JOHN GEYMAN

AUGUST 11, 1996

Dr. Fitzhugh Mullan,
interviewer

Mullan: What is your date of birth?

Geyman: February 9, 1931.

Mullan: It is the eleventh of August 1996. We're sitting in Dr. Geyman's house some 300 feet above Puget Sound and Haro Strait.

Geyman: Haro Strait, between here and Victoria.

Mullan: With a view of the city of Victoria, the Olympic Mountains that are a little clouded in at the moment, the Straits of San Juan de Fuca, and just absolutely a spectacular view of alpine scenery and sea, birds, boats, cities. It's hard to imagine living anywhere else. I've only been here for twelve hours.

Geyman: Here's the rock we sit on.

Mullan: We're sitting on a magnificent solid rock. But this is where you are most recently, it's not where you started. Let's

go back to the beginning and tell me a little bit about where you came from, where you were born and brought up.

Geyman: I was born in Santa Barbara, California, and grew up there. My dad came out from Minnesota as a young physician, and he was in two years of general practice himself. He worked his way through medical school at Minnesota, and interned at Anchor Hospital, which is now St. Paul-Ramsey, and went out in the country and did two years of general practice in a town of 700, decided that he didn't want to do that.

Mullan: What years were these?

Geyman: Oh, about 1921 to '23. Then came back and was the second resident group in radiology at the University of Minnesota. Trained there in radiology, came out to the West Coast and looked at Seattle. He had a letter from his chief of service introducing him out here. There were two radiologists in Seattle, and they thought there really wasn't room for a radiologist in Seattle, that he really ought to look at Portland. So he looked at Portland and got the same story, and then went to San Francisco. The fourth place he went was Santa Barbara, which was a town of 30,000 in Southern California.

Mullan: What <u>was</u> a town of 30,000.

Geyman: Yes, was. So he settled there.

Mullan: When was this?

Geyman: In 1926 or so. My mother moved there from San Francisco. I have two sisters and we grew up there.

Mullan: He practiced radiology?

Geyman: He practiced radiology for fifty-four years. So I grew up there. It was during the war. I've always been very interested in aviation. We had a Marine air base there. You could see all kinds of great airplanes as a kid growing up there. But I missed World War II by three and a half years.

Went away to college, went to Princeton. I got there at seventeen, in 1948, and the first thing I did was sign up with the Naval ROTC. That put me through college. Majored in geology. I wasn't a pre-med at all. Not sure what I wanted to do. By the end of my senior year, I knew I wasn't going to be a geologist.

Mullan: Who not? You didn't like the rocks?

Geyman: I took mineralogy, and some of that physical chemistry, I thought, was awful. Also, if you're in geology, there were two main routes. You could be in soft rock or oil geology, or you could be in hard rock and mining. Soft rock interested me more, but if you go into oil geology, you either work out in very remote places, move every six months, that wouldn't be good for a

family, or you end up on a desk in Los Angeles or Tulsa. So that didn't intrigue me too much.

Mullan: Growing up as a physician's son in the Depression and the wartime in Santa Barbara, what was that like both economically and socially?

Geyman: We were on the coast. Within a few weeks after Pearl Harbor, along our 20 foot cliffs, there were Army or Marines every quarter or half mile with M-1s and a machine gun, and the whole thing was, when was the invasion coming. Then there were gas stamps for your car, and there were A, B, and C stickers, or something like that for fuel. I think my dad, being a physician, had an A. Then there were blackouts at night on the coast. Just two months after Pearl Harbor, we had a Japanese submarine surface and lob twenty-five shells into a oil refinery we had north of Goleta, just north of the air base there. Then it got away. My mother worked with the Red Cross, and she became an airplane spotter, a volunteer spotter, and she worked with the motor pool. So it was a different time.

Mullan: How about the Depression before that? You were a young person, I know.

Geyman: As a little kid, no, I don't remember much. We were never affluent, but we were comfortable. I guess I didn't sense too much about the Depression.

Mullan: How about your dad's practice? Did that interest you? Did you participate in it at all?

Geyman: I would go sometimes to see what he did, and that interested me some. But I have to say, I wasn't very interested in--as a matter of fact, I had no interest in hospitals, which goes back to two little, very small events in my kid life. One, I had my tonsils out when I was five or six. My older sister was two years older, and my younger was three years younger, and they took all three of us off to have our tonsils out, I think by a pediatrician, by the way. I don't think it was an ENT person. And it was an ether anaesthetic. So I remember that ether anaesthetic and the smell of hospitals and the bad dreams. Have you had an ether anaesthetic?

Mullan: Yes.

Geyman: Yes. I thought it was terrible.

Mullan: For tonsils.

Geyman: Yes, for tonsils. I thought it was awful. So for fifteen years later, the hospital would smell of ether to me, and I couldn't stand it. So that's number-one thing against medicine.

Number two thing, here I am a little kid--well, now I may be in the seventh or eighth grade and we're taking a first aid

class. We're learning how to take each other's pulses. So we're standing by a table, and here's how you take a pulse. So I'm taking the guy's pulse and I pass out, and I hit the floor. [Laughter] So, two things.

Then I wasn't much of a hunter. I guess the third thing was I wasn't sure how I'd do around blood.

So for those three little very small reasons, I never considered medicine.

Mullan: Then you went away to college to be a geologist. Why did you pick Princeton?

Geyman: I wanted a smaller school, and good strong liberal arts education. I wanted to try the East Coast. I applied to Dartmouth and Princeton and got in both. I liked the idea of a smaller school in a different part of the country.

Mullan: Did you enjoy it?

Geyman: I did. I liked it a lot. I wasn't the best student; I wasn't the worst student. I played soccer, I was on the swimming team for a couple of years, played one year of rugby and got a bad knee out of it quickly. I enjoyed it, though. I was in the Naval ROTC. That's what we did in the summer. The third summer we went to Pensacola. I thought that was great. Come the senior year, I know I'm not going to be a geologist, I have three years of active duty now, and we're in the Korean War. So I applied

for flight training and I go over to Lakehurst, New Jersey, and take the physical. I'd always been in great shape. I flunked the physical for eyes. They were 20/15, but I had too much astigmatism. They had a depth perception test they've since abandoned, but they used to have this depth perception test, and I think I flunked that. But they since learned that for landing on a carrier, that has nothing to do with how well you do and, indeed, what you do is you train your occiput with changing sizes of images to your depth perception. Anyhow, I flunked the eye test, so I didn't get in for that.

Mullan: Did that mean no Navy or no flight training?

Geyman: No flight training. Then I applied for PT boats, and I didn't get that, but destroyers were the next thing. I wanted small ships. I did get destroyers, and I was in the Pacific for three years on a destroyer.

Mullan: How was that?

Geyman: Which I liked. I liked that a lot. During the time at sea, I knew I wasn't going to be long term in the Navy, but it was a good three years, a lot of responsibility early on. I was a gunnery officer on the destroyer, had a third of the crew in that department. A lot of responsibility for a young kid. But during that time, I started thinking about what after that.

Mullan: Did you see any action in the Korean War?

Geyman: Yes. We were off the coast of Korea with carrier task forces. We had mines to deal with, and we did shore bombardment every fourth day. The ship was hit in Wonsan Harbor a year before I got on by a shore battery, but not afterwards. Mostly it was operational duty and no major problems.

During the time in the Navy then, what am I going to do after that? If I hadn't gone in the service before, I probably would have gone off and taught high school science, which interested me, and maybe coach. But then I started rethinking medicine a little bit during that time. My dad gave me a book by one of his anatomy professors, Logan Glendenning, at Minnesota. I don't know if you've seen any of his books.

Mullan: Yes, I have.

Geyman: Anyhow, I was reading that book at sea. I found that he was a good writer, and that was pretty interesting.

So I get out of the Navy and go back to Berkeley, and did a year and a half of pre-med, then applied for medical school. This is interesting, too. At Princeton I ended up with a GPA of whatever it was, I forget the numbers, but I was at the bottom of the upper third of the class, but that translated out to the West Coast in the University of California system to be below the level at which you'd even be granted an interview, like for UCLA or UC-San Francisco. The reason is that the way they did that

conversion was based on people that have been there and then came out to the UC system. But they're a bunch of dropout people there, or transfers. I couldn't understand all of that, but anyhow, my grades at Princeton I didn't think were too bad, like a B-minus, and Princeton was a hard grader.

So anyhow, I had to do really well on my pre-med, and the only course I got credit for as a geology major for pre-med was one year of general chemistry, so everything else on that long list I had to take. There was thirty-six units, and I got an A in everything. But I was older, I knew just what I was going to do. So that barely squeaked me up to a number that would get me interviewed. [Laughter] Then I applied to twelve schools, and I got into most of them. But UCLA didn't grant me an interview. I went to UC-San Francisco.

Mullan: That was when? What year was that?

Geyman: I entered in '56. Got out of the Navy in '55 and got married in '56. I met Gene right at the beginning of that pre-med year. She was just graduating and going to be a teacher, which she did. Between her working as a teacher and my G.I. Bill, that's how we went through medical school.

So going to UC then, the first year was in Berkeley, the reason being that in the fire and earthquake in San Francisco in 1906, the basic science buildings were destroyed in San Francisco. It took fifty years to get back all four years in San Francisco. But the first year in the mid-fifties was still in

Berkeley. So we were living in Berkeley the first year, moved to San Francisco for the second year. Then we had a class of eighty-four. There were only seven women, an item of interest.

Mullan: Any minorities?

Geyman: A number of Asians, no blacks, no Hispanics. I and maybe seven or eight other guys were out of the service and were a little older. I felt at an advantage. At the end of it, seven of us went into general practice out of eighty-four. When I entered medical school, I was going to be a small-town general practitioner, and I never changed from that. That was my picture of what it was to be a physician.

Mullan: Why's that? That's not what you dad was.

Geyman: That's not what he was, and I don't know. But that just seemed right to me.

Mullan: Is there any person or situation or movie or book that you attribute that to when you sort of shut your eyes and think back?

Geyman: It just seemed like the thing to do, but I cross-checked intwo ways. The California Academy of General Practice had a summer preceptorship program, and I took two of those. Between sophomore and junior year, I took two that summer. I was with

Bill Reynolds up in Dunsmuir, who was maybe ten years older than me, and I thought his practice was great. He was one of two docs in a town and he did everything. He was the center of the system. He did a great job, and he enjoyed it. He worked hard. That experience plus another one, I took a two- or four-week preceptorship in Santa Rosa with an older physician who had a different style of practice, but I thought that was great, too. Both GPs. So I did that and I read some books. I read Dooley's book on work out in the Pacific.

Mullan: What is the book? A number of people referenced Dooley.

Geyman: It was before Vietnam.

Mullan: It was about his experiences?

Geyman: Medico? Wasn't that the name of the program? Medico? He was not a missionary, but he did mission work out in the Southeast Asia. I thought that was pretty interesting. I got some of those books.

I even explored doing medical mission work. Gene and I went to a conference once sponsored by the Presbyterian Mission Board. The Presbyterian Medical Mission Board was the biggest medical mission board of all the churches then, and I think still is.1q So we went to a weekend retreat once in the East Bay. They had a missionary physician and his wife back from somewhere in the Congo. They'd been there two or three years. So he gave slides,

and there was one slide, "Yes, I trained them to do surgery," and here's a picture of three or four gurneys, a gall bladder surgery going on here, a hernia here, and this physician's going back and forth instructing his proteges doing surgeries.

Mullan: Did you like that?

Geyman: Well, it was interesting.

Mullan: And in terms of religious background?

Geyman: In terms of religious background, that's where the problem was. [Laughter] The thing that kind of turned me off was, yes, you have to be very Trinitarian in your belief, and I'm a Unitarian. Indeed, he even made quite a point before induction of anaesthesia, he would say a prayer with the patient, and on and on. I thought it was a little too much proselytizing. If it was strictly medicine, that's one thing. So anyhow, I fell away from that. But we were kind of wondering about foreign work.

The center of my goal was always to be a general practitioner. It fits my personality. I like to work closely with people. I like a lot of responsibility. I always seek it out. I sought it out in the service. I like the variety of it. I like the challenge of it.

Mullan: So what happened? You had a pretty urban setting.

Geyman: Pretty urban setting. So then I looked around, and how do you train to become a good general practitioner.

Mullan: What were people saying about general practice? This was approaching a low point, I would think.

Geyman: We were encouraged not to do that. We were "too smart" to do that. "Why don't you become an internist." The culture of San Francisco was pretty elite. The jargon of your teachers was the "local physician" from "up country." But I still thought that's where the actiion was.

So I looked around. This is 1960. Only seven of us going into general practice. I looked around for a good rotating internship. I applied to Los Angeles County, that was my first choice. I applied to King County up here in Seattle. I applied only to county hospitals, including Denver General, and decided on L.A. County. There was 3,500 beds, second biggest hospital in the country, 160 rotating interns, and I had a great experience there. That was good. I took two rotations of OB, we'd have seven deliveries every twenty-four hours. They had a whole ward of eclampsia. Not pre-eclampsia, they had a whole ward of eclampsia. They had a whole ward of PID. When you're on orthopedic surgery, you did all kinds of medicine. Not as much of orthopedics as medicine. Our maximum, I recall, was 15 or 20 admissions in twenty-four hours. You'd see pulmonary edema, and all kinds of medical problems.

Mullan: In-patients for orthopedic problems?

Geyman: Yes. The jail service was a general practice service. Gabe Smilkstein was precepting on the jail service. You know Gabe?

Mullan: No, I know of him.

Geyman: He was about five years ahead of me and was in practice in Claremont. Excellent GP. About the only GP I saw there. But that was s general practice service. Thirteenth floor of L.A. County. I enjoyed that service.

But then you look around for what next, and there were four or five pretty good general practice residencies in California in the county hospitals. Ventura was, San Bernardino was quite good, Santa Rosa was excellent (Sonoma County). Denver had a program; it was the only university-based program I could find, at Denver General. It was a two-year program. I looked at that pretty carefully, and almost did that, but they were losing their OB rotation, which was down in Albuquerque. So that seemed a little unstable.

So I ended up going to Santa Rosa and liked it a lot. Great maturing experience. Ten residents.

Mullan: That's a two-year program?

Geyman: It was a two-year program. There were five of us in each year. Great experience, a county hospital out in the country, three miles out of town, heavy volume of in-patient and out-patient.

We had one full-time person--the medical director (this is a riot)--the medical director and the residency director was full time. He was an ex-Navy urologist. I think he had a drinking problem. He did no teaching. But the residents ran the program. Santa Rosa had this long tradition of community physicians teaching in all fields. There were, I think, seven orthopedists in the town when we were there, and every Wednesday morning was orthopedic conference from 8:00 to 9:30. They would all be there. They would review our films of all the closed reductions we did, and help us, and teach us, and they'd come out and help us with cases. Friday morning was pediatrics. All the six pediatricians would be there every week. One of them would be attending at any given time. So that was the spirit across the board in the community.

Mullan: I guess I'm not aware of the phenomenon of GP residencies in the period before the advent of family practice residencies. Where did they come from? How were they different than what came after them?

Geyman: I'll get you a paper that I did on just that subject. The basic story, in the fifties there were a number of GP residencies around the country which never filled very well.

Many of them weren't too strong; almost none of them were based in the university, Denver being one of the rare exceptions; and of varying quality. I think California probably had some of the best, and they were in their bigger county hospitals. A number of those were really very good. San Bernardino was strong from 1960 on, and converted to family practice in the early seventies. Ventura, the same. Santa Rosa, the same. Monterey County in Salinas, the same. Contra Costa County was slower to convert to family practice, but eventually did.

Mullan: What was the thinking behind that? Were people recognizing that in order to train a competent GP one year of graduate training was not sufficient?

Geyman: At the time I came along, you'd ask people, "How do you train to become a good GP?" It was actually interesting. One option was to find a GP residency. That's what I did and a number of my friends did. But you'd have to look around, and some were good, and some were not so good. Another option was you'd take a year of medicine, a year of surgery, a year of OB, and maybe a year of pediatrics. I had a classmate who was going to do those four. He took a year of pediatrics and he went into peds. I never heard of anyone doing four years like that successfully. Then a third option was, well, you take a couple years of medicine or a couple years of surgery, then you'd just go out there into practice.

Mullan: Surely there were people still taken a rotating internship and just going out there, were there not?

Geyman: Yes. There were a lot of those.

Mullan: That was the previously established way, was it not?

Geyman: Exactly. But I think by the early sixties, that was being discouraged. I certainly wasn't comfortable with that option.

Mullan: Where did, in the fifties, I gather, these GP residencies come from?

Geyman: They came from county hospitals that needed generalist docs to run their hospital.

Mullan: Was the American Academy of General Practice--

Geyman: It was supportive of these programs.

Mullan: That was the term then? The American Academy of General Practice?

Geyman: Exactly.

Mullan: It was supportive of them, but it was not implementing them, catalyzing them, or was it?

Geyman: No, it wasn't. It was just supporting them in concept, but there wasn't any Presidency Assistance Program that the American Academy of Family Physicians later developed, or any of that. There wasn't close ties.

Mullan: So it was somewhat spontaneous quality to the development of these. Nobody was pushing them.

Geyman: Right.

Mullan: County hospitals, and particularly California, were developing these programs.

Geyman: Right. Exactly.

Mullan: Yours was pretty good, but it wasn't because of the program so much as was because of the community and community docs?

Geyman: And the residents made the program. For instance, when I was there, we didn't have any allergy experience. I started an allergy clinic. I got interested and I read some books; I talked to some people; we bring in the resources; we started a clinic. We had plenty of patients. We got some consultants in there. We

had an allergy service. But that's how we would do it. Some other residents were interested in other things, and that's how they would do it.

Mullan: So you did two years at Santa Rosa?

Geyman: Two years at Santa Rosa.

Mullan: Which years was it?

Geyman: '61 to '63. As I thought about that experience, I think it was very strong on in-patient medicine. It was strong surgically. It was strong in orthopedics and trauma. It was very weak in psychiatry. We had psychiary beds for seventy-two-hour holds, and we would learn a bit about psychiatric emergencies. Thorazine was the main drug then. We didn't have all the wide variety of psychotropic drugs tthat we have today, but we had to manage acute psychoses. But for many of the day-to-day mental health problems, it was a non-experience. It was a real vacuum.

But we were strong in other things, strong in anaesthesia. The residents gave all the anesthetics--generals, spinals, and regional blocks. We had excellent experience there. I had three months of anaesthesia rotation, plus night call. We got two residents on call every night, and the second call would do the deliveries or anaesthesia. OB anaesthesia call was the second

call. So lots of anaesthesia. In surgery, we did appendectomies, hernias, vein stripping, C-sections.

Mullan: Gall bladder?

Geyman: Gall bladders. I did some gall bladders in training. I never felt comfortable about them. I thought it was a step beyond where I should be, and I didn't do them in practice. Some of my colleagues did do gall bladders, did as many as they could in the program. We did abdominal hysterectomies, as wel as A&P repairs. I did just enough A&P repairs to know that was not a procedure that I would do in practice.

Mullan: So it was two years there. What were you thinking at that point and what did you do?

Geyman: I'm still thinking rural general practice. I always thought that. It never changed.

Mullan: Now you had time to deliver.

Geyman: Yes. So still thinking that, and we made a trip a year before the end of the program. Gene and I made a driving trip, and we were going to go to the Northwest, just like we always thought. We went to Hood River, Oregon, which is on the Columbia River, and it's a town of maybe 2,500. We went to Anacortes right near here. We went to Pullman, Washington and Moscow,

Idaho, which is just across the border, a town of 10,000 or 15,000. The University of Idaho's there. We went to Kalispell, Montana, and Whitefish, Montana. We visited about eight places. Those were good prospects.

Mullan: What did you do?

Geyman: What were some of the criteria? Well, Northwest, small town, need for a physician, and not the only doc, though, and it looked like the right chemistry for raising a family and practicing medicine. We were going to go to Kalispell after that trip. North end of Flathead Lake, there's a little place about half a mile out of Kalispell, It was an unincorporated area that had a dentist but no physician. It's on the Flathead River. It's called Evergreen. So I found a contractor who was going to build a building that I could lease/purchase. We were all set to do that, but along about March or so, he decides he's not going to do it. So now, in March, I'm going to finish residency training three months from now. Now I didn't know where I was going to go. By the way, two years later, where that office would have been near Kalispell was washed out in a flood of the Flathead River. [Laughter]

So now I finish the residency on June 30, we get in the car, start north. We're going to retrace our steps up into the Northwest. The first stop was in Dunsmuir to see my friend, and eight miles north is Mount Shasta, where we'd worked a lot, because that was a local hospital when I was there for the

preceptorship. There were three docs in Mount Shasta, but one of them was in the hospital with a glioblastoma multiforme, fifty-nine years old, died. So that practice was available. So that's where we went.

Mullan: This is 1963, '64?

Geyman: '63.

Mullan: What was Mount Shasta like as a town? How large?

Geyman: It was a town of 2,500. We drew on many more than that, I'm sure. There were three of us in the town. There were ten of us in the four towns that used the Mount Shasta Hospital, a twenty-eight-bed hospital. There were three docs in Weed to the north, there were two in McCloud, and there were two in Dunsmuir, and the three of us or so in Mount Shasta.

Mullan: What sort of population?

Geyman: So together we drew on 20,000.

Mullan: Working folks, farming?

Geyman: Working, farming, logging, railroad, small business, all that.

Mullan: Employed by them, or what kind of income levels?

Geyman: A lot of blue-collar. Logging was number one. There were a number of mills there then, some of which have closed during that time and later. Railroad was still big, Southern Pacific. Dunsmuir was a railroad town. The docs usually did contract work with Southern Pacific. You'd see the railroaders.

Mullan: You were there for how long?

Geyman: Six years.

Mullan: Tell me about it.

Geyman: It was a great experience. We were all solo. Three of the ten of us wanted to develop a group coverage system, and we never got it through. But it only made sense. Three of us gave anaesthesia out of those ten, and we didn't even have a plan for one of the three of us to always being there. It happened we always were, because we all worked the most of the time. You'd go to the hospital on Saturday afternoon or Sunday morning, and you'd see almost all of the ten coming in to see a patient or sew up a laceration. The only coverage we did have was ER call. We'd go Friday noon to Friday noon, and one of us for a week would see the transient patients. So we did that sharing. But a first call and a second call for anaesthesia and like that, no way. Or a group coverage system where, say, four of us, or

whatever, would go one and four on the weekends and share OB or whatever, no way.

Mullan: Was the experience as you anticipated? You had a lot of time thinking about small town general practice.

Geyman: I threw myself into it. I loved it. I worked all the time. It takes quite a while to describe, but a lot of blood-and-guts medicine. I averaged about thirty patients a day. My worst day was fifty-six. Fifty-six. I was on call, and everything happening. It was just wild. I had days that were forty a day. It was usually about thirty to thirty-five, though, including hospital care. Mike doing a T and A and maybe a hernia repair, plus an anaesthetic or two, plus the office, plus an OB that night. It was hectic. But it was fun until you got too tired.

Mullan: Were the others GPs as well?

Geyman: They were all GPs, and to a person they were all competent, really competent. I thought we had a really good medical community. They'd all done residency training, kind of putting it together like I had.

Mullan: But you were doing this at a time when American medical education and American medicine were charging towards specialty

care. Do you have a sense that you were out of step or an anachronism?

Geyman: No, not at all. That was a time when Regional Medical Programs were starting. It was a time when coronary care units were starting, the first one in Boston. During the time that we were there, I started our little CCU. For a time we had the smallest hospital with a CCU. We put in two beds, and we put in telemetry with a Berkeley cardiologist.

[Begin Tape 2, Side 2]

Mullan: This is John Geyman, tape one, side two, continued.

So you felt like you were keeping pace?

Geyman: Yes, and under Regional Medical Programs (RMP), I went down and took four consecutive weekends of training at Sutter Hospital in Sacramento to learn cardiac care; and learn to put in transvenous pacing catheters. We actually didn't get to do those there, but were told how you do it; all the drugs; cardioversions; and arrhythmias. After returning to Mt. Shasta we trained fifteen nurses, all volunteer nurses. We got our equipment. We had a two-bed unit in our little ward, and we had nurses on call, and we reported that experience. I think we had an 8 percent mortality for MI over the years that we did that. It was really low. We had a number of saves. That was a really good experience.

But, no, here's Regional Medical Programs, and here was a system to help you in the country to do what needed to be done. That was exciting. We had a regular CME program out of UC-Davis. We would invite speakers up, four to six a year. They'd come to Chico and they'd come up to Mount Shasta with us, and they'd spend a night. So we were on a regular CME circuit which we developed. It was exciting.

Mullan: In your own mind, knowing a bit about your later career, did you have the sense of becoming a family practice specialty, and did you have criticisms or visions that family practice could be more than it had been under the old GP concept?

Geyman: I think so. You always wanted your medical school to do more, and to recognize the importance of general practice. We had medical students in our community for GP preceptorships. We had them every year from the university. So you were always critical of your school for not doing more, but on the other hand, programs like Regional Medical Programs stimulated the kind of changes that were needed in the delivery system. I think we just kept seeing it as a challenge to build a local health care system.

The story of specialization in general practice was a long struggle. There was a proposal to the AMA [American Medical Association] in 1948 to make general practice a specialty. And it failed. It came close, but it failed. Then other proposals in the fifties and they never got anywhere. So you expected that

some day it would happen, it should happen, and by '69 then it did finally happen.

Then the next thing about that to me was I received a call call in August of '69 from a friend who was a year behind me at UC and the Santa Rosa residency, who was now in practice in Healdsburg, California. He said they had put together a Search Committee and wanted a director of the Santa Rosa family practice/general practice residency. They had an RMP grant, a three-year grant, to establish that as a family practice program, convert it from GP to FP, and would I want to consider that.

So I went down and interviewed, and decided, "Yes, I'll do it." That was a big decision, because I was thriving in practice. I liked it a lot. On the other hand, it was an uncontrolled practice, and I was slow in getting help. In retrospect, I wouldn't have been able to practice at that velocity for very much longer. But here's the "rugged mountain doctor" concept that was the ethos we all practiced in. That wouldn't have worked long term. So had I stayed, I would have brought in a partner, and maybe formed a group, which is what other physicians did later on.

By the way, parenthetically, there were three physicians in Mt. Shasta during the 1960s and about ten years later there were eighteen. There are at least eighteen or twenty there now, and only small growth.

Mullan: Before we leave Mount Shasta, you said something last night to me about being able to drive around the town many years after you left.

Geyman: Yes.

Mullan: Give me that again. I thought it was classic.

Geyman: Well, it's really interesting. After just six years of practice there but they were very concentrated years, it was like ten years of experience in six--yes, there's a story. Driving by almost every other house, I can still remember who lived there, or what the family dynamics were, or a delivery in the middle of the night, or a house call for a bee sting anaphylaxis with successful resuscitation. There are so many examples to reveal--indelible memories.

Mullan: About moving to Santa Rosa, the opportunity to get involved on your movement, were you aware of the politics and changing perspectives of family medicine? You hadn't been involved in them.

Geyman: Yes. Well, let me talk a little bit about that. For me that was a great stressful time, because I had left all of the challenge, involvement and support from patients, of a thriving practice, and went all of the sudden, overnight, to become the residency director of a program, and I didn't have any

colleagues. I was the only full-time faculty person. I was an administrator. I didn't have time to have my own practice anymore. The residents were very demanding. We were trying to build a new building for them and get approval through the county Board of Supervisors, which was a real thrash. We did get it done, but it was a thrash. Funding was a problem. All the administrative work, which was new to me, and I didn't have any colleagues. They were out in practice doing what I used to do. Plus all the loss of strokes from patients.

So I found that kind of an identity crisis and, in retrospect, here's what I did: I wrote a book. Not a very good book, but it was the first on the subject.

Mullan: What is the book, John?

Geyman: It's *The Modern Family Doctor and Changing Medical Practice*.

Mullan: What was it about?

Geyman: It's about just what you asked. It's about what is this thing called family practice? Where did it come from? What is it now? Where's it going to go? I educated myself about that, so I read everything I could find. I stuck myself away in our little house down there in Santa Rosa. Didn't have any colleagues, so I did my work in the day, and at night and

weekends I'd write my book. There's going to be twelve chapters. This next two weeks will be chapter one, etc.

Mullan: Any decent circulation?

Geyman: Oh, it didn't sell a lot of books, but it sold some. It It wasn't the first book about general practice. Stanley Truman, in Oakland, California, a GP in the fifties, had written an excellent book about general practice. But this was the first book during this changing time, the first book about family practice. So that's just what I did. I educated myself. I read everything there was, which there wasn't very much. I thought through it, and, indeed, we were on the RMP grant, the challenge was, "Okay, you're going to convert the two-year program to the three-year program. What's the curriculum, and how do you organize it, how do you fund it, how do you recruit residents, and how about behavioral science," and so on.

So that was my way of dealing with the identity crisis. I made a trip around the country on RMP funds, and went to about eight programs or so. I went to Oklahoma, which was quite a good program with a charismatic director. I went to Wichita, where Gayle Stevens was, and he was doing also very charismatic. I went to Miami where Lynn Carmichael was. He was an early writer in the area. I went to Rochester and spent some time there. I went to Ian McWhinney's program up in Canada, and to Hamilton. Each program had its own special strengths and personality.

Mullan: As well as you can remember, what was your perspective on the family practice movement at that time?

Geyman: I thought, "Finally, this is what has to happen, and the reason I left practice was it has to be real family physicians, real generalists, to do this." Indeed, what you don't what to happen is to have a cardiologist or some other non-generalist just move over and run these new family practice programs, and that was happening to some extent. So I thought real family physicians ought to be leading these programs, ought to be teaching in them, and ought to really get on the bandwagon to make this thing happen. It all seemed pretty logical to me.

Mullan: You were at Santa Rosa this time for how many years?

Geyman: Two years. Got the program accredited as a three-year family practice residency. We recruited the incoming R1 class. We planned and built a sizeable Family Practice Center, including a counseling room with one-way windows and other needed facilities for the new teaching program.

I had a clinical appointment at UC-San Francisco in Ambulatory and Community Medicine, a clinical assistant professor. I'd meet with people at the University a lot, or we'd have meetings halfway in between San Francisco and Santa Rosa. But my effort was always to push the school to do a lot more. I wanted them to establish a Department of Family Medicine, so I started pressing for that kind of thing, and to do a lot more

with the student program, and to establish a residency network. "What is the University of California going to do about family practice? Or are you just going to have a token program out here in Santa Rosa?" I was younger. They probably saw me as a foreign body.

Mullan: What happened?

Geyman: I didn't think they were going to do a lot, at least for a long time. My next thing was, okay, it's good to start a residency in a community hospital, but it's even more urgent to start Departments of Family Medicine in medical schools where you do it all. You have student programs, you have residencies, you develop a network of affiliated programs, and you develop a research program.

This is off the record, but UC was doing just what I didn't want to see happen. They had a well respected internist without any primary care experience in the commuinity who set up the Division of Ambulatory and Community Medicine in the Department of Medicine at the University of California. Within this Division of Ambulatory and Community Medicine, there was this token affiliated family practice residency at Santa Rosa. That wasn't the structure that should happen.

So I decided to look for a medical school base, and about that time I looked at Utah. I didn't think UC was going to do what I would love to see them do then. This was in '71. So I went to Utah. The University of Utah had a Department of

Community and Family Medicine, and I was the first division head of family practice at the University of Utah.

This is interesting. Here Utah passes a bill for a Department of General Practice in their medical school. A very competent cardiologist took that on, and was the first chairman of that department. His heart was in the right place, he did a lot of good things in that department. On the other hand, it was not a cohesive or congenial department.

This was my first experience with politics in medical schools. I did that for two years, but I found it very difficult to work with in that environment--there were a lot of cross currents between community medicine and family medicine, and in many ways it seemed like the priority was community medicine, whatever that was.

Mullan: Was there a residency there?

Geyman: Yes. There was a University-based family practice residency just starting up, and during my time there we lso developed an affiliation with Ogden to the north--actually, with both community hospitals in Ogden. There's a long and a short story to that, but that ended up as just one because they couldn't get together. One was LDS and one was Catholic. We were going to start a single program up there that involved both of them, but we never could do it politically. So we actually started two of them up there, but one of the programs was forced

to close about three years later. Whole set of dynamics about that.

Mullan: So you were there for two years?

Geyman: I was there for two years. That was my first time in a medical school. We got a lot done. On the other hand, I was not happy there, mostly because of the kind of internecine politics, much of which was in the department.

Mullan: What were you thinking? What was next for you?

Geyman: Well, I thought I should go be a chair somewhere and I also wanted to develop networks of family practice residencies. Just about that time at Davis, California, they wanted a person to establish such a netwowrk in central and northern California. I'd always liked Davis. I'd been working with them in RMP when I was in Mount Shasta, and they always seemed more like an outreach school than San Francisco did, and I liked their philosophy.

Mullan: Did they have a department?

Geyman: They had a Department of Family Practice, but the network hadn't developed yet at all for residency training. A residency network was needed, this was country that I love, and I came from there.

Mullan: This was 1973?

Geyman: Late '72. So that's what we did. We built a residency network of five or six programs as far north as Redding and as far south as Merced, and made all that work pretty much like that. Those were a good years. Our kids were in middle school and high school, and Davis is a nice university town to live in. I liked all the outreach, and got to fly around within the network.

Mullan: Which years were these?

Geyman: Late '72 to the end of '76.

Mullan: How many residents were there in those five or six programs?

Geyman: Some programs had twelve residents and others had eighteen so that we had twenty-five to thirty graduates a year from the network.

Mullan: Apropos of work as a program director or division director, and now a network chief, you mentioned along the way some of the elements of educational innovation that you saw built into family practice training from the beginning. A couple of things that come to mind you've mentioned are an emphasis on behavioral medicine and use of teaching techniques such as one-

way mirror to observe interviewing and doctor/patient interaction. Tell me a bit about that. My sense is that there was a sort of breath of fresh air brought to medical education by the nascent, young, muscular, family practice movement in terms of educational perspectives and educational innovation. Is that true? Were you aware of it? And can you capture briefly for me what those kinds of innovations were?

Geyman: I think it's true. Behavioral science was a whole new area that none of us knew too much about. We hadn't had formal training in it ourselves. I remember going down to Palo Alto. They had a family counseling and family therapy program there, with a charismatic psychiatrist, some social workers that did a lot of counseling, and an anthropologist in the group. They had counseling rooms set up for teaching, with one-way mirrors, and microphones; you could sit there, critique the session, outside the room, and observe directly the dynamics. That was one example of an innovation we wanted to introduce to our own residency programs.

There were many challenges in developing these early family practice residencies. How do you teach common problems and make them exciting? What kind of conferences are neded? How do you establish teaching practices that emulate the principles of family medicine, including a continuity, comprehensive care, a screening and preventive program, modifying the medical record, using the problem-oriented record, and developing a functional system in a Family Practice Center. The physical space of ech

Damily Practice Center had to facilitate the process of care which we needed to teach and practice.

Mullan: That was the premise of most of these programs that they would have a building, a site, a locus of their own?

Geyman: Yes. Absolutely.

Mullan: The reason for that was what?

Geyman: Family Practice Centers needed to function as the model of how the family physician should work. This is a group practice. This is working with other professionals. This is continuity of care. This is comprehensiveness of care, with quality controls built into the practice.

Mullan: If you were going into a setting and starting an internal medicine program, not that a lot were being started then, but if in 1972 or '73 you were, an internal medicine program would not have requested or set as a goal, I presume, a building, whereas family practice seemed to feel it needed a building. What is the distinction?

Geyman: Our history in general practice training programs, expecially in county hospitals where I trained as a GP resident, should see how not to do it. The out-patient clinics there were just a bunch of exam rooms and a waiting room. Usually there was

noteven an appointment system. There was not a good medical records system. The emphasis was on episodic care, and not real comprehensive care. So to put in a system of comprehensive care, of regular screening and preventive programs, of counseling, of behavioral science, a recall system for selected problems, that takes a real organized system, and you're not going to do that in the old clinic buildings.

Mullan: It seemed to me lurking behind that--and correct me if I'm wrong--was the ambulatory premise.

Geyman: Exactly.

Mullan: And that is that internal medicine was going to see a few out-patients, but mostly was involved with in-patients.

Geyman: Yes, that's a good point.

Mullan: With family medicine, the locus was essentially moved out of the hospital.

Geyman: Exactly.

Mullan: To do that you needed a facility that was extra, that was outside of the hospital.

Geyman: Exactly, where you could model how to apply the principles of family medicine. In general practice, the emphasis was often more on episodic care. Some GPs developed comprehensive care, but it was always ad hoc, and whatever you could work into your system of practice. But in family practice you had to develop a system where you can model a practice and train residents in a group setting.

Mullan: So you were at Davis for about four years--'72 to '76.

Geyman: Yes.

Mullan: And you were successful in getting the network up and going. What happened next?

Geyman: I was still thinking about chairing a department, and that opportunity came open at Seattle. Ted Phillips had started it. He was stepping down after five and a half years. So I threw my hat in the ring. We had always loved the Northwest, and I saw that as the ideal place to go, because here was a school for four states. They had the WAMI program up and going--Washington, Alaska, Montana, Idaho. Only medical school for a quarter of the landmass of the U.S., with teaching programs for students already established in those four states. The dean there was a great leader who started WAMI and was a strong supporter of family medicine.

Mullan: Who was that?

Geyman: Bob Van Citters, Great guy. He was an internist who did research in cardiovascular medicine including cardiovascular systems in giraffes and steelhead. He's an avid fisherman. He was a very strong dean, and despite his orientation to basic cardiovascular research, he could see the big picture. He moved that medical school to family medicine, and to WAMI, and to a whole regionwide system, while at the same time continuing a strong, biomedical research enterprise. He was Dean for 12 years and was a key person in the evaluation of the University of Washington Medical School as a leader in primary care regionalized medical education and biomedical research. That was the ideal place for me.

Mullan: So it was 1976?

Geyman: December of '76.

Mullan: Got the job, moved to Seattle.

Geyman: Yes.

Mullan: How was it?

Geyman: Exciting.

Mullan: What did you find? What kind of department and what goals did you set for yourself?

Geyman: Ted had done an excellent job in the initial organization of the department. The University-based faculty, however, was still small with only six or seven FTE, and several others. But I thought a department ought to have at least eighteen or twenty FTE. In coming to Seattle, I had the Dean's commitment to expand the number of FTE.

Ted had already developed tremendous relationships with the community, with good student programs. There needed to be a lot more done in residency networking, and there needed to be a research arm of the department. We needed to integrate our programs and become stronger in the school. We're successful in that effort. I was chairman for fourteen years. We developed a strong residency network. We further developed the student teaching programs. We developed fellowship training, and recruited some excellent people in research. Roger Rosenblatt was the first. He led the research effort and then we brought more people on later in research.

Geyman: Roger Rosenblatt.

Mullan: Let's pause on the research for a moment, because that is something that you've been distinguished for. The basic negative premise which one hears about from time to time is family practice is clinical grunt work, and family practitioners

are well trained if they know their clinical medicine in a variety of fields well. New knowledge is going to come from specialties who are at the frontier of the various elements of the body that they superintend. So family practice really does not have a role in developing new knowledge for research. Clearly, you don't believe that, but tell me what's the counterargument to that.

Geyman: Roger could be more articulate with the counterargument than me, but basically a lot of common problems have not been researched well. Example: orthopedics haven't been as interested in office orthopedics as in the more major surgical proccedures. So that little example mallet finger, that we talked about. There's an answer to that. But try and find it. Surgical versus non-operative treatment. There are hundreds of examples like that across the board in common problems which beg for systematic, practical research in everyday community practice. If you believe in there should be scientific underpinning to what we do in medicine, based on outcomes, then where's that research getting done? For a lot of common problems, it's not getting done, number one.

Number two, a patient is not justa collection of subsystems. You can't add up the perspectives and recommendations of all the subspecialists and get a whole patient. Every patient is uniquely different, and every patient has a unique story. Every clinical situation has individual problems and circumstances. So problem-solving as a family physician is a very different thing

than what a subspecialist does in reductionistically sorting through a differential diagnosis that he or she has done hundreds of times for a given set of complaints. So it's just a different paradigm.

Thirdly, if you really embrace comprehensiveness of care, continuity of care, and bringing the psychosocial element into what you do in a clinical encounter, that's an entirely different thing. You don't see existing subspecialists telling you how to do that. So those are just the first three things that come to the top of my head, and there are any number of other ways of looking at that question.

Mullan: What was your experience in attempting to find family physicians with research interest and/or capabilities, and what was your experience with the product, the success, in generating family practice research?

Geyman: These are tough questions. I could spend an hour trying to answer that one. But in general, you looked around and you didn't find researchers at that time. We didn't have fellowship programs, we didn't have the Robert Woods Johnson fellowship program. You had a few people with an MPH, and some research skills.

Mullan: You were starting a field, sort of bootstrapping it.

Geyman: Exactly. We bootstrapped from the beginning. I'm not primarily a researcher. I never got to take a fellowship program, but I knew what needed to be done. I have tried to take a scholarly approach to my practice. I wrote some papers from my own clinical experience which were mostly just case reports. But what we needed to do was to bootstrap up, to develop fellowship training, and to get some role models of researchers, and it's difficult. We finally have a group, still not a large number, of trained investigators in family medicine. A chapter in my first book on research in family practice is how one can conceptualize what the dimensions of research in family practice might be, but then how you develop that is the next problem, and remains a problem today.

Mullan: Has the field, since the fledgling days when you conceived of it, and at a few places like the University of Washington, scholarly effort and scholarly resources were invested in getting family practice research going. How has the field developed, not just at Washington, but across the country? How do you feel about its maturity or lack thereof now?

Geyman: I think it's improved a lot, but it's still a vulnerable area of family medicine. It's nowhere near where it needs to be. What I would like to see is a real active research component in every university Departments of Family Medicine, as well as each affiliated residency program, and a solid scholarly approach to practice. Each family practice needs a a good recall sysem and

computerized database, with the capacity to study common problems not having to be at the university to do that. But you look at examples of that where people are actually doing that, and they're usually just overrun with the demands of practice, and not doing studying and reporting their experience.

So yes, I think we made some progress, a lot of progress, and we have a small cadre, still too small, of people with MPHs and real research skills. I think we need to go to new levels. It has always seemed to me that internal medicine has done very well in melding scholarship with patient care. It also impresses me that many surgeons can say, "Well, Ive done 300 of this procedure, and this is my outcome for that procedure." Well, we ought to be able to do that for common problems in family medicine, and we're not there yet.

Mullan: In recent years there has been an effort to meld health services research and certain population-based research with family medicine research, or at least propose that the primary care research agenda, including particularly family medicine as the most cogent discipline within the family of primary care, that part of it ought to be dedicated to, or heavily engaged with, population-based research, health services research. Certainly there are good examples of people who've done that. It's different, however, than focusing on clinical issues specifically pertinent to the practice of family physicians. Are those two concepts, those two research agendas, reasonable cohabitants of family practice, or are they competitors?

Geyman: It seems to me that both approaches are important. Especially as we get to more managed care and better record and retrieval systems, population-based studies can be well done, and that both health services questions and common clinical questions can be answered. As you know, Group Health Cooperation of Puget Sound is our largest managed care organization in this part of the country. They have an excellent Heralth Services Research unit with a number of first-rate clinical investigators and are doing health services research that actually guides clinical practice within the cooperative.

[Begin Tape 2, Side 1]

Mullan: This is John Geyman, tape two, side one, continued. Let me ask about an aspect of what I would take to be the research agenda, or the scholarly, or at least the intelligent agenda of family practice, and that is the sponsorship of and editorship of journals. Something you have been active in from early on. Tell me about that, why you got involved, what you did, and how you feel about your work in that regard.

Geyman: I feel good about that. I've been actively involved since 1973. Actually, we had our first exploratory meeting in the fall of '72 to try and organize a new journal, which we established in 1974 as the *Journal of Family Practice*.

Mullan: What was the thinking that underlay that? Was there a journal in the field at the time?

Geyman: There was one journal, and it was GP, the monthly journal off the American Academy of General Practice, which around 1970 or so, converted its name, but not its structure or editorial goals to *the American Family Physician.* That's the Academy's journal. It's an excellent CME journal. It has always had very high readership scores and it's primarily a CME journal.

Mullan: By CME you mean it does mainly review articles?

Geyman: It does mostly reviews, but not original research studies in family practice.

Mullan: So it's kind of a vocational journal that allows the family physicians access to a kind of overview of this issue or that therapy.

Geyman: Yes, and many of the reviews have been were written by specialists in other fields. The level of peer review has often been less rigorous than in journals of other clerical specialties, but AFP has done a very good job of CME. But my feeling was always that if you're going to be an academic discipline and a scientific discipline, you need a journal to report original work and to define what the content of that discipline is, and to report the outcomes of your studies. You

looked around then and you saw no journal that would do that in this country. In England, you could see the *The Journal of the Royal College of General Practitioners*, sponsored and subsidized by the Royal College of General Practitioners subsidized that, and have to, but we saw no counterpart in this country.

So we were trying to establish that, and we did. I was working with Appleton Century Crofts, who published my first book, and they were supportive of the concept. So we organized that and started recruiting papers in '73, and started publication in the spring of '74. I was with that journal until 1990. At that time the publisher saw their revenues from pharmaceutical advertising declining, and our readership studies were never up with AFP, and those drive the level of pharmaceutical advertising. A change of editors was made at that time in an effort to reverse the situation, but those are unfortunately ongoing systemic problems for clinical journals.

It's a tremendous struggle for any journal that tries to do what *JFP* has done, and to be based entirely for its funding on pharmaceutical advertising. In general, it's not done in medicine successfully; in other specialties, it's generally organizational dues that pay for subscriptions. We didn't have that possibility, because the Academy had its own journal, and it's the big organization. The next organization would be Society of Teachers of Family Medicine, but that is a much smaller group than the whole field. So it's a generic problem. *JFP* is still having that challenge in 1996, and whether it can be done long term still remains to be seen.

Mullan: And your experience with your new journal, The Journal of the American Board of Family Practice?

Geyman: The American Board of Family Practice understands the problem of funding a journal and understands the importance of this kind of journal in the field. Our editorial goals are very similar to *JFP*. We're bimonthly. We get some advertising, but most of the costs of publication are underwritten by the Board.

Mullan: What do you like about journal editing? You've done it now for more than twenty years. It must be a terrible monkey on your back, month in, month out. So clearly there's something you like about it. What is it?

Geyman: I like it a lot. It's an avocation. I feel it's important, and I like the process of editing papers and seeing a product with each issue. It's a living organism. In our journal office at the university, we have a status board on two walls. We do six issues a year now, and we have all six issues on the board. I see that as a living, dynamic thing, and a challenge to publish the best, and to have enough submissions. It's always fun to see what comes across the transom, and who's doing what. It's kind of a living biopsy of the field, or the original work of the field. So I find that exciting and challenging and partly non-predictable.

Mullan: Do you like editing? Do you like writing? What's good and what's bad about it?

Geyman: I enjoy editing a lot, and I enjoy working that into the other things I do, and I find it easier to do that--I've done it a lot now--than to write myself. I've written quite a bit, but I find that harder each year now, but the editing still comes as a very enjoyable thing. It's just one of the things I do all the time.

Mullan: So you were department chair from 1976 to--

Geyman: From December of '76 to October of 1990, then I updated my clinical skills and started doing part-time rural practice, and then that balance shifted to three-quarters clinical practice with lesser amount at the university, mostly for my journal work. I'm planning to change the mix this fall back to closer to a 50-50 balance between rural practice and the university.

Mullan: You stepped down as chair in 1990?

Geyman: Yes.

Mullan: You were saying that you thought there was a certain cadence to your career.

Geyman: Yes. Number one, I wanted to chair a department to get a lot of the things done that I wanted to get done, but not to stay too long either. I looked around and saw other chairs staying, I thought, too long, and I wanted to leave when all of our grants had not just ran out, and where things were stable and time for the next leadership transition. So that seemed to be the time, and I gave at least a year-and-a-half notice. We had a very productive and deliberate recruitment process, and it didn't leave the department in a lurch in any way.

But then personally, I could have done a lot of different things at that point, but I felt I was distanced more and more from the core of family medicine in the chairman's role, being so much administration, which that was the job. I saw some chairs trying to be more clinically active than I was. I was fairly active in attending, and did that, but I didn't have my own practice during those years.

So I felt I was too distant from the clinical coreand wanted to revive that. I'd always liked the challenge and variety of rural practice, as well as the sense of community. I prepared myself again for rural practice and did get back and feel good about that. In fact, I feel like I'm a lot better physician now than in the 1960s.

In the sixties I think I was competent across the wide spectrum of rural practice, including a number of surgical procedures, and felt I was a good doctor. But I was not a good doctor in behavioral science, I didn't have those skills, and I think my practice was not systematic. I was in solo ractice.

There was more episodic care, a lot of acute illness, butnot a good screening program. Now I'm in a group practice setting with a sysstem approach to comprehensive care. I have stronger clinical problem-solving skills, and I'm more sensitive in sychosocial areas. Our small group has a full-time, practicing medical director. He and others have developed a system of practice, an infrastructure that's a lot better than my solo practice was. So now I can practice better and more comprehensive care and have more resources available. I have better skills in terms of solving problems. I don't think I know any more; in fact, in certain ways I know less, but I have a good library, use consultnts by phone a lot, and have more resoruces to call on both within and outside of our grou. I have become more impresssed over the years with the importance of knowing how to access information readily without depending on one's memory for immediate recall of an expanding body of medical knowledge. Larry weed has stressed the use of the problem-oriented medical record as an essential tool in practice, without reliance on immediate recall. I try to practice that way. I'll look up things even when I probably know the anser but if I haven't been there for several months, I want to reassure myself about a dose or some other detail.

Mullan: Let me ask a few overview questions, because you've superintended, you've practiced through, worked through, and to an extent superintended at a period of very interesting change in medicine in the country. First of all, let me ak about your

reflections on the growth maturation, or the growth and changes, in family medicine, starting as you did when it was still general practice. How do you feel about that? Has it been as strong and as fruitful as you'd hoped, or other ways in which it could have been better, or has it been terrific?

Geyman: I think it's been close to terrific; for just one generation, it's amazing what's been accomplished. But as to the future, there's a lot that still needs to happen. This gets to the next big issue. I would like to see 50 percent of America's physicians being real generalists, working well together, and all family physicians. In my ideal world there wouldn't be general pediatricians that don't se adults, internists that are uncomfortable with anyone less than twelve. I am aware of the history, the territorial differences, and the politics that divide the primary care specialties. One can make the argument, however, that a small group of family physicians is the single mosst transportable structure for primary care from one setting to another. In rural practice, that is certainly true. In the city, a multispecialty approach to primary care can be done, but that doens't necessarily make it efficient or effective. A crucial problem in any primary care group is the matter of after hours call coverage most consistent with personal, ongoing continuity of care. In a small group, each physician needs to be a generalist trained to care for patients of all ages.

I think the family practice model is the ideal foundation for the heallth care system. Canada and England are built on a single specialty, general practice foundation. We have a different history. So then you get to the what's going to happen in pediatrics. My guess is that they're going more to the hospital, more subspecialization, more fellowship programs. Internal medicine has certainly done that. At the same time, I believe that there is more in common than differences between family medicine, general internal medicine and general pediatrics. An eventual merger to a single generalist specialty would make sense. I would hope that in another generation or two that might happen, but the odds are more likely against it in this county.

Mullan: You think we will not? You're saying notwithstanding the intellectual--

Geyman: I think we should but we probably won't.

Mullan: because the territoriality nd the history are too deeply rooted?

Geyman: Maybe, although I hope it's not true and that it does happen.

Mullan: So that's work for the future?

Geyman: To me, that's work for the future. So far I think it's been difficult. General internal medicine is a different paradigm. There isn't that much cooperation in most programs around the country between family medicine and general internal medicine. They're separate and now we'll call them equal. The same with general pediatrics and family medicine. I think the fences between these specialties should get lower and lower, and in the ideal world, they would disappear.

Mullan: Let me ask about the struggle within the university for the hearts and minds of young people going into medicine, between generalist practice and specialty practice, and not limited to family medicine, but generalistm versus specialism. Despite certain federal programs, and despite certain disciplines such as family practice that have carried the flag for generalism through the seventies and eighties, at least into the nineties, we saw a slippage of interest in, and allegiance to, generalist training and practice. I'd be interested in your thoughts on why that was such a downward trend--not faily practice alone, but the whole generalist concept. Is it really being turned around in this epoch? Are we to take satisfaction from the changing numbers, or is this simply window-dressing of transient--

Geyman: I think we're seeing aturnaround, and I think the marketplace is leading that turnaround. Practice opportunities for orthopedists in the Portland area marketplace are extremely limited and you're seeing that more and more around the country

for specicalties in surplus. Pathologists, radiologists, and anesthesiologists, and many subspecialists, are findint it increasingly difficult ot be fully employed in many parts of the country. Its amazing how long it's taken for the marketplace feedback to happen, but I think students are finally starting to see that there's a new world out there, and just because they always wanted to be a this or a that kind of physician, there might not be practice opportunities in the field. So that's one factor that's changing.

I also think that generalism, and family practice in particular, has a much better reputation than in times past. It's still lesser prestige, and lesser reimbursed than many other specialties, but it's well reimbursed and is muchc more attractice to medical students than in past years. We're seeing family practice faculty and role models visible in many medical schools now. Politically our organizations are sstronger. So I see a lot of positives. But some ofthe core problems are still there: the olitic in medical schools, the drivers in the university hospital are still the higher reimbursed specialties sthat put more people in the hospital and do the bigger procedures, and the higher technology services command higher reimbursement. That's just the way it is.

Mullan: Let me ask a couple of questions outside of medicine. I know flying this things been very important to you, sstarting

from your would-be ROTC Navy flyer days. When did you train in flying and how is it interplayed with your life and career?

Geyman: I was a sophomore medical student at UC-San Francisco, and saw an advertisement for $99 to solo in San Carlos, south of San Francisco. So I went down and took my $99 course, and soloed for three times a round the pattern. I had ten minutes of solo time. Then I was out of money. (Laughter) That was in '59.

So then in Mount Shasta, a year after being in practice, I could afford to go back and finish my flying lessons, and had a rural instructor up there in the mountains. If you talk about instability and mobility of physicians in rural practice, the instability and mobility of flight instructors in rural areas is much greater. He was there for six or eight months, then he couldn't make a living and moved on. But during those few months, I completed my license. So I learned in the mountains, and I've flown ever since. I was in clubs for many years with small groups of fellow pilots. In the last ten or twelve years I've owned my own airplane. Over the years, I have integrated flying a lot with my life in medicine. In Mount Shasta, I could fly to the Bay Area for meetings in two hours and a half, versus taking a whole day to drive there, and you could get back the same day if you needed to do that. I could fly to Redding, which was sixty-five miles, for surgical assist. I could land at the airport and walk across 400 yards to the hospital, assisst in surgery and return and still be back in the office by eleven

o'clock. In later years, flying was very helpful in getting out to affiliated residency programs. Here on San Juan Island, Seattle is just forth minutes away by air, but it takes at least four hours to get there by ferry and driving, if you don't miss a ferry. So this is a natural here, and flying has enabled me to blend ongoing involvement at the University with rural practice. Indeed on this island, we have more pilots per capita than almost anywhere in this State for the same reason.

Mullan: I believe you enjoy it.

Geyman: Oh, yes. It's where my spirit lives.

Mullan: Tell me a bit about your family. You got you married back a few years ago.

Geyman: Forty years ago.

Mullan: To Gene. Forty years ago. Terrific. How has family life developed?

Geyman: Great. The older I get, the more impressed I am that the most important decision we make in this world is whom we marry. I've been very fortunate. We have three boys. They're all grown and all different. We're proud of them all. They get

along well together. Some of them have problems like all of us do, but we're a close family.

Mullan: One of them, like you, is a physician?

Geyman: Our middle boy is a primary care internist over in Denver at Kaiser, in a small group there. He's liking it quite well. They've just had a big issue of what an internist does in their system, and they've offered them to be mostly hospital-based or mostly ambulatory-based, with a few in between. He opted for the in between, where he has some rotations in the hospital where he sees only hospital patients, but spends a majority of time in ambulatory practice. He is an excellent physician.

Mullan: Has Gene done work outside of the home?

Geyman: Gene has taught school for years, and has also done a number of other things. More recently on this island she became an EMT and did that five years. She just stopped that, but was an excellent EMT and loved that. She does a lot of community work, whether it be with the library or with other groups in town. She's been a professional puppeteer. In our Davis years she did amazing things with kids and puppetry. She's done a number of different things very well.

Mullan: Has your clearly robust medical career been difficult to the family in terms of the amount of time you've been elsewhere?

Geyman: You'd have to ask them. I think our Mount Shasta years were the most difficult. Those were very long days, and ofen up at nigiht without a call system. But I've always tried to be visible and involved. There we built our own house (we didn't build it, but we had a house built). I fenced in a pasture and a little barn, and Gene had a horse. The kids would help me put the fence posts in. So we did things like that. But yes, I think it's always a tension between the demands of practice, especially solo, and family life. I think we've been a close family, in my perspective.

Mullan: We've talked about a lot of things. I know we've been moving quickly over a lot of them. In closing, is there anything you'd like to comment on that I haven't asked about?

Geyman: We've touched on a number of important questions, and ones that are difficult to answer in a short time. But I think it's a great project you're doing and expect that you will flesh out a lot more meaning than might appear when you're in the middle of it. I also expect that it will be inspirational when you see all the talent around the country and all the different individual ways which physicians have found to emulate the principles of family medicine. As a Department Chairman visiting various teaching programs and varied practice settings over the

years in the Northwest, I've found it endlessly inspiring to see how good the people are in family medicine, both as people and as physicians.

Mullan: Thank you for the interview.

[End of interview]

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