**Interview with Dr. John Stoeckle**
**Date: May 3, 1995**
**Interviewer: Dr. Fitzhugh Mullan**

**FM:** This is the third of May, 1995. We're at the Massachusetts General Hospital on the sixth floor, in the Ambulatory Medical Clinic, with Dr. John Stoeckle. It is a beautiful May day, and we are going to talk about Dr. Stoeckle and his life.

Welcome.

**JS:** Thank you.

**FM:** I wanted to start just asking you to tell me a little bit about where you grew up and your premedical life, and what took you to the point of going to medical school.

**JS:** I started life in Michigan, born in Detroit, and my parents then had four children, because when my sister, who is a twin, and I came, they decided it would be better to take these four children to a smaller town. So my father moved to a small town named Sturgis, where he started work for the manufacturing company.

**FM:** Sturgis, Michigan?

**JS:** Sturgis, Michigan. A manufacturing company which made curtain rods, venetian blinds, in which he spent pretty much his entire career there. This is a wonderful town--at least it is in our sentimental journeys there--of about 7,000 at the time, about one square mile. I went over recently, a couple of years ago, when my mother died, the various places we lived. We lived in

about five different sites within the city, because my parents sort of, you might say, moved, when they had a little bit more money, to a little bit better house, to a little bit better neighborhood, and finally settled down and bought some twenty-five acres of farmland right at the edge of the city, which they converted into a development, and then named some of the streets after their children. This town is a very progressive town, in my opinion, and it's considered the gateway to Michigan.

**FM:** Where is it located?

**JS:** Right at the Indiana border, about three miles above the Indiana border, so it's halfway between Detroit and Chicago--150 miles both ways. The city's progressivity, I don't know what it's due to, but I think it's always had a lot of civic pride in its high school--its sports, its band--so it was a wonderful town to grow up in because of those reasons. It was a reasonably prosperous town because it was in a farm region, and if that didn't really support it; it's because it had any number of small industries there. Kirsch Company made all the curtain rods for the United States; then there was a printing company there; there was a chair-manufacturing company there, and there were some small companies that made parts for Detroit.

**FM:** What did your father do?

**JS:** My father was superintendent of this factory, sort of was the factory manager, and did that kind of work. The major shift they had was during the war when, part time, they made gliders

for World War II, for, I think, the Army, Navy, or Air Force. I don't know who it was. But that gave the town prosperity and a sort of civic pride, I think, because it was economically a prosperous town.

**FM:** Which year were you born?

**JS:** I was born August 17, 1922, in Detroit. I was a twin. My sister and I were born at the same time; I was born after her so my mother would remind me. In Sturgis, where we moved to, you went to grade school, which was walking distance from our house. From grade school, you graduated and you went to junior high and high school, which were about a mile and a quarter from the house. So we had to walk that distance between, for lunch. You came home for lunch during those days; you didn't stay in school.

In high school, the athletic part that I was interested in was tennis. The field was very close to where we lived; in fact, the geography of the town was such that everything was really within walking distance, and it was wonderful because it was that way.

The high school experience was very good, because you could do most everything--play in the band, which we did. I had a brother and sister who preceded me. My brother was head of the band, what you call a drum major and clarinet player; my sister was a trombone player and head of her section. They both went to the University of Michigan later. They were about four and five years older than I was. So I played the trumpet, and our family

had a little orchestra--myself and my brother and sister, and my twin sister played the piano.

**FM:** Were there some doctors in the town?

**JS:** There were some doctors in the town. There was a Dr. Gillespie in the town, and she was a woman doctor; she graduated from Ann Arbor, and she practiced not too far from us, as a matter of fact, from our first house, which would be about three blocks. She had a sort of office in her home. Fortunately, I didn't get dragged there very often. My sisters did, I think, but I don't think I had to go very many times. I really don't remember going to the doctors. I only remember going to dentists. The dentists are the ones that I remember badly, because I always felt they didn't give me enough injections to do away with pain I couldn't take.

**FM:** Was medicine at all a significant issue for you, as a child, in terms of thinking of your future?

**JS:** There was one thing, when I look back, it's all respective, my oldest sister developed tuberculosis. We used to go to Ann Arbor, because my parents emigrated originally from Germany to Ann Arbor, Michigan, so their U.S. family roots were in Ann Arbor, and my uncles were in Ann Arbor. So when my sister got TB, she was taken to University Hospital in Ann Arbor, and I think the diagnosis was confirmed there. Then my parents built a little, like in a sanatorium,--a little porch. It was the outdoor cure theory at home. So she stayed in this outdoor porch

on our house, I think for maybe a year and a half or something, taking the cure. So that was the first idea of any kind of chronic illness.

**FM:** When would this be?

**JS:** Well, she was probably--I was probably too young to remember, but the stories about her were told to us often--so she was about fourteen or so. Then I would be about nine or so, something like that. Then we had to get goats, because the idea was, if you take goat milk, you'd get better from TB. So my parents bought two goats and put them in the garage next to our house. My brother, I think, used to milk them, and I think I tried to do it, but I couldn't do it very well. It was well known that goat's milk would be the thing that would keep you from getting further advanced in your TB. So eventually she got cured, or it got arrested, or whatever it was called, and didn't have any further trouble.

**FM:** That's fortunate.

**JS:** That was a major illness. The only other thing I can think, reminiscing while I'm at it, is that there was a doctor that used to come by in an old sort of Ford, and stop in to see my sister. I don't know why--I can't remember his name or anything like that, but I think he was a--

**FM:** This was in conjunction with her TB?

**JS:** TB, yes. He used to stop in the house, make home visits, in other words.

**FM:** Was he a specialist?

**JS:** No, he was not a specialist. He was one of the GPs in the city.

**FM:** You went to Ann Arbor then?

**JS:** No. My brother and sister both went to the University of Michigan at Ann Arbor. The first persons in the family, therefore, to go to college, they were, because my parents had migrated from Germany without any college education. I think my mother had finished to the eleventh grade in Ann Arbor and then went to work; my father, I think, had finished not the whole school, either, and had gone to work in an instrument factory, but he was very sophisticated and self-taught kind of intelligence, became an expert machinist and therefore learned his skills about managing factories and so on. So these were the first two kids that went, in the family, to college. That was influential, that, therefore, the younger kids in the family would also go.

My brother was a big stimulus in that regard, because he kept sending us all sorts of information about where to go to college, not necessarily go to the University of Michigan, which was kind of the only choice that people really thought of, either that or you went to the many smaller colleges in Michigan, like Kalamazoo College, or Hillside College, or Albion College, all

those different small colleges in Michigan. But he said, "If you go to college, just think of where you want to go." He said, "You could apply on the East Coast." We never heard of it, you know. He gave us a list of Swarthmore--what was another one? Middlebury College. Things we would not have heard about if it hadn't been for somebody in the family like that. And he also suggested applying to Harvard, which we did, and we got admitted.

**FM:** By "we," you mean you?

**JS:** Myself, yes, by taking the exam. We didn't have those exams. I've forgotten, SAT exams or something like that. You had to go to Grand Rapids, which is north of Sturgis about 100 miles--no, I think it's 50 miles--and take an exam which was then sent off to Harvard. They looked it over to see whether you would qualify to come in to Harvard. So we passed that exam, but when I came to make a decision on leaving high school where to go, it just seemed like it was too far away. I didn't think I could, as they say, take that big a leap, anyway from home.

So I had a scholarship to Oberlin. I took that. That was nearby. As you know, Oberlin is right there along the lake, in Ohio. That was more like being at home, but still you were going away. The idea behind that choice, that I think sold me, is my brother was very anti-fraternity at the time, at Michigan, because Michigan had been dominated by fraternities, and he didn't think that was the greatest thing in the world. He'd also taken a trip around the world in '37. So I think we were very influenced that Oberlin did not have fraternities and it was a

better place to go to than otherwise. But all the other colleges did. That was a big deal.

**FM:** How did you like Oberlin?

**JS:** I liked it very well, and I should have stayed there, but after a year, my brother had gone to Antioch. He transferred from Michigan, to Antioch College, and he thought it was terrific. It was in Yellow Springs. He had started there after his round-the-world trip. It was during the war, in '40--let's see, I was at Antioch in '40 to '41.

**FM:** At Oberlin?

**JS:** Yes, at Oberlin, `40-'41 rather, while he had already been at Antioch for a year or two, and he had decided to go to medical school. He had joined the ASTP, which was the Army program.

**FM:** What does that stand for?

**JS:** I think Armed Services Training Program--ASTP, yes.

**FM:** This is for medicine?

**JS:** For anybody going on to advanced college education--okay, you're enrolled in that. So he applied to medical school with some friends of his from Antioch, and he got admitted to University of Virginia in Richmond, Medical College of Richmond.

But he was so much "pro" about the ambience, if you will, and the vitality of Antioch, that I just decided to go down there.

**FM:** So you switched, after one year, to Antioch?

**JS:** One year, yes, without prejudice to Oberlin at all.

**FM:** Was Antioch non-conformist?

**JS:** Oh, God, was it ever.

**FM:** Then as it is now?

**JS:** Well, I think it was really excellent then, because it had a very good academic reputation then. It was excellent academically, but in addition to that, it was kind of left-wing. I almost joined the Communist party there, because they had this cell there. Fortunately, I never signed up, but I went to hear all the speakers. It was also sort of the time of so-called "free love" on campus and all that stuff, which was more talk than reality.

**FM:** And that was more Antioch than other campuses at the time?

**JS:** Oh, I think so, yes. Certainly it got a lot of publicity in that. Thirdly, at that time it was also the haven for more people who were resistant to the draft. In my first year, I lived in a rooming house with Art Dole [phonetic], who resisted the draft and was sent to prison. He was from New England, as a

matter of fact. I think he'd spent a year at Harvard College. He's from the Dole family, and he's still alive, and, I think, teaching psychology--oh, no, retired from psychology, was teaching in Hawaii, and is living now in Philadelphia somewhere. Anyway, the place was full of people like that. Jim Norton was another guy. I never kept up with any of these people, but I remember their names.

So with those elements, plus political activism, plus cooperative work, those five things were really, I thought, very stimulating. I got interested. I just sort of joined people in community projects, protesting the civil rights thing, and we picketed the theater because it was Jim Crow and they wouldn't let the blacks, you know, sit anywhere but in the back, and all that stuff. So as students, we marched around doing that, and we helped out some families in the city, in building their houses and things like that. It was social activism, if you want to put it, I suppose, in modern terms, that way. And yet it wasn't fiery in the sense that it was belligerent or anything; but it was, I thought, very progressive.

**FM:** Which years were you there?

**JS:** I was there from 1941 to 1944--three years. During that time, I went to Chicago. We used to go for co-op jobs. I went the Museum of Science in Chicago and was a guide there; gave the science demonstrations in the theater there, of the science section. Oh, one thing I did, I was very young and I ran the coal mine elevator, gave a little talk as people were going down to the coal mine there.

**FM:** Is the coal mine--

**JS:** In the Museum of Science and Industry, there's a coal mine there; it's an artificial coal mine. People used to kid me--"What are you wearing that cap for?"

**FM:** This was Science and Industry?

**JS:** The Museum of Science and Industry. The person who was in charge of the science section was a professor of--I cannot think of his name, but he was a professor of physics at the University of Chicago, anyway, a part-time job that he had there. The exhibits there were themselves, I thought, very interesting. We'd take kids from Winnetka, Illinois, around, you know, and show them the different parts of the physics section.

**FM:** The co-op program was part of Antioch?

**JS:** Part of Antioch, yes. So, living in the South Side of Chicago was a great experience, too, getting away from the college environment and doing work.

**FM:** Was this Antioch environment one that your family was--for a first-generation college family, this must have seemed like an extraordinary college experience. You and your brother both chose it.

**JS:** Right. My other sisters eventually came there, too.

**FM:** Is that right? Was your family supportive of that?

**JS:** They had this sort of thing, a philosophy, I think, my mother and father--my mother was very skeptical about it, you know, in a way. "What kind of a place is this, anyway?" But they had an attitude, sort of as, "Good luck, but make it yourself," and they didn't really restrict you, and that was a wonderful attitude, in a way. They weren't, therefore, critical, on that score. But I think underneath they were sort of skeptical. You know what I mean?

**FM:** Antioch must have been an unusual place for pre-meds. Your brother went that route?

**JS:** Yes, went that route, and a number of people did. But it was very interesting. The professor of biology there, Dr. Federecci, was a friend of Worth Hale, who was the dean of Harvard Medical School here at the time, because they had both been to Harvard College. He had graduated in biology. Oliver Loud, who was a professor of physics at Antioch, also graduated from Harvard in chemistry. So the place was loaded with, in my opinion, high-level, if you will, scholarly kinds of people who had been trained in eastern universities. It really gave it a tone that it was really serious learning, things like that. It was a very good school for that. After that, I don't know how colleges have done, but I don't know if they attract, really, you know, some of the people that came out of eastern universities as easily as they did then, but there weren't that many jobs in

those days, remember, and so, my guess, that's where those people went.

**FM:** How did medicine come on to your agenda?

**JS:** I think it was two ways. I hate to say it, but I think my brother said, "It's a good thing to do. Why don't you do it?" I just followed his suggestion. The second thing was, it was a way you might go to school still, without going to war. I think that was part of it, I can't say that I really thought that through that well. Do you follow me?

**FM:** Yes.

**JS:** But everyone was thinking about what deals you'd do for yourself, and that sort of thing. People said, "Well, why don't you do it, if you've got good grades?" So you had good grades, so why don't you do it? So I sort of followed his footsteps, you might say. I also went down to Virginia to see him once. He was working there with, believe it or not, with Enaceraff, who later became the prize-winning Nobel Prize winner here. He took me over to their lab, you know, and around the medical school, and all that sort of stuff. I think that just encouraged myself more, that if he could do it, I could do it, kind of philosophy.

**FM:** Were there majors at Antioch?

**JS:** No, there wasn't, in a sense. I don't know what my major was in. It's a B.S., probably, in just liberal arts or English, or maybe something like that.

**FM:** But you were not focused on sciences?

**JS:** No, you didn't. They had tremendous courses. They had Professor Geiger, who, again--here's a guy came from Columbia, he was one of the leading students of Dewey, and he still is alive. He absolutely ran a marvelous course in philosophy. So everybody got indoctrinated. There was a guy named Chatterjee [phonetic], who taught social sciences. He was an Indian who had worked as an engineer in Scotland, and very liberal-minded. Then Morgan, who was head of the college, had just finished being head of the college and had run the TVA, and was very socially-minded about co-ops and cooperative living and all that sort of thing.

So ideologically, you got more than just a technical education there; you got the spirit of social work, and doing good, you might say, in some way or other. I can't describe it, except that the atmosphere was that way. We helped build a sidewalk between the dorms, and stuff like that. They would never do that at Harvard College.

**FM:** And your feeling about the war, were you pacifist, in general?

**JS:** No, I wasn't. I was sort of pro-war, in the sense of opportunistic. I think I was, you know: "Jeepers, creepers, if I can go to medical school, then I can finish, then I'll maybe get

into the Navy, Army, or Air Force that way." So I applied to the Navy and got admitted to what they called the United States Naval Reserve Program for Medical Students, a V1 or V6 program. As long as you were in medical school, they also paid my way--that was another issue, as they did pay my brother. So that worked out fine. Then they would keep you in this program, you know. Otherwise, you would go to officer school after college, but if you went to medical school, you stayed in this further, which is what I did, when I got admitted to the medical school.

**FM:** And your thinking on medical school? How did you find your way to Harvard at that point?

**JS:** Well, it was an interesting thing. I applied to Michigan, thinking I might get in, and got rejected. I was sort of mad at that. I don't know why they did that to me, a local high school graduate. But Professor Federwicci said, "You should apply to Harvard and Yale." So I got admitted to both. Let's see. I was admitted to Rochester, too, I think. And I applied to Western Reserve, and I don't know if I waited to get admitted or I had been admitted, but I think I did there, too. I think those were the places I applied to.

I got interviewed in Columbus, Ohio. I remember I had to hitchhike up to Columbus to get interviewed by somebody from the Harvard faculty, and I'm trying to think of his name now. I can't think of it right now, but somebody came down to make regional interviews, so I went up to his hotel and got interviewed there. I was also interviewed there by the guy who was a hematologist at Ohio State; he's since died a long time

ago. So I had two interviews, and they both were, I guess, fed back to Harvard. Two general interviews, I guess.

**FM:** You chose Harvard over the others because of what?

**JS:** Because Federwicci said he'd been to Harvard College, you know, He's a rather older man, but he said he thought I'd like it better. I also got a scholarship, but, come to think of it, I didn't, because I was in the Navy and I couldn't. It was later, that I got some money, help.

**FM:** So how was Cambridge in those days, and how did you like medical school?

**JS:** It was just fabulous. I mean, it was like another world. I couldn't believe it. In Oberlin, you lived in houses, you know. Oberlin had a lot of houses you lived in around the campus, not really any dorms. There was one dorm there, but we lived in houses. Then at Antioch, the dorms were not nice or fancy, just sort of grubby. They have since fixed them up, I understand. But here you come into Vanderbilt Hall, and I couldn't believe it. It was so nice, you know, and everything--imagine, they had a dorm there for you to go to school. The school's right across the street. Later on, I got invited by friends who came up from Yale, to go to Yale, to visit the college. I couldn't get over how the eastern schools were so fancy. It was just like night and day to me, coming from the Midwest.

**FM:** And not having had the kind of science background I'm sure many of your classmates did, how did you fare?

**JS:** I think I kept up with them fairly well, although I think the first two years, I don't know what grades I got, they'd probably be in the files. I don't think they were super grades, but I don't think I was behind. I know the first year I got very good grades, because somebody said, "Oh, you got such a good grade" on this or that. That was histology. But I don't think that was true in physiology or other things. But then the clinical work is where it just came so natural to me, I think. So I didn't have any trouble getting good grades clinically. The first two years in those days, you know, were very sharply separated between what you call basic sciences, and then at the third-year level, you came to the clinic--things like that.

**FM:** As your medical school career progressed, how did you begin to envision what kind of medicine you wanted to practice?

**JS:** Well, I got very interested, in the first years, in sort of social aspects of medicine, too, because we had an AIMS group here, and I became editor of the AIMS journal. You know that little student thing?

**FM:** Yes. The Association of Interns and Medical Students?

**JS:** Yes. I edited some things for them, which were chiefly some of the case report rounds, and so on, in AIMS, that way. So we had a chapter here with interest in that. I remember getting

Talcott Parsons to come over to talk at one of our evening meetings.

Then there were a couple of people there--and I'd have to look their names up, because they're so far gone--who were part of that group that were kind of interested in these aspects of medicine. People in the Boylston Society, which was another student society, had some interest, if you will, in social aspects of medicine.

**FM:** Were you involved in that, too?

**JS:** Involved in that, too, yes. I just sort of took naturally to these kinds of things, I guess, because of my previous experiences at Antioch and Oberlin and elsewhere.

Then the clinical years were just terrific ones.

**FM:** Did you find, with your somewhat different set of experiences and your more developed social precepts, that you were at variance with many of your classmates? Did you feel either passively, or actively, at a distance from others?

**JS:** No, I'm a big joiner, and I had to join everything. [Laughter] Personally, I got along terrific with everybody. But I knew that I was left of most people. I don't mean "left," but I mean more concerned, if you will, about some of those things than other people. Then the crucial thing that also got me was that in the third year, I applied for medicine--I forget, when do you apply for internship? But anyway, the year you apply, and I finished all my interviews for internship, and then I got a

notice that I was tuberculin-positive, and go get a chest film, which was positive.

**FM:** This was your third year or fourth year?

**JS:** I think it's third. Third year, yes, it's the end of your third year, so to speak. Okay? Anyway, it was in 1946. So I was decimated.

I got put into Brigham. I'd already taken my medicine there. Imagine that. I got put into Brigham, up on the same floor that I'd taken my medicine. I had first gone home quickly to tell my family. I was six months then out of the Navy, because the Navy ended in 1945. The Navy ended in, I think, October of '45, and so this was '46. So it must have been in May or June of '46, that this was. I was kind of in tears, and I remember that Dr. Armstrong came around. I'd interviewed at the Brigham, Mass General, Cornell, City Hospital, and I've forgotten where else I'd interviewed, and applied some other places, without interviewing. I was up there on the floor, and I think I was very teary or something like that, and Dr. Armstrong, who later went out from Brigham to Chicago that following summer, said, "Don't worry, Stoeckle, we'll find a place for you." Then I felt good. Or he said, "We've already found a place for you. You don't have to worry about it. There's a place around here for you." So I knew that I would have someplace in Boston.

**FM:** How long were you hospitalized?

**JS:** I went to Saranac, to Trudeau. I was there a year, in Trudeau, so I was out a year. I was out that summer, and then I came back the following fall, not the immediate fall, but I was out a year and a half. Saranac was, again, where I had an absolutely wonderful time. It was sort of like college again. When I was up there, in our house, a particular cottage up there, Krebs I, there was Mahlon Hoagland, who later became head of the Worcester Institute, and I--we were both from HMS--he was a year or two ahead of me; and then Lee Cluff, who went back to Hopkins eventually, and then to Florida, to become professor, and then to, I think, Johnson Foundation. Another student, Ed Wood, who was from Hopkins, too--I can't think where he went to.

**FM:** These were all hospitalized for TB.

**JS:** Hospitalized. We were taking the cure, yes. Then I got pleurisy when I was up there, so I had to go into the acute center for a month or two. Eventually got out, and worked in the san itself, working up patients coming in, things like that, and following, learning from the staff. So I'd had a clerkship there, you might say, during the last six months that I was there. The san life was just fantastic, anyway. There were nurses there from Bellevue who were patients, and we used to go out to dancing and parties all the time.

**FM:** With the nurses?

**JS:** Yes, to escape this place which we called Ecstasy Island, which is out in Lower Saranac Lake.

**FM:** It must have been high-risk business for the nurses.

**JS:** Yes. Actually, it was, in a way, kind of interesting. It's kind of a escapism thing, in a way. A recent book by--it was written from New York--by Sheila Rothman--came out, *Living in the Shadows of Death*. It depicts, from patients' stories, a rather grim view of san life. Anyway, I read through that, and I've written a review but I think, to some extent, the TB san for the lower middle class in State sanitoriums must have been different from the private san life with its attachments, affairs, and escapes. Do you follow me?

**FM:** Yes.

**JS:** It could be grim, anyway. But certainly at Saranac it was not, because it was a cosmopolitan town, with people curing from all over there. Then private homes had cure homes too, like that, as well as the san, which had these different cottages all around it. People like myself, we read books voluminously. I must have read 150 books while I was there. Then we did plays, did these social things. Of course, we were constantly anxiety-ridden. When do we get out? We became very interested in self-reflection and what it was to have a chronic disease. Anado Sanchez, an MD patient from Mexico at Rockefeller, used to say lepers were always expecting to die, while we tuberculars were expecting cures--and yet many more did die.

**FM:** And the physicians who were there, as you described it, were in a particular facility, or you simply found each other in the town?

**JS:** No, they happened to put us student types into one cottage, but some of them (M.D.s) might be in someplace else, and so on. There wasn't, I don't think--

**FM:** Were you all from HMS?

**JS:** No. There were some senior physicians there, too, you know--older people, in their forties and fifties.

**FM:** But the ones you say--Lee Cluff was there, Ed Wood, Bill Lynn.

**JS:** We were all students.

**FM:** And all from Harvard?

**JS:** No, Lee Cluff was from Hopkins, and Bill Lynn, who was from Columbia, and he went down to North Carolina. So all of us were from different places in that particular cottage. Then Amato Sanchez, who was there, was from Rockefeller Institute, but he was from Mexico. Then there were a couple of other people who were non-medical types in our cottage, and I've forgotten.

The medical people that ran the san, Gordon Meade from Rochester, and Roger Mitchell, who died here a year or two ago, he had trained at the City, and he'd been at Harvard. They were

extraordinary, just wonderful physicians and advisors and things like that, to you and your TB. They knew TB cold.

**FM:** Let's pause.

We're picking up again with the end of Saranac, and you were saying it interested you in chronic illness.

**JS:** I could never forget the experience. You knew what people went through when they got diagnosis, treatment, and prognosis.

**FM:** As you approached the end of medical school, what did you envision for a career in medicine at that point?

**JS:** Well, that was interesting, because I came back here before I'd had all my clerkships, senior clerkships, and had them practically all here, and just got attached to the place.

**FM:** "Here" being the Mass General, as opposed to Harvard?

**JS:** Mass General. I'd taken my third year of medicine at the Brigham. I took most of my clerkships here, in surgery and medicine here. I don't think I went anywhere else. I can't remember anyplace else. Most of it was here, whatever it was. So that was a wonderful year, and the medicine clerkships were long. I think they were three months or so, surgical clerkship. So that's almost a half a year here at the hospital.

When I was through then, Dr. Bauer was chief of the service at that time, and he had a lot of patients with rheumatoid arthritis on the floors, because they were subsidized by the

state to stay here. Given the chronicity of that illness, they would not, therefore, be in and out of the hospital, you know, in three days; they would be around there for two months, sometimes even longer, so you got to know the patients. I just sort of liked the floor. Then you get the reciprocal feedback. They liked the work you did, so you get to have an attachment which is both institutional with staff and personal with patients.

**FM:** But you were defining it in terms of medicine at this point?

**JS:** Medicine, yes, right then. Then I think the reason they also--I remember getting--this is a private moment--getting complimented one time by Dr. Bauer, I think, because he said, "Well, all the patients think you're their doctor, and you seem to know everything about them." They were always saying, "That's very good," you know.

**FM:** You liked doctoring.

**JS:** I liked doctoring. So that seemed really good. So when it came time to apply again, it was clear to me that I got interviewed here, and then you had an interview system, in those days, where they sort of screened you by a committee below, and then if you sent up to the top, the committee at the top, which was power enough--I've forgotten who else was around the table--then you sort of knew that you were in. Do you follow me?

**FM:** Yes.

**JS:** Or you knew you'd be on their list and you might get in.

**FM:** Those being selected for internship at the Mass General.

**JS:** Yes. In other words, there was a kind of a funny hierarchical system that they had at the time, anyway. So I felt that I would rather come here than the Brigham, even though I'd been over to the Brigham for an interview.

**FM:** So that's what happened?

**JS:** That's what happened, yes, and I felt very pleased to come here.

**FM:** You described the process of what happened, but did you have any kind of sense then of what kind of doctor you wanted to be, and particularly, had you developed any kind of--

**JS:** Special interest?

**FM:** Or appreciation that you might not want to be a specialist?

**JS:** No, it wasn't either. I think most of the people around you actually were generalists at heart. For example, Dr. Bauer's interest in arthritis. He was interested in the chronicity, the psychology of the disease, the biology of the disease, and so on. It was those kinds of interests that really motivated me. Then the other thing was the atmosphere that you were basically taking care of people longitudinally, was the kind of phenomenon that, I

would say, you got identified with, versus, if you will, thinking of yourself as doing a procedure or only treating acute illness. Even if you were a specialist, you might even be identified with the longitudinal care of patients to some extent, because that was what the meaning of being a doctor really was, to some extent.

So I think, in wanting to come here, certainly to be a medical person--and I'd flirted with the idea of becoming a psychiatrist, you might say, because of these background psychological interests in chronicity that came out of the experience of having TB and so on.

Oh, that's right--I had my clerkship in psychiatry here, too, come to think of it, and met Dr. Lindemann, and we hit it off very well. That was another thing. I just hit it off with him very well. I don't know why. He's a very fascinating man. He set up the Center for Community Studies back in the fifties. He just encouraged me to keep interested in sort of psychological aspects of medical patients, because he was interested in those things, too.

**FM:** You stayed for internship, residency, over a period of several years, at M.G.H.

**JS:** Well, I'd gotten married the fourth year. Oh, I know. My elective that year was also here, because I took an endocrinology with Dr. Albright. He was the head of endocrinology, and I used to drive him back and forth, because he had Parkinson's disease and lived at home. That was another very positive experience, because he, again, was seeing a lot of chronic patients, too,

disabling deformities and disabling, if you will, figures and disabling diseases in the clinics, and I would go to all the clinics with him, too, and on the wards. He and I hit it off very well, and his wife and I met, and we got invited out there, and hit it off very well out there. Hit it off in the sense of being interested in the kind of patients that he had. So that was another stimulus. Then he also gave me time off to go get married, which was very nice.

**FM:** Your wife you met--

**JS:** Met at Radcliffe.

**FM:** Had you known her since college?

**JS:** No, I knew her--she'll kill me if I don't get the dates right, but I think it was before I went to Saranac. We met at a dance at Radcliffe and kept in correspondence afterwards, so it was 1945. Then when I came back, we decided finally to get married in 1947; I take it back--1948.

**FM:** And your internship started?

**JS:** In '48.

**FM:** You were here for how many years, as house officer?

**JS:** I was here from 1948 to 1952.

**FM:** What was that experience like?

**JS:** Oh, that was great, too. These were very positive years. I don't have any real negative things to say about it, that I can think about. I've always felt as if I was treated very well. I don't know how to describe the ambience of the place. I think the staff gave you the impression that they wanted you to succeed and do well. Do you follow me? They weren't critical in the sense that they were scolding you. I may not have done things always right. I remember one time being told by Bauer--I got mad at an alcoholic guy on the floor, and he said, "Don't you want to take care of that patient?" Something like that. They were much more different than the people today, because they were interested in these sort of dynamics. At least, he was.

I remember another case that we had. The resident above me wanted to throw out a lady with--she wanted sign out AWOL, you know, against medical advice. He said, well, he thought that was a defeat, if the doctor couldn't keep the patient in, which is a different psychology, you see, than many people have. It's a failure of the relationship, again, and he was interested in that sort of thing. You know, I don't think you'd find that kind of discussions in the world today, because we are much more technical today.

**FM:** Let me pose an analytic hypothetical to you. With your earlier experiences at Antioch, with exposure to left-wing politics, with your experience with disease, you had encountered elements of life that many residents had not, perhaps. As a house officer in a traditional institution, were there things

that you felt at variance about with the institution, with its structure, with its politics, with its performance?

**JS:** Yes, I did.

**FM:** How did that manifest itself?

**JS:** Okay. The biggest place that came out was in the clinics. I liked the clinics. A resident like this Craig Walsh, who's now out here as a resident, we would have to go out, and we averaged about eight to ten patients. Today the residents come out and might see two or three a day. They don't really work the same volume, because it's structured a bit differently. I remember I liked it, when it was always looked down by a lot of other people. When I look back on why I liked it, it seemed to me so many of the people, even though they were ethnically different, many of them, were like people from the small town I'd grown up in and peddled papers to, you know what I mean? Working-class people who were from the factories in this small town. So when I met these people out there, I got acquainted with them and I got to know them very well, and yet I thought the hospital services often treated them badly.

**FM:** How so?

**JS:** Because they didn't invest a lot of effort and money into the outpatient department, you know, to make it really work well.

**FM:** Was that different than the treatment in the in-patient service?

**JS:** Yes, there were more investments in in-patient service. Things got done faster, you know. You used to have to wait six weeks to schedule a G.I. series and stuff like that, but, you know, you could get it done right away in the hospital. That was the one thing that I felt the institution let itself down in, in terms of the care and treatment of out-patients, and yet it was a good experience out there, too--don't take me wrong that way--because people were still trying to do their best for their patients, but that's the one dissonance in available services that I remember.

Again, in the culture of training, it was looked upon as, "Gee, why do we have to go to the clinic?" And this culture has lasted off and on for years, back and forth that way. But I felt it was something very positive and enjoyed every minute of it, and had a big clinic clientele, pretty well, by the time I left.

**FM:** So ambulatory care, clinic care, was on the rise, with you personally.

**JS:** It's an interest, too, yes, in that respect.

Oh, the other thing I did during the training--you didn't train continuously those four years, because it was during the war and other people were always coming back to train, so they broke up your training program every three months. At the end of a year, you'd take three months off to do something, so I went to North Carolina and worked in the san at Oteen, and lived up north

of Asheville there, at Montreat, which is a sort of Presbyterian retreat up there in the mountains.

**FM:** So this was for house officers?

**JS:** You know, you did it when there was a job. Either it was three months off, and you had to figure out what to do.

**FM:** It was an enforced three months off?

**JS:** Yes, enforced three months off.

**FM:** That's so they could accommodate more people in the residency?

**JS:** Right. Yes, and you had to find some work for yourself. I could have found around here, but because I knew the guy who ran the san at Oteen in North Carolina, a VA [Veterans Administration], and he had been at Saranac--Dr. Schwartz was his name. He said, "Come on down and I'll pay you a physician's salary." I got some money, and I was also be able to live in Montreat. It was a wonderful experience for three months, and I saw a lot of advanced tuberculosis there, and a different culture of care and professional organization of VA hospital.

Another time, I went over to M.I.T. [Massachusetts Institute of Technology], because I met Dr. Hardy on the wards, and she was interested in occupational medicine. I did something for her cases, and got interested and helped her in writing these up. So

she invited me to M.I.T. for three months, to do a short of a fellowship with her.

**FM:** In terms of your years as an intern and resident, the politics of the country moved from left of center to right of center, with the [Senator Joseph] McCarthy period being in full blossom by 1952. Did that affect either you or the training setting in any way that was appreciable?

**JS:** I don't think so, but I thought he was vicious, I can tell you that. I remember I went out to Michigan one time to see my parents, and my wife and I had our first little boy, Peter, and we all went over to Coldwater, because it was announced that he was going to talk there at the county fair. I could not believe what he said and did, putting on this act of reaching in his briefcase and saying--so and so is a communist coward over again.

**JS:** I just felt myself, as a liberal Democrat or whatever those people are called in the way of Democrat, for that matter, and I only remember that when we went to Washington, because I had a decision about going, after the residency, what to do. I had to go to service, because you had to fulfill service for the education-training you had received. I was now cured of TB, so I was obligated and wanted to go back and pay that service.

So the decision was what to do. I kind of wanted to go to the Indian reservations of the Public Health Service, but I got rejected because of TB, and they wouldn't take me in, so I applied to the Army, which did take me in. Then I was going Fort Lewis in New York, but I was talking to Dr. Aub downstairs in the

dining room, and he said, "Geez, Stoeckle, you ought to come with me to the Pentagon."

I said, "You really think so?"

He said, "Yes, it would be a good education for you."

I said, "Okay, if you think it would be a good service, too."

So he pulled strings. In those days I guess you couldn't do that. He must have called up the surgeon general's office or somebody else and said, "I've got this person who's going to be a first lieutenant in the Army Medical Corps. Could he be a director for our Sub-committee on Medical Sciences at the Department of Defense?" The next thing I know, I get this order cut to go down to the Pentagon, to work in there, and when I got there, they gave me fourth degree, I guess, because they said, "Oh, you went to Antioch, did you? So you're a Communist, are you?" or something, and had to go Q clearance to get into the top of the thing. That was all during this McCarthy scare, you know, in 1952--'54.

I finally got cleared to do it, anyway, because I told them, "Listen, I did not join the thing, and I'm not a Communist and I never was." They just stigmatized you by where you came from in questioning. Apparently, if you'd been from Antioch, for the F.B.I. that meant you were Communist. I never realized it was that stigmatized.

Then my wife had a friend of hers whose husband was applying for the State Department. They turned him down, a real eastern Brahmin, who somehow did but one thing, once went to a left-wing meeting somewhere. They scapegoated him, and wouldn't let him go into the State Department.

**FM:** What were the Army years like? This was 1952 to '54?

**JS:** '52 to '54. Well, in a way they were a rest and relaxation, in a way they were an education in how the government works, and they were a perspective on the limitations of what the bureaucracy can do, but also inspiring in terms of what the bureaucracy did. The Committee on Medical Sciences--I was called panel director, Panel on Medical Aspects of Atomic __ , for their Committee on Medical Sciences of the Research and Development Board. So I really was shuffling papers, as a first lieutenant, for a lot of upper Army and Navy and Air Force colonels and BGs on committees, as well as civilian professors who came down to look over the research of the Armed Forces.

So we had these research meetings that you're familiar with, because you're a Washington person yourself, so you know the ropes. So you got these civilian professors that came from Rochester in New York, and Chicago, and so on. So I got to meet Coggeshall, and I got to ride the plane with him, you know, back and forth, to around these different Army research bases. We traveled all over the country to do that. So I got to see all the research done under the auspices of the Defense Department, just saw it, where it was done, knew the scope of it, and I knew the amount of money invested in it and heard the discussions about it. That's really what the job was about. It obviously was a light job, but it was fascinating, and meeting with people and just seeing how the whole system worked.

The one thing I came away from with--and again was treated royally by--I remember Dr. Berry, who was chair of the committee, who was a surgeon from New York, a P&S guy--you probably don't

know of him. But he was originally Harvard, then went to New York--I think in charge of surgery at Bellevue when it was under Columbia's banner. But again, they went out of their way to sort of educate me, being "This is the way things are, this is the way it works that way," and so on down the line, or "I'd like you to see this," or "Go out there and see that."

I was sent out to watch the bomb drop. I saw three bombs dropped off there in Nevada, and so on, things like that. So I came away with a large perspective on the amount of research done by the armed services and what they were interested in, how it was argued out. I came away thinking if you make one or two decisions a year, that's very good, was my conclusion, because that's sort of how you operated, in a way. It wasn't that you knocked off a decision every day, you know. In terms of policy, where are we going to go? To me, it was a great education that way.

**FM:** So at the end of two years you were a civilian again.

**JS:** Yes.

**FM:** What did you do then?

**JS:** When I was in the Army, I also went over and worked in the Armed Forces Institute of Pathology, and did a study over there which I never published, on lupus, and I worked down in the dispensary in the Pentagon, downstairs, and had a little experience of what Army life, dispensary life, was like. The brigadier generals up there would get indigestion at twelve

o'clock, and at one o'clock they'd come down and say, "My stomach hurts. Could you do something about it?" [Laughter] Which reminds me. The oldest behavior that Dr. Zola (a sociologist) had written about in terms of seeking medical help, I said, is really institutionalized in the context of the military service. If you were a BG or something, you could see the lieutenant on call that day, but if you were a soldier or something, you could go directly in to get it from the pharmacist. It was just an interesting sociological experience.

**FM:** What happened next?

**JS:** Well, Dr. Bauer, who was the chief, then, when I left, asked me if I wanted to be chief resident of the medical service, and I really didn't leap forward to say yes. Do you follow me? I also had a fellowship to go into endocrinology with the thyroid unit. Then he called me up one day and said, "If you don't want to be chief resident, would you run the medical clinic?" I said I'd rather do that. So he said, "If that's the case, you have a job." I was in Washington, and he had called me on the phone. That was about a year before I left the services, anyway.

So rather than come back to be chief resident or be a fellow, I came back to be the first paid chief of the medical clinics here. One reason for this was that Dr. Bauer, like me, came from Michigan--or me, like Dr. Bauer, came from Michigan, either way you want to put it--he felt much like I do, in terms of that the hospital had not done enough for outpatients and that they really had sort of used them, if you could use that expression. They didn't treat them with as much respect and

dignity as they should have, sort of still looking at them as sort of custodial welfare problems, rather than people who independently were seeking medical help.

He was reform-minded in this regard, again, in an institutional clinic. He thought the place should be reformed. Interestingly enough, at the same time, Means, who had preceded Bauer, had invited Dean Clark to come here to be chief administrator of the hospital. You know Clark had been head of H.I.P. in New York, and was trained as a public health person. In addition, Allen Butler, who was the chief of pediatrics, had had a strong interest in prepaid care during the war period and afterwards. So here were four clinicians that were interested, if you will, not in education or training alone as an institutional enterprise, but in the reform of services, if you want to look at it that way. Actually, Means and others, I think, brought in Dean Clark, hoping that he might help them form a group practice and make a plan like H.I.P. in New York. However, they never talked the trustees or the staff into doing it, so it didn't turn out.

There was a planning committee that ran for a couple of years, and I was the secretary for it, with Dr. Dana Farnsworth, called the Farnsworth Report. We met loads and loads of times with all the members of the different services. Then when it came to vote whether we should have a group practice or a group building, it really didn't fly. It got turned down by the politics of the surgeons, and, I think, many of the staff. Dr. Churchill, I don't think had a passionate view for it as head of the surgery, and "the privates" thought it would be encroaching on their own interests, (although they did not express it that

way). That was the gist of it. So after a couple of years planning this, it didn't go anywhere.

**FM:** This being the late fifties, now, the latter part?

**JS:** This would be 1956, or '57, or '58, I've forgotten what it was now.

**FM:** What did you see? In assuming this post, clearly you were responding to earlier parts of your--

**JS:** It felt comfortable doing it. Right.

**FM:** Was there any sense that you were foregoing more prestige or a more traditional career?

**JS:** Yes, right away. People would say, "What are you doing out there, for God's sakes?" And they said, "Why aren't you in private practice and earning a little bit of money, instead of working for a salary?" It was very low, by today's standard not very much at all.

**FM:** And how did you respond?

**JS:** I said, "Well, I'm kind of interested in this work, you know. I like it." We may have something to do. They'd keep saying, "Are you going to stay out here?" They kept asking me those questions.

**FM:** "Out here" being in the outpatient--

**JS:** Yes, in the clinic. "How come you're not going into private practice?" That was the one thing. The other thing was, "Well, you'll never get anywhere if you don't do research." And I said, "Yeah." But then it just was such an interesting field, and there were other people around that were supportive. Dr. Lindamenn and his group, with Irv Zola and Marc Fried, and Ray Elling, a bunch of sociologists who worked at the Center for Community Studies researching the personal impact of the relocation of the West End on its residents. From this group Irv came over and started working with me in the clinics. He was the first person who was a non-physician, really, to work in the clinics and in doing research interviewing patients. I remember Dr. Loeb came up for a visit and found out about this from a presentation of the research at a meeting. He went spastic over it, "Why are you letting somebody talk to the patient before they see the doctor?" I had let Zola talk to the patients, you know, in the room off the waiting room. Dr. Loeb, with whom I had made rounds, really admired and liked this. It represented a break in tradition.

**FM:** Was he from Yale? Where was he from?

**JS:** He was head of Columbia. Oh, God, he was Chief of Medicine at Columbia, a very wonderful man, Robert Loeb. He was a leading clinician in New York, a leading clinical scholar, leading clinical teacher who made Columbia a star place to go to.

But anyway, these people we got to come in to look at the clinics, and so on, and other people came, too. So it was an interesting sort of thing, and there was a growing movement of people not just here, but at other places, you know, looking at outpatient care in their community. There was this Center for Community Studies that were looking at health effects of relocation from the West End.

**FM:** This was at MGH or Harvard or--

**JS:** Well, this was all MGH, yes. Then the thing for Harvard was the preventive medicine group. We set up a family health program in 1954; that was the year I came back.

**FM:** That was the beginning of the family health program?

**JS:** Yes. It had already had some experiment over at Children's, but here we started our own program, ran from 1954 to 1960, under Joe Stokes. So we had enrolled about 150 families, again with the idea of providing comprehensive care for people in the community.

**FM:** This was not for training now; this was for service delivery?

**JS:** This was care and delivery, but also for students. Students were attached to families. I just wrote a little section up for a poster that Larry Ronan and I are doing. For care, the program enrolled a group of us--Fred Blodgett from pediatrics, Joe

Stokes, myself and Bob Berg from medicine, and then a pediatrician. Stokes ran the program; we supervised many students, had everybody's case record labeled Family Health Program. That's what it was intended to do.

**FM:** It was for undergraduate medical school training.

**JS:** Yes, undergraduate education, too. The hospital got a grant from Rockefeller for about $375,000, something like that.

**FM:** On the Center for Community Studies and the deployment of--was it a sociologist or psychologist? Was the concept of health services research at all abroad in the field?

**JS:** No, nobody ever heard of it.

**FM:** Did you envision the possibility of doing field research or research on education in the ambulatory setting, by whatever label?

**JS:** No. I think we were looking at patients' views from one level, the social factors in the illness of the patient; and from the other level, at the sociology of health care. But we didn't think of these research themes in terms of health services research, as such. Actually it was medical sociology in those days. Since then, health services research has taken over much medical sociology. It's taken over survey methods, you know; it's also taken over many conceptual schemes like social class. So in a sense, health services research has borrowed ideas and

techniques. Medical sociology, I think, has disappeared into health services research and other fields as well.

But, anyway, research then was added to the clinic by doing it. Then we started having rounds and things with students for the first time out there.

**FM:** "Out there" meaning--

**JS:** In the clinic. We got the psychiatrists to come out and stand in the corner, and that went on for a while. Then, in addition, they started a preventive medicine division here under Vic Sidel. Do you know him?

**FM:** Yes.

**JS:** That didn't last very long. You'll have to ask Vic what happened to it, because I want to write him a note and find out why he left here.

**FM:** What year was that?

**JS:** That's what I'm trying to find out, from Vic. It was a metastasis from the preventive medicine department of Harvard, down here to the Mass General, and Vic was head of it, and Roger Sweet worked in it. They had an office in one of the old buildings here. The goal was, again, research and analysis to improve care and treatment outside the hospital. Okay? That was their mission, the flag that was waving. I don't know what actually they did in those times, but we didn't see much of Vic

as a clinician--do you follow me? I know that he was here. That was another sort of movement.

So when the integrated private clinic group practice thing was turned down, then I think we all turned our interest into, well, how can we just deal with improving the care in the clinics itself? So a lot of administrative efforts to speed things along, make things move faster, efficiency goals, with things like the nurse practitioners, which was started in the sixties--we started that in 1960 or so--I think we were the first ones to a lot of adult nurse practitioner work.

**FM:** How was that conceptualized, and who conceptualized it?

**JS:** Well, I heard about it, from--the pediatricians did it in Denver.

**FM:** That was late '67.

**JS:** I don't think so.

**FM:** Henry Sidell?

**JS:** Well, the first paper we wrote was in 1963, and I think we started the clinic in the sixties. These two nurses out here were the original nurse practitioners in there. I know Sharon Follaytar. Then we had a conference on this, and we invited everybody to come. Chuck Lewis came from Kansas, and I've forgotten where else--some people from New York, some nurses from Rochester. We had a meeting in Williamstown, and a number of

papers were delivered. I edited it and had it ready, and Jack Connelly, who's since died, the pediatrician, was going to get someone to publish them, and I trusted him to do it, but he never did it, so I just have the bound volume of papers up. But we were very interested in nurse practitioner work.

**FM:** Henry Kemp, I guess, that's the name.

**JS:** Henry Kemp is who you're thinking of. Right. Okay. I think, if you look it up, it was a little bit before.

**FM:** Earlier?

**JS:** Yes. I think we did the adult ones, myself, when we heard about it.

**FM:** Was that well received or was it resisted by nursing and medicine and patients?

**JS:** No, it was received by us and the patients very well, received by the nurses here and the patients very well, but it was just something, what you might say, was like a mini-demonstration project. It was continued and was integrated into the clinics, but it wasn't really promoted widely in the hospital, except for Ann Baker, who then set up a course for nurse practitioners so they could get certified.

But then did the hospital then expand its use of nurse practitioners? The answer is, no, they did not, except the ones we had here in the clinics. We did that. Many of them went out

to the health centers that we had afterwards. I think, again, the health center movement came in, and that replaced it, in interest and the fact that we didn't have this group practice organized here. So health centers came in 1968 with the Bunker Hill and then the Chelsea Health Center, Revere Health Center, and then we affiliated with the North End Health Center, so we were, I think, one of the first hospitals that had that many health centers affiliated with or associated with us. We started those three, and the fourth one was affiliated.

**FM:** Which were the three?

**JS:** Bunker Hill, Chelsea, and Revere, affiliated with the North End Health Center, which was community-organized. I was the director for a year or so, just on a volunteer basis. Also we had the Logan Airport Medical Station, which is really a health center at Logan.

**FM:** The comment you made a moment ago I didn't quite understand. There was some sense that the development of, existence of, staffing of those health centers, occupied energy of people who were ambulatory and community-focused?

**JS:** No, what it did was this. I was trying to sketch in that here was an institution where one of the goals was the integration of private practice and clinic practice. Okay? That got turned aside. Okay? But as decisions in the late fifties--

**FM:** Not to have a group health system.

**JS:** So then you looked internally to these efficiencies and other innovations, of doing things, and, in addition, added the innovations of doing the health centers. That's part of that movement. It didn't rob the center from anything; it just was an extension of doing work in the center, along the same lines of having physicians and nurses working together. That's what they worked on.

**FM:** Throughout this period, from 1956 onward, you are the director of outpatient care?

**JS:** Yes.

**FM:** Did that job evolve, or was that continuous as that?

**JS:** There wasn't anything here called director of outpatient care. What it was here was chief of a service clinic, such as chief of the medical clinics, which was the title I think I had. In addition, there was what you'd call Committee on Clinics, which represented all the services, and under this administrative setup, you might say, there was a director of nursing outpatient care--that was Ruth Farissey--and there always a general assistant director, if you will, for outpatient care.

I think I deliberately eschewed going what I call exclusively an administrative direction, because I wanted to keep my foot in what is called the education of students and the treatment of patients, because it seemed to me that the administrative directions were sort of dead end. At least that's how I looked at it one way or another. So, in a sense, you

influenced administration, if you want to call it that way, simply by ideas, if you will, and sort of group consensus about things that you might or might not do. That's how, in a sense, we worked here, as a kind of small collaborative between nursing, the medical service as a major innovator in the pediatric service, and setting up these health centers and things like that. We worked along those lines.

**FM:** Which years were you doing this, or was it continuous?

**JS:** Continuous, yes, until I sort of retired from that sort of work.

Then in the process, with the health center movement being in place, the next big change, if you want to look at change in time, once those were established was the development, if you will, of these residency programs. And the second thing in there was the development of group practices for the first time, which didn't take in the whole hospital, but took in the medical section. So we formed this medical group practice, which wedded private practice and clinic practice together.

**FM:** Chronologically, which came first, the development of the residency programs, the development of the practices?

**JS:** It really was conversations going on at the same time. I wrote the paper, so I don't know what the dates are.

**FM:** Roughly, we're talking--

**JS:** 1972, the primary care program residency training track began.

**FM:** Let's follow that one for a moment. That was built on the family health model?

**JS:** Not really. What happened in that case is that family health model had disappeared, in a way. But the idea, if you remember, had come up that there should be primary care training in medicine, in pediatrics, in complementary, as well, to what family medicine was doing around the country.

**FM:** Right, but before we do that, though, fill in, for the purpose of the tape, a little bit about the experiment in family health training which was for both medical and pediatric residents.

**JS:** No, you see, that's what it wasn't. Here at the Mass General, only students were invited.

**FM:** Only students.

**JS:** At the Children's, where you had talked to Joe, there were residents involved. So it was a distinctive difference in that way. So when the time came for these other reforms that were waving around, that filed these commission reports, then we went ahead with the development of a training track in primary care internal medicine. That came out of a lot of different

interests, you know, nationally, as well as I do, and it came out of--

**FM:** Fill that in for me, because that's important.

**JS:** Well, to some extent, it worked this way here. The hospital had an interest in participating--not being left out, you might say--in the changes going on in training through the incentives of the Johnson Foundation, because they came to Harvard and sort of offered it a chance to get a lot of funding for training in general medicine.

**FM:** This was the brand-new Johnson Foundation.

**JS:** The brand-new Johnson Foundation. So we had a lot of meetings, and Joe Dorsey sort of chaired them, over at the Harvard Community Health Care Plan.

**FM:** Who did?

**JS:** Joe Dorsey chaired them over at the Harvard Community Hospital Plan. They were sort of stimulated by Dr. Ebert, because he represented the medical school, if you will, to get all the services involved in this planning, if you will, for residency that could come under the umbrella of the medical school--not the hospital, the medical school, which they then did.

We had already had Allen Goroll, who works here with us, still. Allen had been a fourth-year student with us, and he had

made sort of an elective in ambulatory care as his fourth-year sort of project. It was a good elective which was just what a resident would do, really. He went around to some of the important subspecialty clinics, like gynecology and so on, to do some work. In addition, he worked in the walk-in units of the hospital here, which we had designed, and then he also worked in the medical clinic, and so on. So he designed a rotation that would include things relating to general medicine or to primary care medicine--worked in orthopedics, too--things like that. So he had already this sort of thing. So when we sat down to plan, we sort of had a little idea of how to put together experience over two years, if you will, for somebody training, in residency, not student.

We took that, really, to the central committee over at the medical school, and that was approved as part of the planning. The medical school, you know, sent in a comprehensive document to the Johnson Foundation and got funding. I think Lee Cluff was involved in it at that time, too. He was president or something.

**FM:** As you recollect the intellectual work that went into that and the institutional analysis that went into that, how much was the creation of the primary care internal medicine concept seen as a new concept, and how much was it seen as recapturing an older concept which had been somewhat cast aside or overrun by the newer specialty training patterns that emerged between 1940 and 1970?

**JS:** Good question. Clearly, to me, it was a recapturing. I didn't think there was anything novel about it whatsoever. If

you read that paper out on the case history of the training outside the hospital, it's all written down there, because we had already--

**FM:** Can I get a copy of that?

**JS:** Okay, yes. I'll see if I've got it. I'll send it to you, anyway. I'll give you a CV. Anyway, I looked it up, the training of the doctor at the Mass General, and it was quite clear that what we had done is, we had moved away from the generalist training, without having any idea that we were doing it. That's number one. So we really weren't going back and capturing a lot. When people said, "What are you going to have--25 percent of time out in the outpatient clinic?" I said that's very interesting; they used to have one-third--33 percent--of their time was spent in the clinics, historically, during the training of a doctor here.

That went on, actually, if you look at the history here, which I went into a lot, that went on, the actual training in that way, almost went on to the early forties before it shifted to all this hospital base. My interpretation of that personally is a little bit that was partly economics, or chiefly economic.

**FM:** That is, the labor value of the resident--

**JS:** You bet.

**FM:** --on the inpatient service.

**JS:** Yes.

**FM:** Something we're still trying to wean ourselves from.

**JS:** Yes. It was a one-to-fifteen ratio, for example, of the medical resident to beds, in 1910. By the 1940s, it was one to three, to four beds.

**FM:** One resident to three or four beds.

**JS:** Yes, right. So that we'd taken these residents and moved them out from the clinic.

**FM:** What is it today?

**JS:** I haven't looked it up for today, but I think it must be about one to two, practically speaking. I'm not sure what it is, because the beds have been declined so much. It probably is--if you take 100 residents, which you have now, I think it must come down to something like that. Well, let's see. I don't know how many beds in medicine now. I'd have to find out. You could get that on the way out, and maybe Larry knows that.

So in a sense we were not recreating anything new, although it seemed new to other places, because the Mass General, historically, has always had a large investment in ambulatory care from the time it was founded. Actually, compared to the Brigham, which had a very small clinic and never sent the residents out there very much, and compared even to the City

Hospital and to the Beth Israel, it's had a much bigger ambulatory service, historically, than any other place.

So those were the things that were coming in. Alex Leaf, who was the chief then, was still very interested in the concept of preventive medicine and feeling that many of the problems that we're dealing in the hospital were failures of care and treatment in the community. With that in mind, he was very comfortable with the idea that more training should be outside. Even though he is a kind of lab person, a person interested in biology, a very sophisticated clinician in kidney disease, he was one of the biggest supporters of this intellectually and conceptually, of moving the residency in this direction. Previously, I think the other chiefs were not that perceptive or that thinking about it, rationalistically. I think the others accommodated to it politically rather than intellectually.

**FM:** Would it be accurate to characterize the development of the primary care residency in 1972 and its implementation in subsequent years as a build-on to the continued core activities that were in a more traditionalist and more specialty oriented and fragmented mode? In other words, you used the term at one point, "reorienting" or "rebalancing."

**JS:** Right.

**FM:** Did it really represent a rebalancing? I've always been impressed in general, not Mass General in particular, that in primary care medicine and primary care pediatrics has often been an add-on stimulated either by Johnson Foundation or Title VII

exogenous money, but in terms of really refocusing over the two decades between 1972 and 1992, there wasn't a great deal of rethinking or re-paradigmizing the medical training model that was resident in the major teaching institutions. Fair, or not fair?

**JS:** You are absolutely right. I've written that and said that myself, in reviewing general medicine for the *JAMA*, because in a sense, it was conceptualized--at least I'll say here it was conceptualized as a realistic model for, in a sense, as you say, getting the grants. On the other hand, it was conceptualized as the way it really should be--excuse me for saying so here--by those of us involved and also by Dr. Leaf; but even though that's the real way it should be for everybody, it wasn't able to be put it into effect politically, so that there's three operational steps, in my opinion, there. But it doesn't disagree with what you've said one way or another.

Now, the politics of the problem is why it doesn't act it out universally, and I think that's simply because--I'm like John McKinley, I think that the hospitals have gone where the money is. Therefore, they didn't want to transfer these functions.

**FM:** Tell me more about what you mean by where the money is.

**JS:** Well, I think the whole development of the hospital bed-care is a symptom, and, if you will, high-tech medicine inside the hospital is going where the money is. I just wrote that little thing for Milbank Quarterly on that theme. I think that the administrators that ran the hospital, the trustees that ran the

hospital, didn't think ahead about what care in society was important. Instead, they were focusing on this stuff (acute bed cost) because they could turn in a profit at the end of the year and show good money, because they're running their beds full. It was a kind of, I think, lack of intellectual understanding of what the mission of medicine was and what the needs of the public were and the needs of society were for care of chronic illness outside the hospital. At least that's how I see it.

So even though it was conceptually narrow, as you were suggesting, and accommodating to, if you will, stimulation from foundations, people did think it was necessary care for the overall system. Now, we did one thing with the overall system, and that was that we had had the residents in the regular program come out here and spend rotations here, too, and I don't think many other places did that. They tacked on this primary care program and had this other thing over here. We might say, we tacked it on and added it to everyone's training.

**FM:** You were in isolation from each other.

**JS:** Right, and you say we tacked it on, but we also made the other residents come out here and work, too, longer than they did before.

**FM:** And they did rotations.

**JS:** They had to come out for anywhere from two- to four-week rotations all the time, in addition to their daily, weekly clinic visit. So they came out and participated in, if you will, some

of the ideological orientations, if you will, and there was also some of the patient care for chronic illness. So in a sense, I think we moved residents more than most places did, that way.

**FM:** If you asked a cohort of residents who had taken the categorical tracks, if you'd asked them their view of the primary care medicine training, would they: a) know what it was, and b) recognize that it had impacted them?

**JS:** I think the answer would be, yes, they would say that they recognized what it is. Now, whether it impacted them or not, that's a good question, because Sherm Eisenthal, a psychologist and I just made a survey. Though we were interested in different questions. We should have put that question in there, now that I think of it. But we've been interested in how the residents and their attitudes to psycho-social care differ between different training programs. It's clear that those in the primary care training program differ from those in traditional programs.

Now, did they meet in the middle after two or three years and change much? Which is the impact of education. The answer is, they don't seem to have. In other words, the traditional people keep their same attitudinal orientations that they had, where they don't give as much value, if you will, to the need for psycho-social care within medical practice as do the primary care residents. I think that's the conclusion of our paper, which we have to finish up on, so that's a partial answer.

Whether they also feel they got other things out of the program, you know, or not, I don't know. I think they would say they got perspective of a kind. Do you follow me?

**FM:** Yes.

**JS:** In other words, they know how the world is constructed a little bit better, even if their fundamental attitudes about the content of care may not have changed a lot.

**FM:** Since we focused on primary care residency, let's walk that on through. If you would give me a bit of chronological history, of how it fared over the years, who ran it, how many residents, and secondly, how it has been--well, let's just focus on that, for a moment.

**JS:** I talk to Mike Barry, who runs the program now. It's up to about twenty-four residents.

**FM:** Twenty-four over three years, or four years?

**JS:** Yes, twenty-four over three years. It will be twenty-eight if you count the med pediatrics program.

**FM:** In the early years, was it that large?

**JS:** No, it wasn't that large at all. No, there's three residents, out of, I don't know, maybe 10 percent of them were primary care, a very small percentage.

**FM:** At this point, if you take all of the residents, if you have seven or eight a year coming in, that represents what percent of the total incoming?

**JS:** It would represent right now, the twenty-eight would represent about a third, getting up to a third of the residents.

**FM:** So over the years it's moved up, and it's 30 percent out of the medicine training.

**JS:** Right.

**FM:** In terms of its funding, it was RWJ-stimulated in the beginning.

**JS:** Then the government funds took over.

**FM:** Title VII, which have been on and off.

**JS:** Yes. I think we've been budgeted pretty well, except the last two years now. I'm not *au courant* with that, because that program got taken over by Mike Barry, the front office, and I don't know exactly how the funding is. Unfortunately, Joanne Perry, who is the secretary of the program, isn't here today, or you could find out from her.

**FM:** It has also been supported by the institution as a whole?

**JS:** Oh, yes. This last time when they lost the money, the institution came right forward and did it all.

**FM:** And what would you say about the nature of the residents in the program over the years, in terms of just generally

characterizing them male/female, social conscience/non-social conscience, practice patterns ultimately, etc.?

**JS:** Allen Goroll was supposed to make a follow-up study of where they went. That hasn't been done. There's been some study that a lot went to academic teaching posts and so on, so that's a banner that they wave. The idea of a hospital as so-called a leading academic hospital training ordinary doctors--Larry Ronan and I talk about this all the time--they seem to have a difficulty now in institutions saying, "I want to train someone," and taking pride in training someone who goes out into practice. Larry and I wrote an editorial recently, sent in to *JAMA*--I don't if they're going to take it or not--which is called "The Obscure Nature of Care," in other words, how academics have trouble recognizing and celebrating, if you will, the fact that people provide care in society as their major role.

At the moment, I think that I can say that as far as knowing the people in it and so on, that they, in general, have orientations that are a little bit more social than the traditional program people. Certainly, they're less specialty oriented in their heads. Obviously, they have more interest in psycho-social care than they do, from the study survey that we've actually done, which a systematic analysis of it. So in those dimensions, if you will, of social attitudes, in general, and psycho-social care, in particular, certainly expectations about practice is good, and those that have gone into research have gone into the field that you know, as well as I do, in health services research, which I don't have to characterize for you, because you know that, in the various outcome studies, or

whatever it is, things like that, and then from there may have gone on to be working in somebody's program, you know, in some other city, doing the same thing.

But I don't say that we've trained--some people have gone into practice, too, but not like they have on the West Coast, where I think the program at UC-SF [University of California at San Francisco] argues that they trained a lot of people into practice. I think we haven't trained as many as they did, from Steve's program--Steve Schroder.

**FM:** I'd like to pursue the current situation more, but before we do that, let's go back to 1972.

**JS:** Go ahead.

**FM:** In terms of other developments either in your career life here or in terms of in terms of other aspects of hospital training, you mentioned several other elements besides the training program that began to take off as primary care became more defined.

**JS:** Well, one of the things was the formation of the practice itself. Since that was revolutionary for this place--I mean, combining, if you will, the clinics, with a bunch of young people that also saw private patients, so you didn't have this dichotomy between the clinic patient and the private patient, in other words, I thought that was an incremental step which we did in this small group in medicine. So now there are, what, some forty doctors in this group full time.

**FM:** This represents the medicine?

**JS:** Medicine group. Okay? And in addition, while we did this in one group, since that's been done, this integration idea, they've formed another subgroup in the hospital called the Bullfinch Medical Associates. Bob Hughes, who had been in our group, moved over and did that.

**FM:** This was also for internal medicine?

**JS:** Yes. Internal medicine, too, which is going to be a teaching group practice, too. And then the Women's Health Center, which Karen Carlson has formed, is another small group centering around women's care. So in a sense, this little "groupie" kind of integration experience, including nurse practitioners as well as staff together, too--that model has been imitated in two other sites, and to some extent, the health centers represent that, too, but they don't represent as much what I call the private world, because, as you know, the health centers' location is far more, if you will, skewed into special populations of one kind or another. In Revere, it's the Cambodians and so on. In Chelsea, it's the Hispanics. In Bunker Hill, I don't know who it is.

**FM:** The economic payment-status integration that you describe in medicine, has that taken place elsewhere? Has it taken place in surgery or in pediatrics?

**JS:** No, that's the interesting thing. It hasn't.

**FM:** In a private service?

**JS:** It hasn't taken place, except in medicine and pediatrics. So, pediatrics and medicine it's taking place in, and there has been other group practices. In psychiatry it's taken place, too. So that's psychiatry, medicine, and pediatrics. That leaves out the surgical specialties. Right now, the big thing is whether or not--these have all functioned under the hospital's banner called the ambulatory care division, and the question now, if we make a private corporation, which we want to do, called the Massachusetts General Physicians Corporation, then are we going to take ourselves out of this credit-card umbrella which has allowed the patients, whether they are gypsies or non-paying patients or they're rich or poor, to come in to see us, and put us under, if you will, a private corporation, how will we operate if we have the ideology of a single standard of care for all people? And can we do it?

So we're at a juncture now in directions of where to go, and that hasn't been settled yet. In other words, as Larry will tell you more, because he knows it, too, because he's on the committees, is that while we continue to have the ambulatory care division, which permits, if you will, care and treatment of anybody. That's what the big issue is.

I'm worried that it will all go sort of two-class, which is what we fought. As a matter of fact, the word "two-class care" was used by Dr. Bauer and those other people, although they never--you know, those original guys who were interested in improving the clinics. You don't find professors of medicine like that anymore, unless you do on your travels.

**FM:** Not often.

**JS:** The question that comes up is why did they--most of those guys came out of the Depression, did you know that? When you look back on it, when you're looking back to that generation of physicians, they came out of the Depression, and even though they were good lab people or other things like that, they came out with an ideology which is missing from the current professors who were mostly trained exclusively in the laboratories and have had private and public education long after the Depression, without any knowledge of the--

**FM:** A different culture.

**JS:** A different culture. But these men [unclear] were very interested in social improvements, which the academic medical centers are not. I think the academic medical centers are way behind, myself.

[Begin Tape 2, Side 1]

**FM:** During the period from roughly 1970 to 1990-'95, your observation about the ebb and flow of medical students, in terms of their perception of what we now call primary care, or generalism.

**JS:** Well, I think two things. The reform that went on in medical education certainly varied a lot. There were people in the early seventies who were very interested in primary care--a

small group of people. Lucy Candib, for example, who is now out of the University of Massachusetts--

**FM:** Lucy who?

**JS:** Candib. She's in family practice. Many people in her group were interested in primary care at that time, and the programs for education for the students were not very many in those years. We used to have, here, if you took your clerkship in medicine on the floor, you would come to the clinic one day a week. That was a structure of the kind of clerkship, if it went that way. So, yes, you went to the floors for most of your training, but there was always a complementary focus in the clinic.

Then with the development of the New Pathway, which came on in the eighties, that's in the mid-eighties, things shifted, and the idea of generalist training got a new definition. Dan Totetson, who was a classmate of mine, who referred to the idea of generalist education constantly, developed New Pathway. He and I argued all the time--or, I quit arguing about it, because it doesn't go anywhere--but we had a friendly disagreement, which is that the idea that the selling of a generalist education for the student really derives itself out of the idea of the general doctor and the generalist doctor. He wouldn't admit that, because then it would be labeled primary care in some way or another, and he didn't want it to have that label.

**FM:** What does he mean?

**JS:** Well, he was trying to mean, simply, that he didn't want to argue the historical roots of what he was saying. In other words; he saw, yes, you should be interested in the relationship aspects of the doctor/patient thing, the social and psychological aspects of illness, and so on, and you should have this as part of your content of looking at illness, as well as your technique being, if you will, inductive learning versus deductive learning, or deductive teaching versus the other kind. He thought in terms of two kinds of knowledge, general an specialized, and that students should have both. But he wouldn't accept the idea that this generalist idea derived out of the general practitioner's functions. He just couldn't put those two together, because that means he would be training generalists.

Harvard, I think, still has an intellectual inability to make that leap that generalist knowledge derives from generralist

Of the doctors in primary care vs. Specialists. They really think that they're training physicians, and they're really specialized, to some extent, because that's the one thing you can celebrate. You can't celebrate the idea of a generalist. You can celebrate the idea of a generalist education for people that do specialist functions, but for the generalist, per se, it's very difficult to do it. I think you can talk to other people about that, but anyway, that's a difference in this whole idea of a generalist education for the students, is the denial over the roots of where these ideas come from, and they come from the functions of the doctor as a generalist.

**FM:** So if I could paraphrase, I would see what we'll call the Totetson interpretation as having elements that might be called

dilettante, as in some regards some have argued that general education for the college student, who is going to be an engineer, we celebrate engineering, and it's nice that he read a little Socrates or a couple of plays of Shakespeare, but, by God, we're training engineers.

**JS:** Right.

**FM:** One could argue the same, that, by God, Harvard Medical School's training the science space-shot engineers of the next generation of medical biotechnology, and it's nice that they--

**JS:** Take some general education.

**FM:** Yes, but it is not really part of their true heritage, nor, goodness knows, their true environment of practice and contribution.

**JS:** Right, and we don't want them to go and use it in that role.

**FM:** Right.

**JS:** I mean, think of themselves as using it in the role from which it originated.

**FM:** Yes. I understand.

**JS:** But I think that's at least a kind of lack of intellectual acknowledgment of the roots, I think, of generalism, here at

Harvard, and the uses of it in designing a new curriculum here at Harvard. Nonetheless, I think that the New Pathway--and I continue to teach in a first-year course and run students here--the New Pathway at least, I think, surprisingly, got it biggest drive from the tension of the doctor/patient relationship. When they wave the flag about the New Pathway outside the halls of Harvard and so on, it's always focused and distinctive in how they pay so much attention to the, if you will, doctor/patient relationship.

**FM:** So you treat it as a victory in that regard?

**JS:** I think it's a victory in that regard. The thing of it is, when you look at what they do in the first year, it's really the students who were with me last week and all, who come down here and interview. I have an interview outpatient here, and they'll sit down here for an hour, taking a history on an outpatient here. There's nowhere else I know that they do that much exposure, if you will, to the patient's history, as a general experience that way.

Ruth Fishback [phonetic], who teaches with me, she's up in social medicine, she and I were discussing, though, whether that gets burned out--you know, when they get on the floor--and some people claim it does. Whether it gets retrieved, when they get into training, I don't know. There is a study going on now by Gordon Moore and, I think, Susan Block, and I don't know what they're coming up with, to find out whether that has permanently affected attitudinal views about medicine and also performance of

doctors, in the care and treatment of patients, those two things. Nobody knows the answer, but certainly it's impressive.

**FM:** As you see undergraduate medical students continue to come through Harvard, what is your reading about their primary careness, their primary care aptitude? Is it increasing? And over the years has it ebbed and flowed, or is that largely a kind of fiction of analysts--I mean, pretty much, that stock is the same year in and year out?

**JS:** I think the darn thing ebbs and flows. Right now it's high, but I do think it can go down startlingly fast and can come up. It's all of a sudden come up in the last two years for these reasons, I think, which are economic, probably, in terms of jobs. So that people are now looking at it as a realistic sort of thing to do and attach themselves to and to learn about, rather than before, they could say that they'll ignore it and they won't pay attention to it because their agendas are somewhere else.

If you take some of the early New Pathway students that remembered coming to Harvard, one of the surprising things--I've forgotten the percent of the class that did research--but I think you could go off and do research and get a Ph.D.; I don't want to be quoted on it, but I think it's almost 20 to 30 percent, did that, which is a way of paying your way through medical school and getting another degree at the same time, and yet I don't think their passions were necessarily in science entirely, although some were, obviously, that way. Comparing that to at least speaking in my own experience, I think there were only two people in my class, myself and Holly Smith, who spent some time

in the lab, you know, during our four years, because there weren't those opportunities available. Government grants have made it available, financial grants from other places may have taken a student for two to four years to get a Ph.D. that way.

So that whole culture, though, where the school was highly oriented on one level here to getting out and training people in this generalistic orientation that we call liberal education for medicine. At the same time, they were offering all these science opportunities for people to go, and I remember the first-year group I had, I said, "What are you going to do after you finish this thing?" and them saying, "I'm going for my Ph.D." Out of six students, I had four going that route.

**FM:** These were out of--

**JS:** First year. After the first year in the New Pathway, they said--I'm just saying that's where they were going. So I think now it's ebbing and flowing, but I think it's going to come back into primary care simply because you can always--

**FM:** Let's use this to transition into talking about your assessment of the present.

**JS:** Okay.

**FM:** Having watched and nourished the concept of primary care, medical generalism, over something coming on a half-century here, how would you assess its well-being at the moment, in terms of

both your experience here, teaching, training, practicing, and as you look around the country?

**JS:** I think it's still got a long way to go. I still think it's at the bottom in terms of status, in terms of power, in terms of influence, but I think it's kind of growing, in a way. [Tape interruption]

Where were we?

**FM:** In terms of how primary care is faring, you said it's still at the bottom, but it seems to be bottoming out, in your judgment?

**JS:** Oh, yes, I think so. I think that the two things--like Dan Fox and I were talking--you know him, because he's a friend of yours--that chronic illness care is now getting a much more major emphasis publicly and privately. If that's the case, chronic care, so much of that is outside the hospital and so much of primary care is therefore going to be responsible for it, and can be responsible for it, I think, so that shift, if you will, from the focus on acute hospital care is a major thing that will improve the status and position, I think, of primary care. That's one thing that's important, it seems to me.

The other aspect of it has to do still, I think, with relationship issues, which really cut across primary care and specialists, too, and that is that communicative aspects of care, not technological ones, are having to have more attention paid to them. That comes out of primary care, I think, in its roots, and primary care, I think, has led that, to a large extent, not

entirely, but to a large extent, in their emphasis on the importance of communication for decision-making among patients and, in reading that little draft there, to some extent, communication inter-professionally, too.

So those things are real, real content contributions, I think, of primary care, to the use of specialization and to the use of technology and to the use of instruments to improve the health of individuals and their prevention. So those are all kinds of things that I think will add to what I call the content-contributions of primary care, those kinds of things.

The position of the primary-care doctor in the professions still is in limbo, a little bit. You know that probably better than I do. Obviously, people are polite and civil, for the most part, but there's a tremendous status hierarchy here in the profession. It's extraordinary when you think of it. You see it in the academic center probably more than in the community. I don't know, because I haven't been out there too much recently. But the idea that you can even be intellectually-minded and a generalist is, in some people's minds, contradictory to some extent, because isn't all knowledge specialized, as somebody would say. Of course it is, to some extent.

But Harvard, for example, and speaking locally, just can't take pride in celebrating, if you will, generalistic functions, although Larry is getting them to do that a little bit more in the Cabot Series, and things like that. So those things are coming forward in terms of what I call interprofessional status issues, in a way. Then I think if the power structure is designed so that the primary care isn't really a gatekeeper but more of a co-manager with specialists, of care and treatment,

then again, that would contribute a little bit to sort of increased colleagueship and increased cooperativeness between the subspecialists and the generalists so that both are involved in the care of the patient, as well as the patients themselves. So those are all positive kinds of things that I think the future holds.

**FM:** How do you feel about the rise of managed care, which some claim is the resuscitation of the primary-care doctor, is the wave which the primary care physician will ride into the future? (A) Is that true? And (b) is that good?

**JS:** I don't know if it will come to that entirely, but I don't like it, personally. I was thinking, at this meeting, I was saying--we were looking just at the communicative aspects of care, and I was saying that it was clear that the people in managed care really would like to improve the communicative aspects of care, which the primary-care doctor has been trying to do for years in their relationships with patients, but they've been doing it in order to--economic reasons, to avoid malpractice costs. They want to get more customers to come in, to use the plan, so you've got to be nice to people. Sort of a customer-approach orientation. And thirdly, they want to substitute talk for tests in some way, so that you don't have to spend so much on tests. But the drive is all kind of economic. It doesn't spring from, if you will, the missions and goals of medicine, put it that way, which is to improve the health of the individual who seeks medical help.

So the answer is, yes, primary care will get more positioning, if you will, under managed care, but will it do it at the expense of losing some of its historical professionalism or missions? And I think that's a worrisome sort of thing. Yes, you want to listen to patients and do everything that they ask you to do, but you also want to do the right thing by them, too, and not necessarily do things which they ask for which are not good for their own health, in a way, things of that sort.

**FM:** It could be a Faustian deal, from what I've heard.

**JS:** Exactly. It could be a Faustian deal, yes. But it's being sold that way, and some people are out there waving the flag for it, and saying, "Oh, gosh, let's step on the band wagon and do that sort of thing." The other thing, it also leads to a counter-relationship with their professional group--not with patients; I was talking about patients--where to some extent they sort of tell the specialist what to do or not to do. That's bad, too, because then you lose this what I call shared decision-making/collaboration that I think specialists should have.

**FM:** But one could argue that has existed only in the minds of a few philosophies, as opposed to in the reality of the practice of medicine.

**JS:** Right. I'd have to agree with you, but I think you can have both.

**FM:** We primary-care advocates may suffer from, or, in retrospect, be seen to have been suffering from a kind of plantation syndrome, where we have been field hands, or maybe, at best case, houseworkers for so long, now that the plantation system's over, we're a little reticent to get out on the landscape under our own steam. I at least could make an argument that it's time primary-care providers sort of seized the means of production proudly, not apologetically.

**JS:** I do, too. I would have argued, too, I don't think you should be deferential in doing it. I don't mean that, to some extent. I guess I'm saying that to maintain a certain degree of having been now the conquering heroes, that you don't slaughter some of your colleagues in the process of doing it. But I agree, I think they should step forward and do the right thing.

**FM:** I think some of our colleagues may fall by the wayside, but we won't be doing them in, wielding the sickles and scythes and guillotines. It's the invisible hand of capitalist medicine that's--

**JS:** Right. The system is the sort of thing. I mean, this case here, where they called me, this patient whom I had a relationship with outside. They called me, not to tell me that she's even inside the hospital, so I could make a social visit. You follow me? I'm called because they need me to okay her to go hospice, and then later to make arrangements to get an ambulance, because the insurance scheme says that. They wouldn't be calling me at all if they hadn't done that. But that's the reason why I

get--in addition to operational control, we also need a new ideology that substitutes for what has been missing, I think, where we have a mutual respect between professionals, we keep each other informed about the care and treatment of patients. But if it's economically driven, you wonder whether that can be maintained. You hear about fights between specialists and generalists as to who is going to take care of the patient and so on, and then they take over and do all the work that you're doing instead of letting you do it. That's going on now, too.

**FM:** Yes. I think that's unavoidable, at least for the near term, as the system--

**JS:** Goes into this transition.

**FM:** Yes.

**JS:** But I don't know where it's going to end up at.

**FM:** Well, that's a good transition to the future. Let's not talk the whole system, but let's talk, to the extent one can, the role of the primary-care physician/practitioner, in the system of the future. A simplistic analysis might say this is the epoch of the generalist--it's arrived--alas, perhaps not for the reasons that you and I might have liked, which is the intellectual triumph of the primary-care model. This is a largely, I think we can agree, market-driven phenomenon. But nonetheless, it does seem to augur a much larger role for the primary-care practitioner in the future. Do you think that's the case? And

how, as that settles out, do you see the primary care role being played? I'm asking the question of, sort of, futurism. Not how would you like to see it, but given all the forces at play, how do you think it will turn out?

**JS:** I think it's got to turn out in favor of the primary-care doctor more, I mean, because we've grown so much specialistism. Like Mark Field, who's a colleague friend of mine, Mark and I discussed it, and he says, "You know, you cannot develop enormous amounts of specialism without having generalists involved," or some degree of generalism involved if you've got all sorts of focused, if you will, specialization, and you're not going to be able to transfer to every specialist a little bit of generalism, either, which is another theory that some people have, so you don't need generalists, which is a second theoretical orientation.

So you do need, if you will, the generalists somewhere, and I guess, therefore, the issue is going to be how can that be acted out, to some extent, in the future. Will the generalists have to be different, so that it's much more age-related, so that you're going to add another generalist as a geriatrician--God help us all, but some people are arguing that sort of thing--so are you going to divide the whole spectrum up along the way, from adolescence, if you will, infancy, and so on, down the line? I suppose you could argue that, and some people would, but I still think there would need to be, broadly, some younger generalists, some middle-aged, some older generalists--those two things, which are still, to me, pragmatic, and sort of a ways along the line. Then if you do have them as trained sophisticatedly, it seems to

me their functions have to be one of integration of the knowledge.

**FM:** Is that a proxy for a general pediatrician, a general internist? I mean, do you see the world functioning reasonably well with that at least age differentiation?

**JS:** Yes. I do at the moment, yes. Even if you get all these old, I'm not convinced that the geriatric knowledge and information is that much that you have to create another specialty for it. I mean, there are some people that do, so I won't argue with it.

**FM:** And how about the necessity of maintaining the pediatric/adult differentiation? Is the Med/Peds model, perhaps with a streamlined training program, a way of the future, or not?

**JS:** That I really haven't thought through very well enough, and it's possible that it could be. Do you follow me? Here again, I'm probably biased, because I think it would be hard, and I'm speaking for myself, and I can't conceptualize it, and I haven't operated in that world, when you leap, if you will, from the young to the old, you know, in one day, in one day's practice. Can you really do all that kind of conceptual work? It seems to me that it's kind of hard, that from youth to middle- and old age, it's a little bit difficult to do. My own inclination is that you'll still have to have something in the way of pediatricians and older doctors, if you will, but it doesn't mean

that you can't have another pathway, which is a mixture of Med-Peds and, if you will, of family doctors.

So it isn't an either/or categorization. It's sort of how people might want to find a mix for what they needed that way. I think, though, at the end the biggest issue is going to be, if the generalist is going to be the doctor, the other generalist is the patient, and I think that this is going to be one of the big things in the future, in terms of all the different missions that primary care wants to do, which is early disease, diagnosis and preventive treatment, and rehabilitation of the chronically ill, and early recognition of disease, in general. I think that the patient, then, is the other generalist in the negotiations, and I think this is not appreciated as much at the moment as it probably should be, although there is a lot of stuff about shared decision-making with patients. One of the ways I see it is that the amount of information that can be transcribed to people, and I can conceptualize--I talked to Steve Lorch the other day, who is a big computer friend of mine--

**FM:** Steve?

**JS:** Steve Lorch. He's a good computer friend of mine, a consultant in Washington, Chicago and all those places. Steve and I were talking about, in terms of if he can devise all of these decision-making trees and routinize, if you will, the care of the patients of internists and pediatrician, why don't you have all these guidelines out there for X, and the patient; then all he has to do is punch in on Internet and get what it is. I mean, it may be then that all you have to do with your doctor is

to generalize an okay on what to do--a sanctioning process, if you will, versus anything else--and where the person won't take a lot of initiative on their own, you've got the doctor. And even without the specialist. You follow me? I think these are the kind of things that are in the way.

So that the future generalism has to be a partnership between the patient, if you will, and the generalist, as well as between the specialist, which is what we've been concerned about, politically.

**FM:** You're raising profound questions about the doctor/patient relationship in an age when information is freely, quickly, accurately, and clearly available.

**JS:** Right.

**FM:** Whereas in the past, the doctor had been the custodian of great quantities of information which were not easily available to the patient.

**JS:** Exactly.

**FM:** So as such, perforce, the physician becomes, in large part, the executor of the information, with a little bit of patient input. If the patient can easily access that information, then it changes the roles, the dynamics. Fascinating point.

What about the presence of increasing numbers of non-physician providers in the realm of medical practice, particularly in primary care?

**JS:** That's another good point, yes. Like nurse practitioners. I think they're terrific and we work with them all the time. Barbara, who just walked out there, Barbara Chase, said, when Mrs. X came in--I'll just tell you that she's a somewhat difficult patient, to say nothing about--and she told me she wasn't here, so she saw the nurse and settled it one way or another. This has something to do with not only making more care available in society, perhaps at a lower cost, because there is an ideology about that, that it's lower-cost care, but just as good. Okay?

**FM:** When you say "ideology," you're disagreeing with it?

**JS:** No, I'm saying that's how we sell it, to some extent, you know. We can do it as well, but cheaper.

**FM:** But, you're doubting that? I'm just trying to be clear about what you're saying.

**JS:** In a way I'm doubting it, because it seems to me that as professionalism increases, there's much more of a tendency to equality in professional pay, that's all. Anyway, there's an old saying that Cabot wrote back in 1906, "better care for less money." You know, that's what the ideology was in forming clinics and group practices in the 1900s, anyway.

So in nurse-practitioner and other "sub" things, the question is, how do they relate to professional life? I think it's two things. One, it may not be economic, you know what I mean? Which is what it's being sold as now. It's sold as

economic. It may be actually the way to maintain professionalism. I think, in that sense, that for example, I'll just use this practice here, if we did not have nurse practitioners here, this pool of physicians we're training now, many of which are women, are working part time. So the professions being transformed from this sort of persons that were doing a calling and available day and night, available, if you will, to do service at any time, that as it becomes much more of a corporate job, the meaning of the non-professional or the non-medical, person, or whatever you call it, the allied health person, I think it's much more that they are, in a sense, co-colleagues in the system, you know, that allows the professionals to have a much more easy in-and-out of their jobs in terms of their responsibility and duties to patients, as a kind of--I don't like the word "team" approach, but something like that.

**FM:** So you see the differentiation between the nurse in the old days, who was a wage-worker, woman of limited training, and the physician in the old days, who was a male, many-hour-a-week--

**JS:** Day-and-night worker.

**FM:** Day and night, with a much more rarified set of knowledge, being kind of blended; with the nurse practitioner functioning at a more advanced level and the physician functioning as more of a traditional worker, with more of a regularized week, and not being the kind of single combat warrior that he, or occasionally she, was in the past.

**JS:** Right, and the office has become more of a school and a ward than it was a solo office. In other words, the health education that should go on, should be going on with all sorts of nurse-practitioner and physician inputs, and it doesn't have to be done necessarily across this chair, because that might be good, but there's no reason that the nurse couldn't have a class to do the same sort of thing, with a group of people in it. So that, again, the conception of this clinic as a series of diadic offices, but at the same time it's much more of a collective space for everyone to work in, although--"You've got your private bed, here, patient, but at the same time you're part of the group experience, because we're going to have you see the nurse the next time," and so on, down the line.

**FM:** Yes, that view of the future, which I can understand, is one in which roles are redefined but, by and large, not challenged frontally.

**JS:** No.

**FM:** Nurses, as you know, today are making a case that they can, and perhaps should, do a great deal of what these primary-care physicians do.

**JS:** Our friend down in New Jersey does that.

**FM:** Linda Aiken?

**JS:** Yes. Or is she in Philadelphia?

**FM:** Philadelphia.

**JS:** She moved over there.

**FM:** She was at RWJ. And others make the case. The president of the American Nurses Association's been on the stump for this. There are quantitatively-based studies that suggest that many functions that hitherto have been physician functions can be quite respectably done--not only functions, but work-ups, and--

**JS:** Yes, they do it here.

**FM:** --professional activities. There are those who will make the argument--in fact, I have heard the dean of your medical school essentially sketch a view of the future in which there are specialists and there are nurse-practitioners.

**JS:** Is that Dan Federman or Dan Totetson?

**FM:** Dan Totetson.

**JS:** I figured it was Dan Tostasen.

**FM:** And it's a case that can be made. I don't know if you've thought about that, but your sentiments in regard to that?

**JS:** I'm against it. I don't know why. Part of the reason is that it seems to me that the nurse-practitioner roles here--and I know the nurses, and they're all, I think, very groupie-oriented

here toward each other, and so on--is that there is the issue of experience and also the interest of knowledge and so on, and so far, the nurse practitioner training is not as in-depth as a medical training, like it or not. [Tape interruption]

So the question is, to some extent, are you going to be an individual in society whose operational knowledge may be okay, because it's all codified and acted out in terms of protocols, and so on, but at the same time, the definition of a doctor is still, rightly or wrongly, I think, rooted in the idea that somehow there is an enormous amount of knowledge for perspective. All the basic sciences kind of operate--not necessarily the operation, but knowledge for perspective.

**FM:** Knowledge for perspective; that is, for rendering the person--

**JS:** Understanding. Understanding the nature of disease and the nature of operational biology and so on. A lot of the education is for that purpose in basic sciences is largely operational. That's certainly basic science. I think my son wrote that, MA magazine I've got to read. Basic science that doesn't contribute to operation knowledge, but other things. I think that this is still true, and the question is, does the professional in society, the patient who consults a professional in society, want to see someone who has some of that, too; or will you just skip that and go to the specialist. Do you follow me? I think it's a kind of organizational principle of that kind. I don't know how to put it any way else. I'm not saying which is right or wrong, but, for the moment, I still think there should be some very

well-trained generalists, too, who are in-depth, in terms of their medical knowledge that is acquired in medical school, I think which is far greater than is what's provided in nursing schools. Nurses might argue that, but I don't think. They're not as knowledgeable. Do you think they are?

**FM:** I think it's a tough issue, and I can't pretend to total objectivity because my instincts are very much where yours are. That argument, in my judgment, is best made by the premise that--[Tape interruption]

The premise that seems to me to be the most plausible in defense of that is that the perspective that is garnered by the duration and intensity of medical education, and then the experience of intense and ultimate responsibility in patient care renders a pattern of proficiency that is quantitatively more advanced or more comprehensive than that garnered by the shorter training, the more limited protocol-based training that's afforded by nursing school and nurse practitioner training, and by the less acute nature of the care and experiences garnered by nurses in practice. That is, I think, the argument that at least I've made from time to time.

**JS:** Well, that's the same argument I have, yes.

**FM:** I'm not sure it is--it is certainly intellectually assaultable, and I don't know that we have the quantitative instruments to sort that out, but the obverse is certainly true; that is, there are plenty of individuals who have been trained in

medicine, with all of the benefits of intensity and length of training and exposure, who are not good generalists.

**JS:** No question.

**FM:** Who do not have the intellectual or personal ability to provide the kind of intangible elements of care that we're talking about, and there certainly are individuals who come up through nursing who do have those intellectual capabilities and personality traits which make them eminently good at doing that. So my own--

**JS:** Let me stop you there. But there is one thing. The nurses say that, but they characterize themselves as different from the medical person; that "we care." I mean, it's sort of garbage kind of slogan that they use. The problem is that actually, when operationally looking at nurses, that's not true of all nurses either. Anyway, I just wanted to get that in.

**FM:** No, that is true. They have been, I think, both effective and somewhat irresponsible in terms of their simplistic characterization of the nurses being uniformly caring and the doctors being uniformly not caring. But I think the paradox we're forced to live with is there's enough truth in that about the medical profession that the likes of you and I have struggled against all these years, that is going to come back at the time--the very moment of triumph--if you will, simplistically put--of primary care, it will come back to bite us, because the record is replete with physicians whose abilities to provide the kind of

quality comprehensive caring that is essential to primary care, just isn't there. I mean, there are many who haven't had a--

**JS:** I can't but agree with you 100 percent, yes. It's true. The things you hear, when people are sitting in here, telling their stories, are exactly that. They didn't get it from the doctor.

**FM:** Yes. I think when you hear the Totetsons and others--I mean, Dan is an articulate, perhaps thoughtful, purveyor of this point of view, and in fairness to him, he didn't say that frontally, he said that by inference. This was a conference in the United Arab Emirates, as it happens, a couple of months ago, that he and I were both at, and he was discussing the future of primary care. The future of medical education in the United States is heavily specialty-oriented; and when I asked about who was going to integrate this care, he said, well, we will practice by teams, by teams of specialists.

**JS:** Well, to some extent. Ask Larry, because he and I were talking about that. They want to create sort of specialist teams here, too. So you've got these contradictory things going on within our institutions of being sort of centers, they call them, instead of teams, in a way, where you've got something neurologically wrong, or something "X" wrong, you go around to that. So it's like a specialty shopping division, if you will. That's different than, it seems to me, which the public likes, which is sort of going around, if you will, and stop and shop compared to grocery stores, you know. You can see the whole

works at the same time. Because if it is going to be made sort of into a kind of supermarket orientation, it seems to me it would have to meet still, these, again, decision-making qualities of patients, and I'm not sure that they're ready, necessarily, to fall into what is an intellectual paradigm of the profession by saying, "You can see the nurses, because they know just as much." I think the patients, culturally, are also centered on this sort of thing. I don't know how you feel.

**FM:** I think medicine has that going for it.

**JS:** Yes, that's what I'm trying to say.

**FM:** Yes, which I think is fine. My own sort of ethical and intellectual standards kind of want to push beyond that and look for reasons or identify rationales which--other than the public's inclined to go to docs because they think they're better.

**JS:** You want to keep the market going, right?

**FM:** Yes. I do think that, as you have taught over the years, and as more people are paying attention to these days, there are a set of skills--communication skills, decision analysis--that go beyond the clinical skills, that can be taught, that can be selected for. It is my belief that medical education at both the undergraduate and graduate level must embrace those fully, that selection for that, the training for that, the graduation of that into practice, because if not, the continued production of 17,000

U.S. medical students a year to feed our somewhat reduced need for specialists isn't going to keep these places open.

**JS:** Right. What do you think if I propose at the Harvard Alumni meeting in June that we cut the Harvard Medical School class?

**FM:** You'll certainly get a lot of blood pressures up. You'll get attention.

**JS:** You think that we should do that?

**FM:** No.

**JS:** I think we should.

**FM:** Well, the reason is this. (Mine is a "no" with an asterisk on it.) The question is, are we putting too many doctors into practice?

**JS:** That's what I said.

**FM:** The answer is yes. But if you cut 100 people, under the current circumstances, and even under foreseeable circumstances, you cut 100 people out of a Harvard class, there will be 100 more physicians from the Philippines and Pakistan, imported by the graduate medical education in this country, two-thirds of whom will stay and practice in this country. So it is quicksilver that you are dealing with.

**JS:** I see.

**FM:** Until we deal with the importation of thousands per year, international medical graduates into graduate medical education, and subsequently into practice, until we have some manner of controlling that, cutting undergraduate medical education is--

**JS:** Not the way to go.

**FM:** Is not the way to go.

**JS:** Are we going to solve that other problem? I'm interested in this. Is there sense to that--cutting down the foreign medical education?

**FM:** We do not have our hands firmly around it. If we had had the Health Security Act, we would have put our hands firmly around it. But the same folks who run these institutions were very ambivalent about the graduate medical education regulations contained in the Health Security Act. I mean, they liked some of the elements of it, to the extent the government would continue to pay, or even increase the payments for residency. They liked that. But to the extent that government would control by setting numbers, residency, they were uncomfortable.

**JS:** Is that act anywhere around?

**FM:** This was the health care reform program of the president.

**JS:** I see. Is there anything around that will come back individually like that?

**FM:** Well, they're struggling with it now in the non-regulatory environment, but the astigmatism that many American medical educators have is that they think they are controlling the system by controlling the amount of students going through U.S. medical education, and that is not the truth. What controls practice in the United States is the output of graduate medical education, because that is the ticket you need to have in order to get licensed in this country.

**JS:** Right.

**FM:** And until we figure out a way of managing that--and right now it's totally unmanaged--it is driven by a hospital sector eager for cheap labor and currently, not only that, it's subsidized by Medicare. Until we can control that and manage that in some fashion, what we do with undergraduate medical education is a minor concern. If we cut it, the hospital employment will simply import more.

**JS:** We've got to cut that hospital market.

**FM:** Absolutely.

**JS:** Right.

**FM:** Let's, just by way of finishing the interview, because these are good topics that we could--

**JS:** Very good.

**FM:** As you reflect back, finally, we talked a bit about the future, a bit about the present, and a lot about the past. As you reflect on primary care, in your long engagement with the concept and the actualization of primary care, are there any other observations or points that you'd like to make?

**JS:** I think the only thing, we're having a celebration of sort of primary care, and I just wrote up a little--I can give you maybe a copy of this little topic. The thing that interests me is that the hospitals have been so dominant in the society, and although I'm a hospital worker and a booster, I just think that the movement of care outside the hospital is so important, and its enhancement, if you will, and organization improvements are so important. So that you cannot just get cheaper care.

[Begin Tape 2, Side 2]

**JS:** I just think the emphasis on acute care is the thing that has gotten us relief of pain and suffering, but hasn't necessarily improved our health, and we've simply got to move the mission outside much more, where there's some degree of prevention, despite what cynics say about even that, because I still think there's a lot that can be done in special populations

and in special individuals to prevent disease. We've got to do that, I think, to improve the general health of the public.

**FM:** In a sense, your career has been one of emphasis on ambulatory, or non-hospital care.

**JS:** You've got it. That's because the
make primary care more central in care.
**FM:** Virtually as much as it's been primary care.

**JS:** Right.

**FM:** Those two concepts are overlapping, but not entirely synonymous.

**JS:** No, they're not. Right, I agree.

**FM:** And you have championed both.

**JS:** I've championed both.

**FM:** I presume you would be very enthusiastic about ambulatory non-primary care.

**JS:** Sure.

**FM:** Ambulatory specialty care, and the development of a much higher intensity use of ambulatory settings for surgical and other kinds of procedures.

**JS:** Right. No question about it.

**FM:** Actually, one could say your career was something of a paradox. A slave of the hospital environment as you've been, you have been a deconstructionist.

**JS:** Right. A deconstructionist. That term, I like that. I'm going to give you this paper on that very theme before you go.

**FM:** I want to thank you.

**JS:** Okay. Good.

**FM:** And we'll stop there.

[End of interview]