's something natural and persistent about the core features of family medicine. The things that we hold to be important, the ways we go about solving patients' problems are broader, thicker, and more diverse than those in the rest of medicine. Yet, we're



Dr. Schwenk

being hammered on all sides by forces and people and events that challenge our value system. What happens when these cultures and these value systems clash? How can we manage that to our benefit?

The interface between conflicting cultures is where the action is today. We need not become diminished and divided and discouraged. We need not see it in a negative way. We need to see it in a positive way, as an opportunity. We can become emboldened and focus on what's important. That is the major challenge at this 25th anniversary point.

So much has changed since I became involved in the late 1970s. There has been an amazing development. We are now much more organized and more powerful than we were, but that's just gotten us to the point of being in the game. Now the question is: How well will we play their game?

Richard Younge, MD, MPH

Dr. Younge is a professor and chair of the Department of Family Practice at the State University of New York Health Sciences Center at Brooklyn. He was the founding co-chair of the STFM Task Force for Minority Health Care and currently serves as a member of the Legislative Affairs Committee.

When I started college, my goal was to become a mathematics teacher. Then, in the second year of my undergraduate studies, I took a sociology course for which I had a field placement in rural South Carolina. I worked for six weeks in the summer of 1972 in the Beaufort-Jasper Neighborhood Health Center, one of the first Office for Economic Opportunity-funded community health centers in the country. As a result of being in the health center, I began to understand that medicine and working with communities were things I enjoyed doing. They struck me as means of connecting with people in rich and important ways.

I spent a great deal of that summer working with Dr. Jerry Galloway, a family physician at the center. I shadowed him while he saw patients; I went to the hospital on rounds with him; I watched while he delivered one or two babies in the middle of the night. He was my introduction to the idea that family physi-

cians saw people of all ages and gave cradle-to-grave care.

I particularly remember making home visits with Dr. Galloway. He had wonderful abilities to make contact with his patients on a personal level, to understand what their lives were about, and to recognize not only the medical factors but also the social context of his patients. He touched his patients' lives in meaningful ways, and the patients with whom he worked enriched his life as well. The relationships he had were mutually beneficial. Having witnessed his experience, I went back to California and decided to become a doctor.

One year later, I started at the University of California-San Francisco School of Medicine carrying a notion of becoming a family physician. I began looking for people who were doing things like I had seen done in the community health center in South Carolina. I ended up finding my way to the Division of Ambulatory and Community Medicine, where I took a course from Bob Massad. The course was part of an experimental curriculum in which Bob was trying to develop functional health care teams. Faculty members from the schools of medicine and social work and nursing worked with student teams in the family practice center at UCSF. It was an important experience; it helped me formulate an image of the kind of doctor I wanted to become down the road.

I aggressively sought out family practice because I thought a different paradigm was spoken there, both in terms of working in health care teams as well as regarding the biopsychosocial approach. Bob Massad confirmed my thoughts. He introduced me to the fact that family system theories could be incorporated into medical care. He turned me on to the notion of working with the larger system that affects people's lives, like housing, socioeconomic factors, and cultural differences. He influenced my concept of family practice, pointing out that the specialty was not just an amalgam of medicine, pediatrics, and OB, with a little dermatology thrown in, but that family physicians really thought about their patients' medical problems in a different way than other specialists.

I am fortunate to have been stimulated by folks who understood the practice and theory of COPC, community-oriented primary care. Jerry Galloway was happy in his family practice. I remember the positive emotional charge he got out of his work. Bob Massad likes what he's doing, working at the interface of primary care development and New York state health policy. Through these role models, I've been shaped by the best of two worlds in family practice. I find personal satisfaction from the day-to-day work of seeing patients, while the whole process of COPC and public health intellectually enriches me.

Right now, we're at a critical and exciting juncture in the discipline: Public policy is moving to increase the practice abilities and rewards of family physicians



Dr. Younge (right)

at the same time the academic discipline is coming into its own. It's a wonderful time to be in family medicine and practice.

The narratives included in this series have chronicled the organizational development of family medicine. They also have offered a glimpse into the personal and professional lives paralleling this development and have revealed the hopes and visions of some of those who took part in the growth of the discipline. We believe that these motivating forces speak to all generations of clinician educators and hope that, through these narratives, nascent leaders in family medicine can better understand the past and prepare for the future.

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