ALEXANDER McPHEDRAN

Dr. Fitzhugh Mullan,
Interviewer

McPhedran: My name is Alexander McPhedran.

Mullan: What is your date of birth?

McPhedran: January 3, 1929.

Mullan: We're in Dr. McPhedran's home in Readfield, Maine, which is, what, ten or twelve miles from Augusta?

McPhedran: About.

Mullan: And it is, in fact, I have learned, the Townsend Farm marked 1913?

McPhedran: Well, that's just the barn, 1913. The other buildings are older and newer. There had been another barn, a smaller barn, there before which burnt down, and then this was the one that they built to replace it at a time when it really was mostly a guest house, so that it was a farm in name only.

Mullan: They were the immediate owners?

McPhedran: Well, no. The Townsends actually had gone from here some time before we got here. It was I don't know how many years

McPhedran: Well, no. The Townsends actually had gone from here some time before we got here. It was I don't know how many years ago, but Robert Ifill, who lives down there, a power company person, bought this building. He was an engineer. He bought this house in order to get that site, which was part of the property, because he knew he wanted to build there. He'd had his eye on that site for a long time. So he lived here while he built that house himself and then sold this property off. It was occupied by various and sundry people before we bought it.

Mullan: Well, that's not where your story begins.

McPhedran: No.

Mullan: We'll pick up your story rather than the Townsend story.

McPhedran: Okay.

Mullan: And we'll catch up when the two merge a little later in our chat.

McPhedran: Okay.

Mullan: Tell me about yourself, where you were born, grew up, and your youth.

McPhedran: I was born in Philadelphia, in the part of Philadelphia which is called Germantown. My father was a physician, and my mother was at home. I was the third of four siblings, two older sisters and one younger brother. For various reasons I always thought of myself as being a physician. I went a private school called Germantown Friends School. I remember people always spoke of me as a future doctor, so I always intended to be that, although I don't think I had much of any idea what it was like, even though my father was a physician, my grandfather was a physician, my father's brother was a physician. It was really in the family.

Mullan: What sort of physician was your father?

McPhedran: He was a chest physician. He took care of tuberculous patients, having had, himself, pulmonary tuberculosis when he was in the Canadian Army in the First World War. His father had been professor of medicine at the University of Toronto. So the medical people go way back.

Mullan: And your father's family is Canadian?

McPhedran: Yes. My father immigrated into the U.S. in the twenties, actually, when he married my mother and came to the U.S.

Mullan: She was Canadian?

McPhedran: No. She was born in New York City. It was a curious thing at that time that if you were a native-born American and you married a foreigner of any kind, you lost your citizenship. So my mother lost her citizenship when she married this Canadian, even though she remained here, and she had to be naturalized when he was. They settled in Philadelphia. They were first in Saranac, because he had a fellowship at the Trudeau Sanitarium in Saranac.

Mullan: Was this following his tuberculosis?

Mullan: Yes. He was in bed for two years in a sanatorium in Ontario somewhere. He was sick for a long time and had repeated pneumothoraces. He was all of his life something of a pulmonary cripple. He had very, very marked shortness of breath on exertion all of his life. He took care of people with tuberculosis and did research. He was at the Phipps Institute in Philadelphia. There were two Henry Phipps Institutes, I think, one in Baltimore and one in Philadelphia. He was at Phipps, Philadelphia, for a long time and then had his own Department of Research in Respiratory Diseases at Germantown Hospital, which is the place that I remember as his work place. I can recall going to the Phipps, but not really very much about the place.

Mullan: But you, from early on, had a sense that you wanted to be a physician or were going to be a physician?

McPhedran: I guess the latter. I'm not really sure about that. I know that I didn't really think about it in a serious way until I went to college, and then I thought about it more. I wondered about doing other things, wondered about teaching.

Mullan: You went to Harvard?

McPhedran: I went to Harvard College.

Mullan: What was that like, and what did you major in?

McPhedran: I was a history major and did pre-medical requirements; I got most of them done in the first two years and really enjoyed history. I enjoyed liberal arts, and I really had a very good time at Harvard College with academic pursuits and enjoyed it very much. In the last couple of years, I wrote a senior honors thesis, picking history as an honors candidate. I thought it was a great experience having tutorial sessions.

Mullan: I was a history major, too.

McPhedran: I had a good time there.

Mullan: Yes, absolutely. Was it American history, European history?

McPhedran: Europe, modern European history.

Mullan: Me, too.

McPhedran: "Since 1789," I think was the way it was entitled.

Mullan: What did you write your thesis on?

McPhedran: I wrote it on a 19th century man called Hutton, who was a theologic critic, actually. He was part of the Oxford Movement, or he was on the fringes of the Oxford Movement of neo-Catholicism of the 19th century, and sort of a moral and ethical philosopher. He was an interesting man. I enjoyed writing the paper because I enjoyed reading all those Victorians. I liked that a lot. Recently I read a book by A. S. Byatt called Possession, which is a sort of a 19th century literary who-done-it, and it just brought back memories of those people and what their thinking was like. Fascinating.

Mullan: So what was it like applying to and going to medical school?

McPhedran: Well, I had worked pretty hard, and I had reasonably good grades in the science courses, and I guess I felt that I would get into medical school. So I applied to four and got accepted at Temple. Harvard held out a little bit, but when they said yes, I thought that's what I wanted to do. My parents, would have liked to have me go back to Philadelphia, and I didn't particularly want to. I liked living in Greater Boston, and so I

decided to go to the Harvard Medical School, and they didn't give me a hard time about it at all, so that's what I did.

Mullan: And what was it like, moving from history into full-time science?

McPhedran: Oh, it was a really hard. I thought the medical school was very hard work. I worked a lot harder at medical school. But then I got into it, and I liked it. I liked especially the clinical years. I think that the really intensive time in basic science was hard and not so rewarding, but I liked the clinical years a lot, especially at the Beth Israel Hospital. I had a wonderful teacher in the third year of medicine, a man called Hamolsky, who was a really good clinical teacher and careful and methodical and thoughtful. That was just an outstanding experience.

Mullan: What were you thinking about in terms of your own career?

McPhedran: I was thinking about medicine, internal medicine. I thought of myself doing general medicine, and as general as I thought medicine could be would be internal medicine. I got interested in neurology some while I was at Harvard Medical School, although I think I really became more interested in it once I got into internal medicine. I had a gradual evolution toward neurology. I liked the clinical methods in neurology and

the pursuit of the problem with history and physical examination, which was the predominant thing that neurologists did. At that time testing was such a trivial part of clinical neurology, testing and imaging. The clinical activity was paramount. I really liked that. I was interested in people who did that and the way they thought and the way they drew on their clinical experience. I thought that they were exemplary in that kind of thinking, people like Raymond Adams and Maurice Victor.

Mullan: You stayed in Boston for your training. Tell me about that.

McPhedran: After medical school I went to the Pennsylvania Hospital in Philadelphia for internship, not because that was my first choice. I would have stayed in Boston if I could, but they didn't accept me, so I didn't get into any of the Boston places. My parents wanted me to come closer to home if I could, so it looked to her like a blessing in disguise. I didn't really like Pennsylvania Hospital very much. It was a rotating internship. I was reminded of how nice it was to have sort of general competency. Of course, in Pennsylvania at that time there was a requirement for practice to have a rotating internship.

Mullan: And that no longer existed in Massachusetts and elsewhere?

McPhedran: That's right. You could go into practice in other states without having had a rotating internship.

Mullan: Then the rotating internship was declining as a requirement?

McPhedran: Right. At that time not very many states that required that. Pennsylvania was one. So there it was. It was kind of like a general practice internship with very little outpatient work, almost entirely inpatient. In that way it was a reflection of the times. But the inpatient clinical disciplines were all represented. I performed 100 obstetrical deliveries, and that was in a two-month rotation. It was just a tremendous clinical experience, really, on patients who had had no prenatal care.

We were married in my fourth year of medical school so that Winnie was with me in Philadelphia. While there I thought about staying on at Pennsylvania Hospital, but I really didn't want to very much. The medical chief, Garfield Duncan, said that he wouldn't try to keep me as a resident if I got drafted. So I was afraid that I'd go part way through the year and get drafted. The doctor draft was still on.

Mullan: This is Korea time?

McPhedran: There was Korea, yes, and so that the doctor draft was operating in 1955, and I thought that I would be better off

and in a better position to choose for myself what position I'd go into if I got myself into the service. I would be able to control the times of going into programs and coming out of them rather than to having the service control me.

So I got into the Public Health Service at that time, and I was able to enlist, in the Public Health Service. I was astonished, and not at all pleased, to be sent to Mobile, Alabama. I thought, "Oh, that's terrible." I just didn't think ever of living in the South. That's a thought that never occurred to me, that somebody would send me to the South.

Mullan: Was this integration, quarantine?

McPhedran: No. There had been a Marine hospital there. It had just closed and what remained was an outpatient clinic, serving mostly merchant mariners. There were three cutters in the Port of Mobile, one called the *Sebago*. I didn't realize how amusing that was at the time. I guess it was named after Sebago Lake in Maine. And then there were two other vessels, I guess they were buoy tenders. There was one cutter and two buoy tenders. And we took care of the officers and crew. It was a no-appointment clinic.

I had my first experience with not having enough to do some of the time. We would sit for hours and not do anything, and then have a sense of outrage when somebody came. It was really a strange experience.

Mullan: Were you in uniform at that time?

McPhedran: I was in uniform. I had to wear a uniform, and one of us had to be on call. The call was nothing. I had another colleague from Boston that I worked with at that time. I was, for a while, in charge. There was a more senior officer when I first came, but later with one and a half stripes, I was in charge. A strange experience. I got paid between eight and nine thousand dollars a year and we lived on half of that. Winnie, who has always been the one who's run the finances, sent half of that to the Harvard Trust Company, saving for no-pay positions later on.

But it was a great experience for me because I learned a lot of things about the South. I learned it was possible to live in the South. I had had a lot of prejudices about the South but had a very good time there. It was really interesting to meet people who were working on race relations, Southerners who were working on race relations, because it was, and I think still is, a problem of overwhelming importance in this country, probably the most important social evil in our country. That's the way it seems to me. So that was an opportunity to begin to learn something about it.

Mullan: This was really pre-Civil Rights Movement or right at the brink of it.

McPhedran: We met two people who had both been born and raised in Mobile, had moved to New York City, and who came back to live there at this time with their adopted child because of the *Brown* decision. The *Brown v. Board of Education* decision was 1954. So the Zelnickers had come back and hoped for better times, and were hoping that their child would be able to have an integrated life experience. Of course, that wouldn't happen for a long time, but it was very interesting to see people who knew something about the South, who had been raised there and had hoped for desegregation. It was a difficult time.

Mullan: Clinically, was the experience rewarding at all? You were functioning as a GP?

McPhedran: No. I don't think it really was. I saw some interesting things, but I didn't really know how to get help. I needed supervision. I needed more consultation and help. I got some, but it was pretty spotty. I would have been better off, I think, in a more supervised experience.

Mullan: So you were thinking, nonetheless, of returning to training?

McPhedran: Yes. I always thought about returning to training, and this gave me an opportunity to reapply to residencies, and I applied in particular to Beth Israel Hospital, where I had had a good experience as a student. I got accepted as assistant

resident in medicine. 1957 that was, that I came back. Herrmann Blumgart was still the professor and the head of the department then, and a lot of people that I had known as students were still there. So that was really where I wanted to go.

Mullan: Had neurology risen as an issue?

McPhedran: Not really, no.

Mullan: You were still thinking of being an internist?

McPhedran: Yes. That's right.

Mullan: What happened then?

McPhedran: At Beth Israel, I had a really good experience. I did an awful lot of clinical work. It was all inpatient. My outpatient experience was so trivial as to be unimportant. It wasn't unimportant, but it seemed unimportant. I liked colleagues, and I thought I learned a lot from colleagues and from teachers there. I thought the internal medicine service was a really distinguished place, and I got interested in neurology. We had rather poor neurology consulting there. The individual consultants were okay when they got there, but they weren't there all the time. I got more interested in it, and instead of going into practice with my friend Julian Snyder, with whom I'd been a

resident, (we shared a chief residency position my second year there) I decided to go on in training.

Mullan: In neurology?

McPhedran: Yes, and applied to the Massachusetts General Hospital, and spent the next three years there. So I was a resident for a very long time.

Mullan: Tell me what it was that decided you to pursue neurology as opposed to internal medicine.

McPhedran: I think it was the nature of the clinical work, the attraction of how the problems could be defined in anatomic and physiologic terms. The symptoms seemed to have such precise meaning and you could interpret them with a knowledge of the anatomy; and the same thing was true of the physical examination. I think that was very appealing to me, and you would do it from the history and physical examination.

Mullan: Forgive me if I address that thinking in presentist terms, but that sounds like the classic example of a physician wanting a higher level of certainty, which is usually not associated with generalist thinking and practice choices. Was there, first of all, in the environment in general, any recognition of generalist-specialist tug-of-wars or different world views at that point? And was there, in your own head and

decision-making, a reflection of any of that, or was this simply responding to your own desires or interests as you saw them running in front of you?

McPhedran: I don't remember any tension between generalists and specialists, any tension that seemed important to me. I can remember physicians in hospitals, in general, responding, to physicians out of hospitals who were sending in patients, in a disparaging way. I can remember that. I can remember people who were doing general work in Boston being disparaged, those who didn't have an academic teaching connection. I can remember being part of that. But a tension within the community that I worked in that way, not much. There was tension between individuals, personalities, and tensions between surgeons and non-surgeons.

Mullan: What about the pressure to move into subspecialties after a more generalist training? Certainly this was a period, if you look in the statistics, where the number of people both doing residency and all of those doing fellowships or some specialty training was on a fairly rapid course upward. Was that palpable?

McPhedran: Yes. I think that the pressure to go into subspecialties seemed less then--I mean, it was there, but it really wasn't the same as what it is now. For example, think about people doing gastroenterology, which I never was

particularly interested in. But the gastroenterologists that I knew at the Beth Israel Hospital also were primarily clinical. They were taking histories and doing physicals, and they weren't peeking into people's innards much, you know, hardly at all. The technology wasn't there yet. There was so much less technologic drive to do those kinds of specialties. Cardiology was beginning to get technologic. Paul Zoll devised a pacemaker, and he had patients on external pacemakers and defibrillators and stuff like that. That was beginning to happen, but it wasn't a big inducement and there wasn't a big push toward that.

I think that it was much more likely that you were interested in something because you admired somebody who was doing it. I think people might become cardiologists at the Beth Israel because they admired Louis Wolff, and for me, you know, internal medicine because I admired Blumgart or, subsequently, to do neurology because I admired people like Joseph Foley or Maurice Victor.

Mullan: This notion of reductionist thinking and the ability to master a particular biomedical model, which you characterized a bit in your decision, in terms of your own personal life and professional decisions, this seems at counter purposes to decisions that you made later, as I understand them. Is that the case, or how do you put this in your own personal galaxy of decisions?

McPhedran: Well, I don't know. I guess I felt obliged in answering that question to say what there was intrinsically about the discipline that I admired. Maybe I could alternatively say I've watched people interviewing patients and taking care of them and coming to conclusions, and I thought that it was so wonderful to be able to combine kindness and consideration together with precision in diagnosis, and the neurologist stood at the cutting edge that way. They weren't all kind. Some of them were pretty coarse and mean, but they could be kind, some of them. Maurice Victor must be as much an example in my life as anybody. I thought he was funny and kind to people and terribly well informed.

Mullan: And he was the chief at--

McPhedran: No. He was an assistant neurologist when I was a resident at the Massachusetts General, I had no assigned supervision. When I was the chief resident I was consultant in neurology to the ward services, and there was <u>nobody</u> assigned to supervise me in that capacity. It was just amazing when I think about that now. No staff person was responsible to see that I gave proper professional service to the patients on the ward service. There were individuals that you could ask for help: Maurice Victor was the one who usually got asked. He would stop what he was doing and go with you or do what was necessary to help you out. Maybe he got paid for it. I don't know. I don't think so. But the degree to which senior residents learned

unsupervised in their activities in places like the Massachusetts General Hospital at that time is something I think people nowadays would find astonishing.

This was often true on the surgical services too. The chief surgical resident had very little supervision. He supervised all those other people under him. I think it was Dr. Francis Moore who once said about the surgical service at the Mass General at that time that it was the blind leading the blind.

Mullan: He had reason to know. [Laughter]

McPhedran: He had reason to know, right. I think that that was true of services at academic institutions. You never see that now.

Mullan: You had reason to pick up your Southern roots again. That was the next stage.

McPhedran: I began to realize that I was interested in teaching when I was a resident at Massachusetts General. I liked it. When thinking about staying on in Boston or going elsewhere, I realized that the opportunities for doing clinical teaching were fewer in Boston than they might be elsewhere. I had met some former MGH trainees, and one of them was Herbert Karp, who was at Emory, who had been a fellow at MGH and a fellow on the stroke service. I thought he was a really interesting guy, and people

liked him a lot. I talked to him about--he was looking for faculty members. So he offered me a job at Emory.

Mullan: What year are we at now?

McPhedran: 1963. I was three years at the MGH, and then I did go on and think about doing a career in research. I looked upon this as something I felt I had to do. I had to find out what it would be like to work in a laboratory. The standard routine for people who wanted to do any kind of academic work was to do two or three years of clinical training and then spend a couple of years doing some sort of laboratory research so that you had a laboratory activity to work with.

I did some muscle physiology work at the Harvard Medical School with Elwood Henneman. I did it for only a year, and I liked it. I enjoyed it. It was terribly interesting. I think from that experience I learned something about the difficulties of investigation, bench investigation, how hard it is and how much you have to learn in order to begin to do experiments, and I think that it has been useful to me in thinking about medical affairs, but I don't think I was a suitable person for doing it. Elwood was taken aback when I left after a year. He thought if I put a year into it, I should have put in two, and I'm sure he was right about that, but I think it sort of foreshadowed a tendency or a trend in my work that if I had some laboratory work to do over here and some clinical work to do over there, it wasn't a

hard choice for me to do the clinical work. I would always choose the clinical work.

Mullan: And you went to Atlanta?

McPhedran: So I went to Atlanta and had a big responsibility for teaching medical students, medical residents, neurology residents, people all the way from beginning--or from second- or third-year medical students and eventually first- and second-year medical students, up to people who were five years out. So I had a lot of teaching experience and a lot of clinical work, mostly teaching at the Grady Hospital and some at the Emory Hospital and Clinic. It was hard work. I don't think I ever worked harder in my life than I did there. It was every night coming home at 9:00 or 10:00 o'clock after leaving the house at 6:00 or 7:00 in the morning for days and days.

Mullan: How did you find Atlanta after Boston in the sixties?

McPhedran: Well, I was a colleague instead of being somebody way down on the clinical ladder. I was suddenly in a more important position. I liked it. I was treated in a collegial fashion, and it was fun. I had a lot to do, but I learned a lot.

Mullan: And the culture at Emory, it was a place you enjoyed. How would you characterize it as an institution?

McPhedran: Well, I think it was a really good place, and I think they felt they were pretty good. When you come from Harvard, almost every place I've ever been wonders how they compare with Harvard, you know. Emory was no exception to that. I just think that's part of an insecurity institutions had about being compared to Harvard. It's funny, it's less of a problem now than it was then.

I had a good time there, but I remember controversies. Willis Hurst was the chief of medicine. He got interested in what was called the Weed System at that time. He was converted by Larry Weed to the problem-oriented system, and it became an absolutely consuming passion with him. We in neurology were a division of the Department of Medicine, and it was such a preoccupaiton to the point that it extinguished almost everything else that there was in clinical activity. You couldn't write a note anymore that was temporally sequenced without causing problems. You couldn't write it. I never could think about problems, the problem-structured way and I still have certain disagreements with it. I had a different way of writing clinical notes. It's really true that this overwhelming enthusiasm that Willis Hurst had about problem-oriented systems--it was called the Weed System then--a real millstone around my neck for several years there.

Mullan: During that time, you must have gone through some evolution in your thinking that led you to your decision to move to Maine. What was that?

McPhedran: I did some other laboratory work there. I dabbled in that. I tried to do some of that again. I tried to be an academic neurologist, and it didn't work for me there either. I had a good time with an associate in the Basic Science Department. It was interesting, but it certainly wasn't what I wanted to do.

I found at the Emory Clinic that if I had a patient who came to me with a neurologic problem, they were very often self-referred. To put it another way, I couldn't find doctors in the community who would take care of patients in a regular way. There were not, it seemed to me, any doctors who were doing regular practice, of general medicine in Atlanta. I'd be looking way down south in Atlanta outside of town before I'd find somebody who didn't regard himself as a consultant. Everybody was a consultant in Atlanta, as far as I could tell. That may seem extreme, but that is really the way it appeared at that time. I caught on to that in the late sixties.

At that time I received a notice in the mail that I had been appointed as a member of the National Advisory Council for Regional Medical Programs (NACRMP). Being a council member was an important appointment. Nobody understood how I came to get this position during the (Richard M.) Nixon Administration. I was a registered Democrat so there was no identifiable political reason for it happening. And in fact, Michael Debakey, who was at that time another member of that Advisory Council (and who had been the person, I guess, that had influenced [Lyndon B.] Johnson

in the first place to establish it), Michael Debakey talked to me about it and he concluded that they had made a mistake when they appointed me, that simply. He wasn't speaking for himself but he was saying that I wasn't a suitable appointment to that Council.

So I was a neurologist on the National Advisory Council for RMP and the importance of that to me was that the staff and the leadership at RMP were the first people that I knew who had developed a sort of systematic idea of their own that primary care had really disappeared from the country. Now, what their charge was, as RMP staff, was to take all those fruits of NIH (National Institutes of Health) research that had been garnered after the Second World War and put the results to work in addressing the clinical problems of heart disease, cancer, and stroke, and later on kidney disease. But those specialized orientations of the RMP were, the staff began to feel, not the only ways to improve medical care in the U.S.A. and the staff discovered that there were no doctors interested in primary care who were accessible to patients in the community. Harold Margulies was a person who came to that conclusion.

Mullan: The director or deputy?

McPhedran: He was the chief executive officer, whatever it was. I guess he was the director. I can't remember what the title was. I thought Harold was a really distinguished intellect. He was very, very good.

Mullan: So the availability of physicians, primary care physicians, to deliver on recruits of medical research, biological research, really wasn't there, the infrastructure?

McPhedran: Right. They were saying that there just didn't seem to be doctors to take care of patients and that maybe, in order to get better specialized care, you needed to have better primary care.

Mullan: Let's pause for a moment.

[Begin Tape 1, Side 2]

Mullan: This is Dr. McPhedran, tape one, side two.

Were the terms that were being used, as well as you recall, in the late sixties "primary care" or "generalists," "GPs"?

McPhedran: What I remember is "primary care." I'm not really sure. You know, it's interesting, having thought about this over and over again, now I begin to doubt my own memory about it, but I think it was "primary care," because I remember talking about that and then getting into trouble with family practice people when I got interested in family practice, because they were a little put off by "primary care." They wanted to talk about Family Practice, and people who talked about primary care, it was almost as if it were a disparagement of what they (family

practitioners) did. So I think "primary care" was the way I came away from the RMP meetings.

There were on that Advisory Council very distinguished people. One of them was Edmund Pellegrino, who I think is really a wonderful person, a wonderful thinker about medical care, not vitally interested most of his life in this issue, but he could talk intelligently on almost anything. He's a medical ethicist. And then Anthony Komaroff came on the council a little bit before I left, and he has a distinguished record as a teacher of primary care in Boston, and--

Mullan: Komaroff?

McPhedran: Komaroff. He's been interested in training physician's assistants and primary care givers of various kinds. He's mostly at the Beth Israel Hospital in Boston.

When grants were being applied for by the local RMP's (a couple or three million-dollar grants seemed like a lot of money at the time) Council Members really had a lot of influence and a lot of authority. I can't remember anything else I've ever done that gave me quite such a sense of influence and authority.

One of the other Council members took me under his wing, was very helpful to me, and he said, "You know, if you prepare a position on a given grant and really prepare it well, you can have your way." That was true.

I remember preparing a position on a Maine application, only it wasn't my assigned job. But I read this Maine application,

and I thought it was good. It had to do with primary care, setting up infrastructure for the care of patients with heart disease, as I remember, and the Council member who was assigned that grant application for review was slipshod in his preparation, and also he didn't recommend it. He thought it wasn't a good program. I had prepared, and although I wasn't the assigned reviewer, I told them what I thought was good about it, and I had my way. The memory of that lesson was not lost. It was very interesting how careful preparation and something written down and well written had made a big difference. You could have a real influence on policy, and I don't know, maybe I should have known that, but it certainly hadn't occurred to me before somebody told it to me.

Mullan: Having spent two years of my life on the Health Care Reform Task Force writing many, many position papers on issues not dissimilar to this, I came away with the opposite conclusion.

McPhedran: You did?

Mullan: You can write lucidly, you can have excellent, well-quantified thinking, and come up with a goose egg.

McPhedran: Well, the thing is, on the Advisory Council, there were different people, different sorts of people on the National Advisory Council. There were some who were sort of dilettantes about it at that time. I mean, Debakey was a dilettante. He

never prepared anything. He always thought he could have his way because of who he was. And there was a neurosurgeon from Memphis called--a wonderful name--Bland Cannon. He was the same way.

Mullan: Bland Cannon.

McPhedran: Isn't that a wonderful name? And they didn't give a damn about what they did. They were kind of like drones, you know. There was a Review Committee, who had gone over all the material before us, that's where you might have had the same experience you describe, because they did careful preparation and sometimes were ignored. But for some reason, the Advisory Committee, which was composed of presumably more August people, were the ones who had the final say. And in the Advisory Council it was true that people who did more careful preparation tended to prevail, because many of the members were slipshod in preparation. Maybe that's the difference.

Mullan: The times are different. The stakes were different. The players were very different, and ultimately a resistant Congress.

McPhedran: Yes.

Mullan: During this time, as you describe it, I presume the RMP experience was having an impact on your own personal thinking,

your own personal professional thinking. How did that develop, and what was the connection to Maine?

McPhedran: The connection to Maine was that we were summer people, had been since 1957.

Mullan: Where did you come?

McPhedran: Little Sabago Lake. We had friends who owned an island in Little Sabago Lake, and we would come in the summertime for a couple weeks or more. We continued to do that from Georgia. It was really a big effort to get in the station wagon and go to Maine from Georgia but had a wonderful time doing that. So that interest in Maine was a big part of our lives. Actually, I got into some of the Maine programs in the Advisory Council. The RMP was beginning to look at this whole issue of how you train physicians for work in a place like Maine, and the RMP in Maine had a better idea, at least as I see it now, of the issues of training people for primary care than most other RMPs did. They weren't alone, but that's the way they were thinking. They had this poor rural state. They had very few physicians in most rural parts of it. They needed some specialized services, but even more than that, they needed the infrastructure, as we call it now.

The guy who was the director in Maine was Manu Chatterjee. He was an American-born person who was of Indian descent. He was a really interesting and kind of magnetic personality.

Mullan: With the RMP?

McPhedran: With Maine's RMP. He was the director of the Maine Regional Medical Program. He convened people from around Maine in his own advisory committee, and they thought what they needed was a medical school. It was going to be a medical school without walls. I don't remember all of the plans. It may sound funny in retrospect, but at the time it seemed as though what they were trying to do was like the model in the upper peninsula of Michigan, that kind of model of teaching in remote sites. That sort of thing is what I remember being talked about. I did get interested in this. They were beginning to talk about this, and I saw it in their grant applications. So I talked to them about it. I came up in the summertime, and let me tell you, they were willing to talk to me for sure, because there I was, down there in Washington approving the grants. So that was fun.

Mullan: So when did you really begin to think of that as a possibility or a reality?

McPhedran: I began to think about it in 1971 or '72.

Mullan: And what was "it" as you envisioned it?

McPhedran: Well, I didn't know, really, at the time. I guess maybe it was in the summer of '72, they said, "Look, we're going to start a medical school here in Maine, and we're going to begin

by having a family practice program." They knew about family practice residency programs. "Would you be interested in helping to work on something like that? Would you be interested?"

I said, "I guess I'd like to think about that." So I think that was in the summer of '72, about a year before I came to Maine.

Mullan: Did it seem to run contrary to your neurological base, your base in neurology?

McPhedran: Yes. I knew I wasn't qualified to do primary care, you know. I knew perfectly well but I didn't know the depth of my ignorance about primary care. The profundity of it doesn't come through to you until you try to begin to do some of it. Then you realize what you've lost. I knew I'd lost some, but I guess I didn't know how bad it was until I tried to do it.

Mullan: What was the arrangement that brought you, and what was your plan?

McPhedran: The residency wasn't the central piece, in Maine's RMP plan. The central piece was the medical school. But the residency was there at the beginning, and, "We'll begin working on the residency, and everybody will see how good it is, and that will whip up enthusiasm for the medical school. So please come and work on the residency."

"Well, why me?"

"Well, because you have experience in teaching, and nobody else does."

The other people on the premises: it was a practice of family physicians, the two principals of whom were expatriate Brits. One had trained at Edinburgh, and the other had trained at Manchester. They'd been in Maine for a couple of decades, and they were working GPs and they had been joined by a fellow who had trained at the family practice program in Rochester, New York.

Mullan: This now was a new generation family practice program?

McPhedran: Right. Their ongoing practice would be brought into the Family Medicine Institute. We had three residents that came in at second-year level from various kinds of other training. We were not yet fully approved for residency training, but we had provisional approval.

Mullan: The Family Medicine Institute had been established by the RMP?

McPhedran: No. Maine's regional medical program and a consortium of hospitals established this residency program. The people who were the principal players, were also people who had contributed to RMP who were in the Maine RMP councils at various points. The Togus VA Center, the oldest Veterans Administration

hospital in the nation, is near Augusta and physicians from Togus were important players.

Mullan: Where's Togus?

McPhedran: It's on the other side of Augusta. It's really the Augusta Veterans Hospital. It's the first VA hospital. And there is a man, Robert Ohler, who is still living, not working anymore, who had been chief of medicine. He became Chief of Staff in this non-deans committee VA hospital. He desperately wanted to have teaching in this hospital and had had a long interest in getting outside teachers to this hospital. Ohler wanted badly to have medical teaching at the Togus VA Center. He wanted it to be a teaching hospital. Then there were medical directors of other hospitals, and these were mostly internists. All these people, practically were all internists. They were people at the then-Augusta General Hospital, Jeffrey Wheelwright. And Stanley Herrick at Central Maine.

There were actually five hospitals at the beginning: Togus; Augusta General; the Thayer Hospital in Waterville, which is now part of the Mid-Maine Medical Center; the Central Maine General Hospital, now Central Maine Medical Center; and Saint Mary's Hospital in Lewiston. So there were the two hospitals in Lewiston, one in Waterville, this one in Augusta, and one in Togus. What was envisioned was a program in which they would use the strong points of all these different hospitals for training family practice residents.

You can imagine how they learned about this, none of them really knowing how to do it, going off to meetings in Kansas City, reading literature, getting advisors. They didn't really know how it was going to go. It was inchoate. I'll tell you that it's absolutely remarkable that this institution is still here. It's absolutely remarkable that it survived. There's no good reason, looking at how it began, for it to have survived, except that it was an important issue. It was so vulnerable at the beginning and so enormously difficult, that there's just no damn reason for it to have survived.

Mullan: In terms of principal players, you became one over time. You mentioned Chatterjee.

McPhedran: Well yes, Chatterjee, but, you see, he didn't really work in the program. He didn't teach residents. He was a political person.

Who was important? I think I was important, and I think that it was important that the residents be favorably looked at in the hospitals, and I could at least do something for them at the Augusta General. One of the things that was important in my work at the Augusta General is that I was able to be a neurologic consultant that the medical staff wanted. They didn't much want a family practice program, but they did want a neurologic consultant. If they had to get the neurologic consultant as part of the package, they might choke that down, and that's one of the things that happened. I had never even thought about it

beforehand. It never even occurred to me. It made me less of a pariah, because I could be a neurologic consultant, and this enabled me to communicate to members of the medical staff who were pretty cool to the idea of the family practice training program.

Mullan: And the Institute, was this consortium of five hospitals formalized?

McPhedran: It was formalized but it wasn't incorporated.

Mullan: But the Institute had a life of its own?

McPhedran: The Family Medicine Institute was actually a department of the Augusta General Hospital, later the Kennebeck Valley Medical Center. I talked to you about the doctors who were important, but one person who was absolutely essential in the survival of the program was Warren Kessler, who was then, and still is, the CEO of the Augusta Hospital. He was called something different then. Now he's the president of the Kennebeck Valley Medical Center. Warren is a hospital administrator by training, from Yale, who grew up in Maine, and then when he came to the hospital--and he refers to it as his hospital--he thought the outpatient clinics were terrible. The patients got bad service because the doctors didn't regard it as a high priority. The staff <u>had</u> to do clinics as part of their service obligation. He thought that he could have his clinics

transformed into a teaching institution where the patients would be looked after by residents and that the clinic patients would be much better served and that the quality of medical care would be improved in the hospital. He wanted the Family Medicine Institute in his hospital for all the right reasons, as far as I'm concerned.

At Togus they couldn't do it because they were just taking care of veterans. At the Mid-Maine Medical Center, the then-Thayer Hospital, the model practice unit was an incubus that they really were not interested in. They thought the staff wouldn't like it. The staff didn't like it at the Augusta General, and Kessler anticipated that. And the same at Lewiston. Nobody else really wanted it, but Kessler wanted it because he thought it would be good for his hospital, and so he took the heat from his medical staff.

Mullan: And it became the nidus of the family medicine residency?

McPhedran: Well, it was an essential part of a family practice program, that is the outpatient experience. Every family practice training program must have a model practice unit.

Mullan: To whom in those first years did the residents belong?

McPhedran: They belonged to the residency program, which was a consortium of five hospitals, including the VA. By the way,

because the Veterans Administration paid all of the faculty and resident salaries for everybody, even though they were all off site, for the first two years. How about that? Can you imagine anybody having that much clout with the Veterans Administration? That's what happened. Ohler got them in Washington to say, "Yeah, we'll pay for it. It's off-site? They're working in other hospitals? Yes, we'll pay the salaries." Can you imagine? Residents did work some at the Togus VA, but most of their time was spent "off-site" in the other hospitals and at the Family Medicine Institute.

Mullan: For the residents as well as faculty?

McPhedran: Yes.

Mullan: So that really was the seed money that got it going?

McPhedran: Yes.

Mullan: And how did it develop?

McPhedran: There was the Family Medicine Institute, the outpatient practice, at August, and also a pediatric rotation. Internal medicine was taught at the Togus VA Center some of the time, the Thayer Hospital at other times, and at the Central Maine General in Lewiston at still other times. Psychiatry rotation was at St. Mary's in Lewiston. The first three

residents, I think, had quite a difficult time of it because they had to go to all these different places and be good and make everybody like them, and they weren't an orthodox bunch of residents at that time. Who would come to a place like this? Imagine that. I mean, it was a very difficult thing for them too, from their point of view, and they didn't always put their best foot forward, so that we would get calls about, "Your resident did this and did that." They had a hard time, and the staff had a hard time with them. They couldn't cover any service because there weren't enough of them. There were only three of them, and they had all these hospitals they had to go to, so they had a lot of driving to do.

Mullan: And how many per year, starting what year?

McPhedran: This was 1973-4. The year ending July '74, we just had three, and one of them subsequently dropped out. In 1974, we matched four people, having been approved, and also took on some other people at the second-year level. Those four that we took as first year residents in July 1974, while they turned out to be quite variable in many ways, were strong, solid people who thought of themselves as old time general practitioners. I think they were kind of a throwback, really.

Family practice, it seems to me, is a discipline in which the ideas of access and humane treatment of persons and various kinds of important ethical and social qualities like that are very much a part of the outlook, and I don't think that that is

as true of other medical disciplines. I think these residents were much more wanting to be general practitioners and not so much interested in the kind of principled approach to the care of patients that I think is a central part of family practice.

Mullan: Was that part of the vision of those of you who were putting this unorthodox package together?

McPhedran: Well, I think so. The first director was a surgeon by the name of Phillip Lape. He was a general and vascular surgeon who had gotten interested in medical education and wrote the RMP grant to fund the medical school. He also wrote some grants that helped to fund the family practice program's beginnings (before VA paid for it). Phillip was philosophically very much interested in fostering a training program. He had strong ethical views about how medicine and surgery ought to be practiced. He's a very interesting and unusual fellow. He dropped out of his practice, a very lucrative practice in South Portland, to come to work in RMP before there was a residency program, and then he stayed on as the residency director for about a year and a half. He was, I think, much more interested and committed to training humane physicians with all those attributes than were our first residents.

Mullan: Your role as it developed was what?

McPhedran: I was called curriculum coordinator. I was supposed to help design the curriculum, and I really wasn't well suited for that. I don't think I knew enough to do that. Looking back it's not possible to be pleased about that, because I wonder if it wasn't kind of irresponsible of me to have tried it, but on the other hand, they couldn't get anybody else to do it, so I had to learn it on the job and do the best I could. I had a hard time figuring out what was really important for a curriculum.

And there were all these political considerations, because somebody at the Thayer Hospital wanted to have the residents there because he does this or she does that--mostly "he" does this--and very good at it. The residents should come and learn that. Togus paid the bills at first. Eventually the other hospitals were going to be paying the bills, and to the extent that they had influence, they would also want to have their piece of the residents. It was really very hard to answer all those various calls and to deliver enough people so that you could have a service and a program that you could start and establish for a while, to teach residents those in-patient disciplines that are a part of family practice.

I don't think that we really felt on solid ground until we could go into a hospital and say, "You know, we're going to cover such and such a service with residents for the next several months. We maybe can't do it for the whole year, but we can do it for five or six months, and the residents will be on call. There'll be somebody there at night." That made a big difference.

Mullan: And how long was it before you could do that?

McPhedran: Beginning the third year of the program, something like that.

Mullan: By then you had how many residents per year?

McPhedran: We got four residents in the first year in '74, and got six residents in the first year of '75. And those six were much more like modern family practice residents. They were a terribly good bunch. They were just wonderful, those people. One of them does mostly emergency room work now in Farmington. His name is Cameron Bopp. He comes from Missouri. Cameron Bopp did as much for this residency program as almost anybody I can think of because he was good and he was funny. He could get along well with people. Staff people liked him. Maybe they didn't like the residency, but they liked <u>him</u>. He just had a wonderful effect. Individuals like that can have an enormously important effect on how the program is accepted.

Mullan: You came as a practicing neurologist.

McPhedran: Yes.

Mullan: At some point you got boarded in the family practice. Did you actually begin to practice?

McPhedran: I did some family practice, but I didn't do much, and I think that that's one of my regrets. One of the uncertainties I have is whether I should have deliberately and intentionally stopped doing neurology to do more family practice, whether my life would have been better or more interesting and whether I could have done better with the residency if I had done that. And I didn't. I continued to see neurology patients. They were referred to me. I had a certain amount to do. I liked it. I never stopped doing it. I didn't come here because I didn't like neurology. I came because I got more interested in something else as part of my life's work. So I've tried to straddle those two things, and I don't think I did that very well.

Mullan: But you did work as a family practitioner? You did take call?

McPhedran: I did take call. I took call as the faculty person for the residency, and I worked with other people who had done a lot of primary care.

The residency was helped enormously by Douglas Collins, about whom I think I talked to you on the phone. He was here from 1975 to 1980, and he was a really distinguished primary care doctor. He's one of the best doctors I ever knew, terribly good. He knew a lot and learned rapidly and had very high standards. He was easy to deal with, at least I found him so. He's a real Maine person, which practically nobody else was.

Mullan: Did you do any retraining, conscious retraining?

McPhedran: Douglas Collins said to me, in 1978, "I'm going take the family practice boards."

I said, "Well, you don't have to do that."

He said, "Well, I don't have to, but I think it'd be a good idea. You can take them now if you want to, but after this they won't be giving them to people who have had no training in family practice programs before. Do it. It'll make your life a lot easier, I'm sure."

That was really scary, and I guess I was afraid I wouldn't pass them. So we went and took them. It was some of the best advice that anybody ever gave me, just about. We both passed okay. I recertified the last time in '91. I think it did make a big difference in my credibility as an educator of family practitioners.

Mullan: Was it your training in internal medicine that you fell back on? Is that what was the cognitive base?

McPhedran: Yes and I read a lot. Being Board-certified helped me with the family practice people. I don't know quite how to put this, but there were so many crosscurrents in this residency early on. First of all, when I came to Augusta and Waterville, I thought that the doctors on staff would welcome the residency. They didn't welcome it. They thought, "What are you doing here? Why are you training these residents who don't know anything and

taking our patients?" You can think of any one of a number of issues that came up.

The first couple of years attending the staff meetings at the Augusta General hospital, the monthly Tuesday morning staff meeting was a terrible experience. The residency would come in for abuse over and over again. And then in addition to that, when I went to the Kansas City national meetings, I was the neurologist who was helping to run this family practice program. "What are you guys doing up there with this training program?" I mean, "You don't have any business doing this. You don't know anything about family practice." And blah, blah, blah. I felt like a pariah. It was difficult.

Mullan: And yet you became program director in 1980, was it?

McPhedran: Collins left to go back to practice in Caribou, and I became program director because it was really going pretty well. I liked it, and I thought it was a really good program. We were by that time attracting very good residents constantly. We were able to get women to come into the program. We really did have an affirmative action program to attract women residents. It was something we worked on. I've always been interested in equal opportunity, always cared about it, was concerned about it. We were having real success in the hospitals, too. The hospitals were liking the residents better and thinking the residency was a good thing for them.

I wanted to stay on with the residency. There was another person who was a candidate for the directorship, and I couldn't really abide the idea of that person being slid in on top of me. I had negative feelings about that other person. I didn't want to be directed by that person, and I felt that might easily happen unless I was director.

Mullan: So you decided to do it yourself.

McPhedran: So I decided to do it myself.

Mullan: And how was that?

McPhedran: It was okay. I had been acting director for about five or six months after Phil Lape left and before Doug Collins came. And I thought I could do it. It was okay. There were other reasons in my life at that time that I wasn't as happy as I might have been, but I learned a lot from being director, I think. I compare myself to Dan Onion in this. I think Dan Onion has a wonderful sense administratively of what this project needs, where to go with it, what the policy decisions are that have to be made. I don't think I had that same sense. Ever since he came into my life, which was about 1979 or '80 and he began to do some part-time teaching, I've been learning from him. I think he really is a distinguished thinker about issues of this kind, very good at it. He has a real grasp of the policy issues

and strong opinions about them. You can argue with him if you inform yourself. He's really good about that.

Mullan: What happened to the medical school?

McPhedran: The medical school, the enabling bill, whatever the legislature had to do, was passed by the legislature and the then-governor, whose name was James Longley, vetoed it.

Mullan: What year?

McPhedran: Probably '75 or '76.

Mullan: What was the thinking?

Mullan: It was too expensive. Longley was an independent governor. We didn't like him at all, but he was probably right about this.

Mullan: It would have been Augusta-based, was the idea?

McPhedran: You know, I've forgotten. I'm not really sure. Maybe it would have been Portland-based as much as anything. We thought it would be very hard to base any kind of medical school in this state other than in Portland or Bangor, although the Osteopathic Medical School is working in Biddeford.

Mullan: The family practice residency remained the sole offspring of the concept of medical school. There were no other programs that were started?

McPhedran: There were other family practice residency programs that were started, but they didn't come from this original RMP effort. The next one was Portland, based which was a few years after us, and then there was one in Bangor. The hospital in Lewiston which had been in our program wanted to have their own program. They wanted to have their own model practice unit and they split off from us. But all those things proved to be good for us in the long run, because it was nice to have other programs in the state to work with, and the Lewiston program, I think, has done well on its own. It's been a good residency program.

Mullan: What has been the overall growth in the annual number of family practice residents trained in the state starting from the three in the first class? How many are being trained now, would you guess?

McPhedran: I think there are nine in this residency.

Mullan: Nine per year?

McPhedran: Nine per year. And there are maybe eight or nine in Bangor. I'm not sure. This is per year. The Lewiston program

must be six a year. I think maybe four to six per year. And the Portland program, I think, is six per year.

Mullan: Then 25 to 30 a year that are being trained now?

McPhedran: Yes. Between 60 and 70 percent have stayed in Maine and they have gone mostly to small communities, communities under 10,000.

Mullan: And what has been the dynamic? Have they been replacing old non-residency-trained GPs? Have they been breaking new ground? And what have they done to the overall provision of services in the state?

McPhedran: They have replaced others, but they've also gone to places that were not served before. There are a lot right in and around Augusta and many more than there used to be, family practitioners. But they've also gone out to smaller communities. It turns out that small communities want family practitioners, although it's hard to support them. It really is. Most of them that have done that have also worked with physician's assistants.

Mullan: You mean literally PAs or PAs who were not nurse practitioners?

McPhedran: I mean PAs and nurse practitioners. I know some of the differences, but I don't know in individual cases what their choice has been.

Mullan: Why don't we take a break there. That's the end of tape one, side two. We'll go on to tape two.

[Begin Tape 2, Side 1]

Mullan: This is tape two, side A, with Dr. McPhedran.

I want to ask about the development of the osteopathic medical school at the New England University College of Osteopathic Medicine. They did succeed in putting together a medical school, which has now produced a decade or two of graduates and seems to be doing pretty well. What is your observation about that enterprise, and what lessons are to be derived from its existence and the failure to generate an allopathic medical school?

McPhedran: We have had students from the University of New England College at the Family Medicine Institute, and I've talked to some of them. I've seen some of them. It is nice to see that they're able to solve problems, and they're interesting students often. I have been overcoming prejudices that I learned years ago about osteopathic medicine. I've been laboring under these prejudices for a long time. I was brought up to think of osteopathy as a kind of quackery. When I was in Regional Medical Program on the National Advisory Council, I went to some meetings, especially in Missouri and in Michigan, both in East Lansing and also in Columbia, Missouri, where for the first time encountered groups of osteopathic physicians who were working on

Regional Medical Program projects, and I thought some of them were just outstanding. So I realized that at least part of my difficulty was a cultivated prejudice, and maybe I've been trying to get rid of that ever since and have, to a considerable extent, but those things die hard.

For a long time I've wished that I knew more about their practice that was different from allopathic medicine and be in a position to work with them in improving medical care. So I really welcome this. This fall, actually, I'll be teaching in the nurse practitioner program at University of New England. So I'm interested in their projects. I think it's been good. I can't remember how you put the question.

Mullan: The question was, they have succeeded in pulling off "medical school," whereas the traditionally based thinking didn't succeed.

McPhedran: Right.

Mullan: Why?

McPhedran: I don't know the answer to that, why they did it and we couldn't with the bill that Longley vetoed. I'm not sure, and I wonder whether the cost was borne differently so that it doesn't seem to come out of taxpayers' hides or what it is. I'm not really sure. I don't know why that is. It's a good question, and I don't know the answer to it. I think that the

whole osteopathic discipline must have a somewhat different power base in politics than allopathy, but I wouldn't have thought it was any more. I would have thought it was different, maybe, but not more. So I don't know how it happened.

Mullan: Embedded in that question is, I think, a very important lesson that I don't understand fully either for medical education at the current juncture where we see allopathic medical schools teetering, some of them, on the brink of collapse and osteopathic schools still being generated. They seem to do it in a private-sector fashion in which they don't rely on either major public resources or in traditional teaching hospital bases. Since hospitals themselves are so vulnerable these days, you're seeing medical schools tied to hospitals sinking along with the hospitals. So that the old shibboleth or the old conventional wisdom that medical schools require enormous capital input and huge public commitment or large endowments is being given the lie by these close-to-the-ground, pay-as-you-go, low-rent osteopathic schools. That addresses the question of the quality of education, but if you look at performance as measured on examinations, the osteopaths are performing quite well, and their output, of course, of primary care physicians exceeds [unclear].

So there's a nugget of wisdom there that I think is going to be very important to the future, actually, even though they started in the shadows of allopathic medicine, and the main story where the two ideas co-existed for a while, and the allopathic

one, as you say, perhaps appropriately, withered in time but the osteopathic one went ahead, is an interesting parable.

McPhedran: It is interesting. In connection with what you were just saying, I wonder whether schools like--well, I was talking about the Michigan model, the upper peninsular, the more dispersed kind of medical school, does that have the same costs, fixed costs, as a regular allopathic school. Allopathic schools like that, if they've liberated themselves from the big teaching hospital and all those costs, would then be able to do better, to be able to prosper and survive.

And then there are some schools that were started initially with an eye to training family practitioners, primary care physicians, and Southern Illinois sticks in my mind as one that had that mission, have they done it at lesser cost? I don't know the answer to those questions, but maybe if the intent in the first place, the whole thrust of it were to train primary care people and do it apart from big city hospitals, maybe it wouldn't be so expensive.

Mullan: I think that's probably part of the osteopathic formula. You referenced a couple of times the values of the Family Medicine Movement into family practice as they had been taught, presumably, in your program and as they exist in practice. Tell me a bit more about that. How would you articulate what the values, the unique values, are?

McPhedran: Well, I think that although sometimes they feel perhaps a little self-conscious about this, I, nevertheless, on the whole, I think that people who do medicine often want to do it because they want to help people. It is one of helping professions. I think that when ordinary people get into it, they may feel a little bit self-conscious in speaking about themselves that way. I don't know why that's true, but that does happen. Some doctors don't want to be looked at as what people refer to as "do-gooders." But I think that in family practice there's been a more willing acceptance of the idea that it really is important to help people and help them to be happier and more healthy. The health maintenance part of that is a very big aspect of that.

I think that also there has been a consciousness of need to avoid excessive cost so that care is accessible to people, so that this helpful service is accessible. I think that family practice advocates have been interested in humane approaches to medical care so that persons who may be hopelessly ill with cancer or something like that, can be looked after in a way that respects their humanity and yet gives them the benefits of whatever medicine can produce. Everybody would embrace those ideas, but in family practice I think they've been more consciously accepted and in the forefront of thinking rather than sort of baggage that comes along like the caboose: "Well, we all do that," you know? Well, the fact is we don't all do that, and in family practice training, that's been sought after and put up in the front. That's what I think is different about it.

Patient care is valued in a different way and in a way that I always thought was good.

Mullan: In terms of your own work, you walked between the worlds of knowledge and the worlds of family practice. What over the years, and particularly in recent years, has been the most fun for you? When you look at your work, what do you value the most and how would you characterize that?

McPhedran: I think that I value the most the relationships with doctors-in-training, but also patients. It can happen that we both learn something. I've had experiences with patients where I think that they learned something of importance from me and at the same time I learned from them, and we were both conscious of that, and I think that that's true with residents, too.

I remember a patient that I took care of a number of years ago, a young woman who had a rare and terrible brain disease from which she died. It was hemorrhagic leuko encephalitis of Weston Hurst. She was taken care of at Augusta General. We made the diagnosis. The family realized that we worked very hard over this young woman, and afterwards, when she had died, I remember saying to them, I said, "You're going to miss me, but I'm going to miss you as well." [McPhedran crying.] I'll never forget that.

Mullan: How many years ago was that?

McPhedran: When Collins was here, 1978.

Mullan: The patient care made it important?

McPhedran: The experience of sharing that part of life with somebody and the intensity of it and the support that you get and that you give, and then, all of a sudden, it's gone, but the memory of what you went through is still there. [McPhedran crying.] That's happened to me a number of times, I guess. The older I get, the more it affects me. Sometimes I wonder whether my emotions are getting harder to control. These things affect me in a way that they didn't used to, more intensely.

Mullan: Are there residents or physicians in practice that you count as particularly close, people that you've mentored?

McPhedran: I think there are. There are residents that I've been very close to and who are colleagues as well. Collins was a wonderful colleague. I really was very much attuned to him, and he answered my needs emotionally in a way that was really important. I had a lovely time working with Collins. He was really fun and very supportive. He cared about what I thought about and was interested in, and he changed things that he did, changed behavior in response to suggestions I made, not because he desperately needed to, but just because we had that kind of relationship.

Mullan: At some point Dartmouth became associated with the program. Why and what was the import of that?

McPhedran: Well, in the seventies we thought it could be a free-standing program. When I left Emory, the then-dean, Arthur Richardson, really disparaged family practice terribly, and as far as I know, most deans of big medical schools had found it pretty easy to do that, at least for quite a while in the seventies and eighties. People are less able to do that now. I don't think that most major medical school deans disparage family practice now, at least not openly. But their faculties still aren't particularly supportive of the idea for the most part. So I think that the old ideas die hard. I'm not answering your question. I got off on a track.

Mullan: Dartmouth.

McPhedran: Dartmouth. Collins first thought that we should have medical school affiliation. Like Onion, he thought better about policy matters like that than I did. Collins said, "I think that we need to have medical school affiliation. I think that in the future it's going to be important for the survival of the program," and so he started what he called "courting." He courted Dartmouth and actually courted Tufts and tried to court Harvard. Bob Lawrence was then at Cambridge Hospital, and he had some conversation with Bob. Nothing ever came of that. And Tufts wasn't interested. We were too far away, I think. Nor was

B.U., but Dartmouth did get interested, and most of that took place in the late seventies.

Our affiliation goes back to about 1979. I can't remember exactly when it happened now, to tell you the truth, but it was very loose at first. The advantage was that they sort of put their imprimatur on what we did. We had sort of academic credibility because Dartmouth couldn't give us faculty appointments unless we were academically credible. In the seventies it hadn't seemed to me a particularly important issue, but then in the eighties it did get more and more to seem that this academic connection would be necessary for survival.

Mullan: And has that been helpful, having the affiliation?

McPhedran: Yes, it has.

Mullan: What has it meant? Do you have students?

McPhedran: We have some students that come from Dartmouth, and we've had some faculty exchange back and forth, but I think it's mostly the students and the interest of the students. And then, at least on one service, the Dartmouth hospitals have done us enormous service in obstetrics. Residents have gone there to do high-risk obstetrics. There was no obstetrical residency training program at Dartmouth, so our residents were right there being the residents and they learned a lot about high-risk obstetrics.

In some ways, I may not be qualified to judge the value of this service. People who have been in the program, family practitioners like Dave Shinstrom, now out on the West Coast, who did take care of obstetrical patients and was trained in our program, he didn't think Dartmouth training was really good for residents. So when I say that I thought it was a good thing, I'm going counter to what some others that probably know better have thought. But it seemed to me that residents came back with skills and knowledge and understanding so that obstetrics could be part of their work in family practice in hospitals. For me, coming from where I did, obstetrics had seemed to be the least likely part of family practice that would remain as a part of current practice.

I came to this training program with profound skepticism as to whether or not obstetrics should be part of family practice, but I have been reassured over the years by people that I knew whom I respected. After they were trained by us former residents were able to do obstetrics with adequate consultation, so that so it seems to me that my skepticism was not well founded. At least in the best of all possible worlds, where you wouldn't have huge liability problems, it would be quite all right. Maybe the liability aspect of obstetrical care still makes it kind of difficult and chancy, but I think that the argument that having obstetrical patients keeps the practice a true family practice is a really good one. It's a powerful argument, and I think that it is important for the kinds of care that family practitioners can give that they continue to have renewal of their practice from

the bottom up. I really believe that it ought to be possible, and so we ought to try to make it happen.

Mullan: Let's talk a little bit about the current situation and the future. You had some skepticism about the rifts in medicine. Tell me about that. Where do you see medicine headed, and particularly from a family practice, primary-care perspective, where is it headed?

McPhedran: I think that having the process of care governed and managed by people other than those who have professional training, other than physicians, other than nurse practitioners, to the extent that it's governed by people who are only paying the bills, that that's a really bad situation. I'm thinking that the management of care by people who are not actually caring for the patients is a pernicious trend. I understand how the financial problems brought this about, how the increasing cost brought it about, but I can't help but think it's going to interfere with medical practice, notwithstanding the fact that perhaps, in some instances, algorithms and policies about medical care have been developed that are probably good for patients. There may be instances in which patient care suffered because some physicians' practices were too loose about safeguards that ought to be adopted for patients.

I used to get into trouble with Dan Onion about this. When I was in the RMP, I saw the beginnings the U.S. Government being

interested in pre-paid plans and health maintenance organizations. They were interested in the Sidney Garfield model that had been developed in Kaiser Permanente, assuming a risk for a population for a certain stipend and then taking care of people using good preventive practices. That's what I always understood about the health maintenance organizations.

But what seems to me to have happened, as far as I understand it, is that the U.S. Government came out concerned only with cost containment. So I like to twit people about it, and I say, "Don't call them HMOs. What they are is CCOs. They're cost containment organizations," and that's really the heart of what we're looking at, at what's called HMO. There may be people in that movement who are still interested in health maintenance, health protection, although something I read in a journal the other day suggested that some of the big payers couldn't care less about that, like Columbia HCA, for example. I know that Onion was always interested in health maintenance, and that's at the center of his being. That really is what drives him. I don't know anybody who has taken a more principled approach to medical care than Dan Onion, but I think that a lot of people in the vanguard of pushing "health maintenance organizations" really don't care about health maintenance. All they care about is cost containment.

So I think that people like Dan Onion are overshadowed by what is primarily cost containment. I do think that cost containment is important but it surely is not the only thing we need in medical care.

Mullan: What about the role and positioning of primary-care/family practice?

McPhedran: Well, that is something we talked about before, and, again, I think that Dan is right about this. Part of the cost containment organization approach puts family doctors in a position of what is called "gatekeeper," really a disparaging term. I think that's a loathsome idea. First of all, it's so demeaning to the doctor or to the nurse practitioner to imply that all they do is let people through the turnstile to the specialists; but also, even if they are regarded as the important first people who decide what's the proper care and whether the proper care includes consultation, whether they're called gatekeeper or whether they're called physician, there is still that potential for conflict with the specialists who are excluded from firs contact, or whose services are used only by referral. So I don't know how to deal with that conflict at the moment.

Mullan: But how are your people being used and viewed? Certainly, family medicine is a much more popular and prominent part of the medical landscape than when you cast your lot in it.

McPhedran: Right.

Mullan: And you must feel some gratification in that.

McPhedran: Oh, I am gratified by that, and I think that it's an idea that's been a long time coming, and it is a good thing. I think it's a good thing when neurologists or neurosurgeons are not the first doctors to be seen for headache, to use as an example I am interested in. That was a bad trend in our previous usage when people off the street with a headache would walk into the neurologist or neurosurgeon's office. Not good; I mean, costly, and the spectrum of illness that the specialist sees leads to an approach and a kind of testing and various other practices that are unlikely to give the best results.

I talked about headaches at the residency yesterday, and I think that people with good training in primary care are bound to do better with common problems like that than the legions of specialists who may have been initial caregivers before. So I think that's good for medical care, although I think it gets the primary care doctors, to some extent, in hot water with the specialists if they don't refer them sometimes.

Mullan: Are you seeing that in Maine? Is the role of primary care doctor more difficult now?

McPhedran: I don't really know whether that's true or not. I'm not sure.

Mullan: My own sense is that the availability of specialists in Maine is sufficiently modest that that's not a big problem.

That's different, of course, in urban areas where you've got specialists falling all over each other.

McPhedran: It must be bad there. Is it bad there?

Mullan: Oh, yes. And if you have managed care pushing it, where penetration in urban areas tends to be much higher, you'd have it anyway, because our training pattern is skewed so far towards specialists that we were just building and building and building them, and now that the market has cooled, they're scrambling for work. The market has been particularly chilled by managed care arrangements which have reduced [unclear], so there's no question that's so.

McPhedran: I have to tell you something. Last fall I taught nurse practitioners students at the Mass General Institute for health professions, teaching pathophysiology. The woman who runs that program told me about one of the possible future teaching opportunities that I might consider. She said, "At the Mass General there are physicians who have done specialty work and are looking for opportunities for retraining in primary care. Would you be interested?"

I thought, "No, I wouldn't." I thought, "That's too hard. I'm too old."

Mullan: Yes. That's a much-debated issue these days, and obviously retraining a radiologist to do family medicine is

different than retraining a cardiologist to do family medicine. That has not been differentiated.

Let's focus for a moment on the future, if you could pull out your crystal ball. Where do you think the system is headed? You can define a domain if you like, eminent domain. What is the practice of medicine going to look like in twenty years, particularly in regard to the generalist side of it?

McPhedran: I don't know that I know how to forecast that, but I think this trend that we're going through now, insurances and managed care--I suspect that the public will react against this eventually, and there may be a single payor system or something like that will happen eventually. I think that medical care is an important enough public good so that it isn't possible for it to remain sort of regulated helter-skelter the way it is now. That's what I think is going to happen. Just as the schools are not all going to become private, I think medical care is eventually going to be more in the public sector. I don't know what it'll look like, but I think it's inevitable that that will happen because I think it's become such an important commodity.

I think that in order to keep the cost from going out of sight, there will have to be resource constraint, sort of like what happened in the British National Health Service when it was at its best, or at least when I thought it was at its best, and that that will be hard to deal with, but that it'll still work. We could work quite well with a lot more resource constraint and a lot scarcer technology. We could have just as good statistics

and not have the cost. Maybe that's what I wish would happen. Sometimes I think it's going to happen but I don't know whether it will or not. And it'll be probably paid for out of some sort of taxation, and there will nevertheless be a two-tiered system to some extent, because some people will be able to afford private care, and they'll get it outside the system. I think that the double tiered system is almost inevitable and is not a good thing, but I don't see any way to avoid it in a free society. Do you think differently about that? I'm trying to serve your needs, but I guess I'm curious to know whether you think that's all wet.

Mullan: No. I don't think it's all wet at all. Although I'm not an apologist for managed care at all, I've never practiced in it, I never received my care in it, and I'm troubled by many aspects of it, I think there's an element of something which is compatible with the American way of doing business, and I think some form of it is likely to remain with us. I don't see the American people--an expression I hate when politicians use it, and politicians going for the single-payer system, even though it's what I wanted and made most sense to me, for a couple of reasons. One, because it's too communitarian, it's too public, it's too socialistic, and even though we're there to some extent with public schools, that's well rooted back in our history, I don't think at this point in time, particularly after coming off welfare reform period, I think that seems beyond reach. Some

form of commercial private-sector management of health care is going to be with us.

The other reason I don't think single payer will make it is because even the leading practitioners of it, the Canadians, are having trouble cost containing with it because there is not a feedback loop or discipline ultimately in there, and a physician can churn or can expand, either consciously or unconsciously, market share by doing more, and somehow that tension has to be kept in the system.

I would agree with your analysis that we have a system which was functioning in some ways pretty well, but it wasn't cost contained. Well, that's not a minor blemish. That ultimately was toxic, and it isn't a few doctors saying, "Oh, golly, if I ordered few less tests, everyone will live happy ever after." Somehow a discipline has to be built in the system that enables it to live within its means. Managed arrangements have the elements of that within them.

Now there are enormous ethical problems and significant delivery problems and huge opportunities in self-dealing that are going on, and I don't have the answers to that, but I skeptically and unhappily have sort of concluded, as I look at the serious practitioners, both individually and organizationally, of managed care, it seems to me these are the futurists. They've got a notion of a discipline that involves finances, outcomes, patient satisfaction, that adds up to something like a potential system. I don't have the details of it in mind at all, but the broad framework, I think, is there.

Then I think there's going to have to be a public add-on, because the essence of managed care as it's being practiced now is not reform, if reform means universality. You're not dealing more people in, and the commercial sector isn't going to cover all the population. So we've got to have some rigorous, formalized, permanent gap-closing, and the only potential player in that is the government.

McPhedran: Thank you. I appreciate that.

Mullan: We haven't touched on family at all, and I'd like to have you go back and if you'll just give me the essence of that and kids and how it's all integrated with your work.

McPhedran: We have four sons. The first one was born when we were in Mobile, 1955-1957, and then two while I was in residency training, and one after we went to Atlanta. As they've grown up, none of them wanted to go into medicine. One expressed some interest once. Maybe it was at a bad time: I certainly didn't encourage him.. They all went to universities and graduated, finally. Some of them took longer times than four years. The eldest works at Walmart, is married, and has four children.

Mullan: Near by?

McPhedran: Yes, up in New Vineyard, Maine. The second son is a schoolteacher and is single, and he works in a school near here.

He is a terribly popular sixty-, seventy-hour-a-week schoolteacher. He works really hard, gets there at 6:00 o'clock in the morning and goes home at 8:00 o'clock at night.

Mullan: What grade? What age?

McPhedran: Well, he's teaching mostly what's called co-op education. It has mostly to do with the children who really would have dropped out of school if somebody hadn't been there to gather them in and get them into some sort of--work study program.

Mullan: High school age?

McPhedran: Yes. I think Dave is the Catcher in the Rye. He's good and he's very, very popular. The kids like him, and he gets to do all kinds of things with other students who are not co-op students because they admire him. He's still single. He's 38. Right now he's doing what he likes best: skiing out West on glaciers in the Rockies.

The eldest went to University of Maine, Farmington; the second went to Bates, and the third went to Colby. That's Tom. He's the carpenter, but he read Latin and Greek in college and got a degree in Classics and also geology: now he builds houses.

Mullan: In these parts?

McPhedran: He builds houses around here. They all live in and around Maine. John, the youngest, is the only one in graduate school in Burlington, Vermont, and he lives over there with his partner. John has lived with a woman for five or six years to whom he's not married, a circumstance, you know, that I never would have thought would happen in my household. (to have people living together not married). But it's such a commonplace occurrence now. His wonderful partner is a schoolteacher. Tom, the carpenter, is married to a woman who teaches school also and waits on tables.

We're very close to our children. We see a lot of them. They like to come here. I think that that's true. They come to family gatherings and family parties. We probably have more support from our children than most couples do. There are very few people who have it as good as we do.

Winnie stopped work. When we got married she stopped her formal education. She had an invitation to go to the London School of Oriental Studies. She had been in Japan working for the American Friends Service Committee for two years, in the fifties, before we got married in 1953, and she could have had a career, I think, in Oriental studies, academic Oriental studies, but instead of that she got married to me and worked in various jobs since we've been married. She continues to volunteer a lot with the American Friends Service Committee and has over the years. She's been on the board of the AFSC and is now on the board of what's called the Community Relations Division, which is

the social action arm of the AFSC. She spends a good deal of time doing that.

Mullan: Are you Friends? Are you Quakers?

McPhedran: Yes. We don't attend meeting anymore. I am a member, or was a member, of the Germantown Friends Meeting. I think she's still a member of some meeting, Atlanta or Gwynedd, Pa. My father was a Convinced Friend, and I became a Convinced Friend. She actually began working with the Quakers when she was in high school. But there are other volunteer activities that she's done over the years. And she was employed for a while by our school system as a curriculum planner. This came out of experience that she had volunteering in special ed. When we were in Atlanta, she did some special education tutoring, got interested in that, and then when she came here, she was hired by the school system to write grants. She wrote grants for particular projects that they did, and she is hired as a special contractor or consultant.

Mullan: Your work surely has impacted your family. How has it impacted them?

McPhedran: I really didn't see a lot of my older children, when they were little. Alex is the oldest, and Dave next. I saw very little of them. By the time John was born, I was still working very hard at Emory, but somehow I got to see him more. It was

really difficult. I understand residents' feelings. Residents in training continue to wish for more time off, more and more. I've been training them for a long time and was a trainee myself, and the degree to which residents need time off is limitless, I think, absolutely limitless. It is different now than it was: a lot of concessions have been made.

[Begin Tape 2, Side 2]

Mullan: This is tape two, side B, Dr. McPhedran.

Concessions?

McPhedran: Well, that's such a loaded word, but allowances are now made to permit a humane existence for trainees that didn't use to be made. I think this is good, and yet on the other hand, I think that there was a value to the very intense experience, professional experience, that I had that I think was important. I guess it was the Bell Commission in New York State that said that the hours of work of residents was clearly inappropriate, and nobody learned anything after 60 hours in a week and it put patients at risk. I have a hard time arguing with that, because they studied it and they were important teachers. All that's true. But I don't really think that was true where I was at MGH or Beth Israel. I just don't think that the long hours put in by residents put patients at risk. You worked hard and you learned a lot, and yet I think our families did suffer.

Mullan: Did your family, as you moved to Maine and made the move to family medicine, as you see it and as they would see it, was that a positive development?

McPhedran: It was a positive development. They wanted to come to Maine. I moved two high schoolers to Maine and really didn't get any complaint, no substantial complaint. Try that sometime, moving two high schoolers away from their high school friends. They wanted to come, and they looked forward to it. There were some wistful partings and saying goodbye, but they did pretty well with it. They've had a good time here, and not one was willing to look at Harvard or Yale or Princeton or places like that. They all wanted too be in small towns. One of them went to University at Farmington, one went to Bates in Lewiston, one went to Colby in Waterville, and one went to the University of Vermont.

Mullan: Is there any animus towards medicine, in the sense of they didn't want to do it, they saw you doing it and--

McPhedran: I don't think that was ever voiced to me. I don't remember it.

Mullan: We've talked about a lot, and I'm delighted with what you told me. Is there anything else that you want to touch on?

McPhedran: No. It's been nice for me to ventilate and tell somebody who's obviously interested in what I did. I think that this project, the residency, had enormous social utility, and so I think this simply really is a wonderful thing that way. I feel that I caught onto something important in the late sixties and the early seventies, that is, the disappearance of primary care and I comprehended how bad that was long before it occurred to others, and I feel pleased about that, that I understood that. I think it was a true observation, and while I don't feel that I understood how to develop policies about it, and I think that's never been something that I have done well with, the whole policy development, but that at a fundamental or basic level, I could come to grips with this problem.

Mullan: I suspect as a teacher, a mentor, a hands-on contributor to it, you've been essential.

McPhedran: I think I have been important to it, and that pleases me.

Mullan: Certainly as I talked around the state about who one should talk to, all roads led to Alex McPhedran.

Before we end, let's spend a moment on John McPhee, the writer who has written eloquently about family practice in Maine in the--what's the name of the book?

McPhedran: *Heirs of General Practice.*

Mullan: *Heirs of General Practice.*

McPhedran: It's a play on words because it's H-E-I-R-S. John was a staff writer at *The New Yorker* magazine. My brother-in-law, Bob Bingham, was his editor at the New Yorker. Bob Bingham knew about the beginning of this residency program, and thought it was really interesting. He thought John McPhee would be interested to write about it partly because John McPhee often talked about his own father, who was a physician and a general practitioner, family practitioner. McPhee had been interested mostly in geology for some time. Bob Bingham died of a brain tumor in 1982, and that was very sad for John McPhee because he was terribly attached to Bob. Bob Bingham was a wonderful person, a writer and an editor. McPhee admired him.

After Bob Bingham died McPhee got in touch with us in 1983 and said he wanted to write an article about training family practitioners. He came up here, and he embarked on this article. It just so happens that he began it a year before we had our worst political debacle, which was when the Mid-Maine Medical Center, hard-pressed for funds and after a change in administration, dropped out of the residency program in December of 1983. McPhee had been here, gathering information and interviewing people to write this article. That was one time when I sort of think the residency nearly went down, in 1983-84, when Waterville dropped out.

John's article was published in July of 1984, and it has enjoyed enormous popularity. Farrar-Strauss has put it in at

least one collection, and it also was published as a separate piece. The Academy of Family Practice bought a number of copies and distributed them to prospective residents. I think it had a very important effect in family practice, and I suspect that it had something to do with the fact that the Waterville Hospital came back to support the residency. There were others who played a part in that, but I think that John McPhee's part was not trivial.

Mullan: Did you steer him towards the people he talked to, or how did he find them?

McPhedran: Yes, to some extent. He came to the residency because of his connection with my brother-in-law. But the form and content of the article are his own. There were people here who complained, "Why didn't McPhee interview me?" Well, that's because he was not going to be influenced by what somebody else thought what the piece should be. It's really interesting to talk to somebody like that and realize about how they make up their mind about what goes in and what stays out. It's a wonderful experience to talk to him about that and listen to him about how a piece of writing is worked up.

Mullan: And how long did he spend in the state? How long did he spend researching?

McPhedran: Months. He was up here a number of times, and I must have talked to him for, I don't know, fifteen or twenty hours, I think.

Mullan: And how does he work? Does he use a tape recorder?

McPhedran: He does now. He uses a tape recorder. Mostly, at the time, they were pencilled handwritten notes in a little spiral notebook. He now uses a computer/word processor. I don't know whether he takes a laptop with him. He uses a tape some.

Mullan: Good. Well, that's an important codicil to the story.

McPhedran: I don't know why I didn't mention it, because for me, it was like a godsend, you know. It was like *deus ex machina*, here comes McPhee to--

Mullan: To tell your story.

McPhedran: He said of the Waterville Hospital when he had finished this piece, he said, "That's the hospital on the cutting room floor," and they were not happy about that. [Laughter]

Mullan: Thank you for that add-on.

[End of interview]