QUENTIN YOUNG

Dr. Fitzhugh Mullan,
interviewer

Mullan: This is the 19th of January 1996. I'm in the study of Quentin Young's apartment in Hyde Park in Chicago. For the purpose of this interview, I'd like to start, not going all the way back as I will do at some point, but talking about your professional career, or starting with your interest in medicine and training, and then to get fairly quickly to your experience as an internist. So tell me a little bit about you.

Young: Okay. Well, I chose medicine as a career when I entered college thereabout in 1940. It was pre-med. However, I left pre-med, left college, to join the Army. After that heroic effort, the Army, in turn, chose to take the likes of me and arrange for us to go to med school, which I started in '44. I don't think I had a clear notion of specialism or not at that point, but when I went to Cook County Hospital, my goal was internal medicine.

Mullan: This was as a student or as a resident?

Young: Resident. I went there about '47. We had a very accelerated three-year medical school experience.

It's worth noting generally, that's the immediate post-war period. Virtually all the young doctors who were physically fit, had been drafted or volunteered for the military, and that

interruption in their career, plus G.I. Bill of Rights, was really the engine that drove the huge surge on the young doctors' toward specialism. They had already seen in the military that rank has its privileges, and specialty had its rank, so the data is clear that the huge shift toward specialized training commenced in the World War II aftermath.

I wasn't particularly caught up in that. Internal medicine seemed attractive to me because my two-year internship at County convinced me a bit of the specialist mystique, mainly that there's a lot to know out there, and maybe you can't both take care of kids and adults, or do surgery and be a good clinician, but, obviously, general internal medicine came close to a generalist model. But I must say, I wasn't thinking in those terms, and my early career experience was heavily loaded with tuberculosis care. We have to remind ourselves, TB was big in that period. In Chicago, for example, of 12,000 hospital beds, 4,000 were dedicated to tuberculosis. So in 1953 I had finished my internship and residency, quite typically I had to supplement my slowly growing practice income with a job, and the job I had was in the Oak Forest Tuberculosis Hospital.

Well, it turned out that that activity was the precursor of the yet to be created pulmonary specialty, and I had a lot of experience and could easily have moved into pulmonary medicine as a specialty. Indeed, when I was attempting to get hospital privileges at Michael Reese Hospital, merely being a board-certified internist from County, which I thought was a passport to heaven, or anyplace I wanted to go, wasn't that interesting

to them. When I indicated large experience in tuberculosis therapy, working in the TB hospital, the separate Department of Chest Medicine which existed at Reese, reflecting that hospital's historic commitment to TB therapy, relating, in turn, to the Jewish experience where TB was an issue among immigrants and so on, the door was opened.

Mullan: This was a Michael Reese tradition.

Young: That's right. And so--

Mullan: R-E-E-S-E?

Young: R-E-E-S-E. Michael Reese. Happily, my privileges weren't limited to chest medicine ever, and not too many years after, that department was absorbed into the medicine department.

But the point is that I had, if you please, a dalliance with specialization, and it was exciting. This was a period when tuberculosis therapy had just come on the scene and changed from a *Magic Mountain* [novel by Thomas Mann] script to actual treatment with effective drugs. Important gains were being made in treating asthma and chronic obstructive disease, and there was certainly a greater interest in lung cancer, albeit there was very little to be done, as it was exploding thanks to the cigarette-smoking addiction of the population. All of this is by way of saying there was plenty to entice me to pulmonary medicine as a specialty.

Mullan: What was the other side? In terms of both your medical student years and your residency years, many of your colleagues must have not been going on even for residencies, let alone into subspecialties.

Young: Yeah.

Mullan: What was the kind of hallway attitude then? Was that okay, or was it looked down on already?

Young: No. It has to be stressed that this is very transitional. This is literally the moment when the pre-World War II presumptions of a year internship and hang out your shingle, transformed into economically attractive specialization. This occurred certainly among urban docs, at a place like Northwestern where I went, you got into the mystique of further training.

Now, to say something you're not asking, the real shift resulted from the post-World War II federal policy of subsidizing full-time faculty in all the med schools. That guaranteed specialism: the peer models that the medical students got were specialists who, because they chose to go academic, were making a statement that they placed research and education above practice. I could dilate on that, but I think it's a terribly important event, a cultural and academic event. Mind you, who picks the incoming students? The faculty? Who trains them and who tells them what to do with their career as they're leaving? This same

faculty almost to a man--mostly a man, an occasional woman--were specialists. So that rapid transformation was facilitated, I think fortuitously, by the generous decision of the public through the federal government to fund full-time faculty.

Mullan: Was there any sense of a dying tradition, or losing a tradition on the other side? Was the general practice concept celebrated or mourned by anyone?

Young: It sort of died quietly. I don't think that there was an awareness that something was happening, if you know what I'm saying. In other words, there weren't regular pep talks or even scientific talks that, "We must end this primitive useless form of care." It was quite the opposite. The people going into it achieved a transformation, but they didn't know it. Like the guy who was speaking prose all his life and didn't know it, they were part of an obviously profound shift in health care arrangements which were reflected at once in the explosion of technology, the expansion of health insurance, a variety of concomitant events facilitated, almost guaranteed, this trend. I feel comfortable in saying, on the ground, first as a medical student, then a trainee, and junior faculty, that at no point did I have a sense, as I have in other issues in health care, that here's a change coming, we should facilitate it, we should resist it. It sort of crept up, and I think--

Mullan: It was seen, I'm sure, by virtually everybody as an augmentation or improvement in the level of education.

Young: Oh, yes. It was only considered good. Now, implicit in your question, was there a sense of rejection or criticism or denigration of the historic doc, the GP [general practitioner]? I would say not. There is a whole lexicon starting with the acronym LMD, which meant idiot, local medical doctor.

Mullan: Local medical doctor.

Young: Yes, which was postured already in the teaching centers. But I don't believe that consciously they were considered mediocre because they were unspecialized; they were just mediocre because they didn't know as much as we did. I think that's my best recollection at the time.

Mullan: How about the distinction between doing an internal medicine residency and going beyond that for semeiology? Was there any kind of company or general attitude or awareness of the distinctions there, and how was that manifested?

Young: Well, I think we were in a proto phase, a really early stage. Frankly, internal medicine was considered a specialty. It had all the trappings, it had board certification, you did take three more years of training, and if you asked a person whether they were specialized, "Yes, I specialized in internal

medicine," just as these days the tendency is to say, "Oh, no, I'm a general internist," to make a virtue of that contemporary explosion in the direction of primary care.

So I think the phase about which I'm speaking, which I repeat is a very early stage, the people in the specialties were thought of as being caught up in an academic setting, a person who was a nerd or a person who just was preoccupied with a narrow focus. He wasn't a regular fellow. Because these fellowships, say endocrinology, or whatever--but it doesn't even matter whether it's a medical or surgical discipline--subspecialization always implied research, implied long hair, if that term means anything anymore, the whole idea of an academician, a person who wasn't hands-on. Now I'm overstating, but I think that's true in this early stage because they were uncommon.

You realize at the time I'm speaking, each of these subspecialties were developing like popcorn. All of a sudden there was a stampede--and then in latter years specialties begat the subspecialties. So even though the surge was generally toward surgery and medicine, OB/GYN, and peds, the subspecialization was not fully developed in my training period. That was to come the decade or two thereafter. I would say culturally, there was no hierarchy. We didn't look down on anybody. Part of this is that we were all at County Hospital, which is a battleground kind of place. Everybody was a few days behind on their showers and blood-stained, from just the sheer volume.

I always mention one of the County roster things. The emergency room, which was very busy, not as busy as it is now, but very busy, was a supplementary duty. They had a roster, and whatever you were doing that day, you had to do in addition to emergency room. Everything else somehow could be put to one side, whether you had a patient load of thirty patients who were sick, or scheduled to do surgery that day. You had to work it in around the ER [emergency room] stint. It was literally a duty for interns every three or four weeks.

Mullan: Everybody had an ER stint?

Young: It was like KP in the Army, if you please. [Laughter] That gives you an idea of what an internship was: it was a training ground, but also we have a lot of service to do and we'll pick you out of your regular duties at any time.

Mullan: Take your medical school class. Presumably everybody did an internship.

Young: Oh, yes.

Mullan: Some percent went on for training in the general field, and some smaller amount went on for subspecialties, but some went into practice after one year, presumably.

Young: Not a hell of a lot.

Mullan: At that point not a lot?

Young: No, I'd say at Northwestern, not a hell of a lot. I'd be very surprised if there were very many. I don't know the numbers.

Mullan: Most of your classmates would have gone on for residency training.

Young: Yes. You read the alumni book and they describe how, my contemporaries just retired from urology or another specialty. I never hear them even say family practice, because that hadn't come on the scene. That was a latter-day reincarnation of so-called general practice, with a three-year training period.

Mullan: Well, then as you moved on in your career, you had a dalliance, as you put it with pulmonary medicine, but you moved back towards general internal medicine in practice. Tell me a bit about that.

Young: Well, that is probably as pure an experiential thing as a career choice could be. I went to practice in Hyde Park where I was born, grew up and live today, in a little office with one other guy. I should say parenthetically, my vision as an activist medical student and, for that matter, if there is such a thing, an activist resident at the time, I say if there is such a thing, because I lived through the destruction, the extinction of

the Association of Interns and Medical Students, which had a very honorable, progressive, expression into World War II. You can look at AIMS's, protocols and goals and they look good today, but it was smashed. The AMA [American Medical Association] told medical students, through their deans, "Stay in this and you'll get kicked out of school." It didn't take but a year or two before it was obliterated.

Mullan: This was a McCarthyite--

Young: Yes, [Senator Joseph] McCarthy period. Yes. At Cook County Hospital, in my period there, during my training period, there was a small, to be sure, group of doctors supporting the Rosenberg clemency effort, which was a worldwide. It included in its ranks the Pope and many American people. Nevertheless, that was enough to get at least one guy cut from his residency, and a number of people warned darkly to stop. So all I'm saying is that while my background was activist, I saw myself in a prepaid group practice in some kind of salaried position, things that would not have the taint of commerce that simple fee-for-service practice did. But the irony of my career is that with some exceptions, I started out and remained in private practice--

Mullan: A shopkeeper.

Young: Shopkeeper. I don't mind small. I kind of like small. I think if I've learned anything about magnitude, you should keep

it small in medical situations. I'm part of a group of four internists. I would see us maxing out at about seven or eight. As long as you know each other and see each other, it's okay. But I wanted--

Mullan: But you went into essentially solo?

Young: Solo, actually another guy, but we were really office-sharing, we weren't partners.

Mullan: This was what year?

Young: It's got to be '53.

Mullan: What you're telling me, is that because of the environment, part of the reasons you ended up in more of a garden-variety private practice, was because the environment was so inclement for doing it?

Young: No. No. I could go anywhere I wanted. My appointment at Reese was chest medicine, which meant I got referrals in chest. And there were only about five or six of us, in a 1,000-bed hospital, so it wasn't as though the nurture of a specialty practice wasn't possible. A very junior person at that time had a lot of clinic responsibilities at a place like Reese, I had three or four clinics a week. Then I maintained affiliation with County as a junior faculty. So I did see a lot of patients.

To get to the point, it became clear to me real early that the joy and the comfort and the satisfaction mostly lay in seeing all kinds of people with all kinds of illnesses. Hyde Park, where I practiced, offered me diversity of patients in urban Chicago. If you're downtown you tend to be a monotone kind of doc with a monotone patient load. In other words, a mingled practice is uncommon except in a place like Hyde Park where you'll see a professor who is head of a department, and then a working guy, and then a welfare mother. I always enjoyed a relatively younger patient. I like adolescents, and that was part of it.

So it became clear to me there was no age group I liked best, no gender I preferred, at least medically, and no disease entities that I felt, "Gee, this is for me." In a word, I gloried in generalism; I didn't come out for that because philosophically it seemed better.

Mullan: How would you have characterized that in the mid-fifties? I mean, words like primary care and concepts like medical generalism--

Young: Were subsequent.

Mullan: --were subsequent, and we use them now retrospectively. What would you have characterized yourself as doing?

Young: Well, I like the idea--it's probably derivative from my County Hospital mentality is like a mother with open arms to any child, wounded, sick, infirm, or just imagining who comes to the doors. There's no barrier--economic or otherwise. There may be the barrier of a six-hour wait in the ER, which is a barrier to be sure, but you just never have the option of saying, "My schedule is full," or "I don't see these kind of patients," or "I don't take blacks," or whatever the exclusionary classifications that medicine was riven with then, somewhat today, but much more clearly then.

This was a period, mind you, when racism in Chicago medicine was demonstrable at hospital after hospital with no black patients, and black doctors were segregated. That kind of reactionary propensity of the profession and the practice was onerous.

At County, that was out of the question. Whatever your personal ideology, and it could be anywhere from extremely reactionary to ultra-left, there was a commonality of understanding you'll always be judged by your peers by how well you take care of the patient in front of you. I think that's a good explanation, in my own mind at least, for the generalism that flowered. I'm getting a little romantic. But I mean it created in me an appetite for everything. My residency might have been a reason. In retrospect, it was sort of a family practice intern--I mean, the internship. I had to take two years of internship. Why? Because the demand for the specialty option, meaning internal medicine and all the other specialties,

was so great by this influx of post-war vets, that they could ask somebody who aspired to get one of those specialty places to give two years of servitude first.

Mullan: Take a second year of internship.

Young: Yes. And that was understood. You don't apply for our residency if you haven't had two years internship. Not to make you a better doctor, although it might have, but really to get more slave labor. But it made you very sophisticated. I had five years there.

Mullan: Now your Hyde Park practice started in '55?

Young: No, no. '53 or '54. No, it's '53.

Mullan: And you practiced up until the time you went back to County as chief of medicine?

Young: That's right. I went to County in '72, and stayed on until '81.

Mullan: So you basically had twenty years with your principal activity being as a--

Young: General internist.

Mullan: In Hyde Park.

Young: Yes, sir.

Mullan: What, over that period, from the entry point that we've talked at some detail, what evolution were you aware of or do you see, looking retrospectively, in concepts about, in this case, general medical practice, primary care? Family medicine had begun to percolate. There were criticisms about the system becoming too specialized. How did you see those and how did those influence your medical experience?

Young: Well, almost all the important elements that went into my thinking about practice, from an organizational viewpoint, if you please, made me more and more clear-eyed about the plight of general medicine--primary care medicine is the term we use now--and its importance in addressing the already very serious problems of health care access, the usual litany, quality, and equity in service. To be precise, as a practicing general internist, which I had evolved into, I began to see the rewards of specialty practice at a place like Reese, which had a very wide array of specialties. It was comparable to any university-type center, in that respect. From the subjective viewpoint of a practicing generalist, the outstanding features of specialism, were that it was much better rewarded. I mean, I never counted the money, but from what I could glean, with the years of increasing experience, that depending on the specialty my

colleagues would make two, two and a half, to four, five times what any general internist, I mean that--

Mullan: Your internal medicine colleagues or surgical or--

Young: No, the specialized internists, and certainly the surgeons more. Because I never felt myself in any way inferior to them in training or in skill or in devotion, or whatever it takes to go to earn your way, this inequity generated a modest kind of "class consciousness." This was the reality in medicine as I saw it, and everything I read, all the data, confirmed that this was a built-in hierarchy of economic inequality. I think that by and large the generalists worked harder, longer hours, had more demands on them by patients, than the typical specialist.

The other thing I saw, reinforced my enthusiasm and commitment to general internal medicine: it struck me that most of the people who did the subspecialized stuff had a very limited world as far as medical gratification. Explicitly, I was struck with what I thought was the tedium and narrowness, the loss of not experiencing the variety of things that happen in health care, that is the lot of even a busy subspecialist. I'm not about to write off excitement of fixing a crippled hip into a fully usable limb, but I've never been able to understand, no matter how great the economic reward, how an otherwise normal human being could do that all day, every day.

The other critique that I make of surgeons, which is obviously a cheap shot, is that they're dealing with their patients when they're asleep. That doesn't seem to me a particularly attractive side of medical practice.

So those were two things that stuck in my mind, that the reward system was skewed very sharply, favored specialism, and doubtless the market place operated very mightily there and accounted for the ever larger fraction of my colleagues who were choosing to be specialized and became so. The other was my view, and this is maybe parochial or naive or shows flaws in my intellectual prowess, it seemed to me duller, more monotonous, more mechanical, however great the tactile skills.

Mullan: Those observations on your part are commonly argued today. Were they then? Were there others who were raising these issues? For instance, being in medical school during the latter part of that period myself, and knowing you, I was very aware of issues about community medicine versus traditional medicine or institutional medicine. The issue of generalism or primary care, although it fit well ultimately with the criticisms that we were making then, was not in the front of my mind, as I recall.

Young: No.

Mullan: Was that in your experience beginning to be articulated or not articulated?

Young: Well, I think it was articulated, in contrast to what I said minutes ago, during my training period and just after a decade or more, thereafter, it was well established, equally subtly, but unquestioned, that the hierarchy of values was that specialism was better. Generalism was poorer.

Mullan: Right. I did feel that. But the question was, was objection to that or an antithesis to that developing that you could feel? Carl White, for instance, wrote his piece in 1961 in the *New England Journal* about one patient out of 1,000 in a population actually gets hospitalized every quarter or every month in a university hospital, and yet that's where all our training goes on. That's wrong. Well, that was obviously an early intellectual commentary in this area. That was '61. But during the decade of the sixties, were you aware of others picking up on these kind of criticisms?

Young: In the '60s, my answer is no. In the academy, in the training world, or in the all-powerful world of organized medicine, the criticism was not there. Paradoxically there was an inordinately strong voice coming from the old general practitioner. Who formed the cadre of organized medicine calling for generalism. Later coupled with demands from medical students, we saw the emergence of family practice, in part a reincarnation of the old GP. To answer your question frontally, I think Carl was a voice in the wilderness. There was no impulse to say, "What the hell are we doing here? These teaching

arrangements don't work. This is wrong. We're leaving our clients who deserve better out of the loop of primary care. We're just not capable of treating them well in terms of a one-on-one responsible managing physician. Or we are excluding them based on economics and the racial and geographic issues." So my answer is no, if we're talking now, '60 to '70, no.

In fact, I can illustrate it with a precise personal experience. When I went back to County in 1972 as Chair of Medicine, one of the things I articulated to people who hired me was that we're going to have a program of general internal medicine whose goal will be to turn out general internists, rather than a program of general internal medicine which is a stepping stone to one or another specialty, which was the *de facto* reality. I wish I could find it, because I remember at least when I reread it some years later, it sounded very good. The letter we sent out to the students who applied, the medical students who were looking at our place, was very explicit. We said, "The mission of the Cook County Hospital Internal Medicine Program is to train general internists." Let me tell you what I did.

Mullan: This was starting in '73?

Young: '72. I came on in April. Let me tell you a practical but, I think, very important way that's applicable today to deal with the value system. At County, as it was everywhere else, and maybe still is in most, the sequence of a three-year residency

internal medicine was internship first year (equals slavery); then general wards, get them behind you, somebody has to do it; then the last year was the year of specialties. I viewed that sequence as a statement that's saying, "This residency is a progression towards specialism. If at the end of those three years you're still stupid enough to end a general interest, you have failed to enter the elite world of subspeciality."

I said, "That's the statement? We've got to change the statement." Year one, internship, can't do much about that. Year two, specialties, with heavy emphasis on how a general internist would use that specialty. In other words, when you went to endocrinology the emphasis, insofar as you could make an emphasis, would be on what endocrinology has to offer you when you become a general internist. Then the third year, which was considered the climax, the gem of your training, then you're good enough with those two years of buildup to go on a ward and maybe manage the much more harder job of the whole patient. And that was the rule.

I did other bad things. [Laughter] We made all the fellows--and we had a lot of fellows, we have about seventy fellows, can you believe that, go serve in the general internal medicine clinic every week.

Mullan: As fellows.

Young: Yes. They all had to put in--

Mullan: I'll bet they loved that.

Young: They didn't like it much, but after a while they took it, and occasionally one would say it wasn't bad.

Mullan: The argument was to keep their general skills up?

Young: Oh, yes. I said, "You're no damn good as you know more and more about less and less," you know the cliche, "until you know everything about nothing." It's fun to walk in and your colleagues are puzzled with this difficult diabetic, and you come in and find that the lactic acid was what the problem was all the time. But what about the person who ends up in your care as a complicated diabetic and God forbid she develops something that isn't in your discipline? Wouldn't it be good if you had a little bit of a sense of what your limitations are or what to do next? Obviously that was prescient. Today we have this ironic, latter-day scurrying back to general internal medicine, with actual specialists being retrained. Right?

Mullan: Well, what was the '72 to '83?

Young: '81.

Mullan: '81. How did the environment, both within County, how successful were your efforts, how did it change, and how did the

environment outside of County change in regard to the specialist generalist issues?

Young: Well, I told you my strategy was not covert, it was explicit. We put it in all our announcements. Now there's some reality factors that obviously modify any estimate I make of the outcome. The reason I was asked to come is because the residency was falling apart, and it was desperation that brought me in, to be explicit, it was no secret. The executive director fired a very gifted chief, cardiologist by trade, Rolf Gunnar, who was a classmate of mine by the way. Rolf was--

Mullan: G-U-N-N-A-R?

Young: G-U-N-N-A-R, yes. Went on to become chairman of the board of regents of the American College of Physicians. We became good friends. We weren't good friends in med school. We represented the right and left of the class. I was left of Roosevelt and he was right of Attila the Hun. But he ended up at County, and he was a very good chief and to this day is very good on policy regarding health care equity.

But Rolf was fired, just take it on faith, a ridiculous act. It was very destructive and threatened the program mightily. When he left, most of the attendings, the most distinguished ones, went with him.

Mullan: This was just prior to your arrival?

Young: Yes. That's the reason I was hired. One of the house staff, Nick Rango--do you know Nick?

Mullan: Yes.

Young: Convinced the executive, Jim Haughton that I was the only one who could salvage the situation.

He says, "What do you mean?"

Nick says, "You can't get anybody to come here since you fired Gunnar." He says, "Quentin can," because he claimed, that my years in the vineyards had created a whole crop of hearty activist docs that would come in. Right? Haughton apparently bought that. Turned out to be only a little bit--

Mullan: Haughton is H-A-U-G-H-T-O-N.

Young: G-H-T-O-N. Yes.

Mullan: Jim Haughton.

Young: Yes. Poor Rango, may he rest in peace, he was a very bold man. At the time he told Haughton that, he was in court, having been fired by Haughton, too. But Jim and he were friends.

Anyhow, to get to the point, I came on, and somehow I thought I'd do pretty good in attracting attendings. There were a number of people who went through the--well, you're one of

them--who went through that whole Medical Committee for Human Rights experience, who were quite achieving. What's his name, Gil Omnens, does that mean anything to you?

Mullan: Yes. Yes, I know Gil.

Young: Yes, very nice. He came through and looked at what we were. I wanted him to become deputy, and a guy named Clyde Crumpacker [phonetic], he's chief of infectious disease at Boston. It became clear, I mean, this is a little harsh, but that careerism had taken over. These were genuine progressive people, and most of them remain so to this day, but County, they came and gave it a good look, but I had virtually no success in recruiting attendings from that group. I had to stay pretty domestic, and did fairly well. A program, no matter what its lofty goals, is going to depend on the strength of its faculty. Then we did better on house staff, many of whom, you know, the Gordy Schiffs of this world, and Bert, for that matter.

Mullan: Bert King.

Young: Yes, Bert King. I mean, there were a number of remarkable people who took a really tough situation there and made it possible for something to happen. On the other hand, the residents were always predominantly foreign medical grads, and some very good ones, who were in accord with our goals. The effort at County to achieve that noble verbal commitment, aside

from telling would-be candidates what the ground rules were and what we were looking for, we started and got going on an outlying clinic. There were none. We had three places built and up, which were essentially--

Mullan: Ambulatory care?

Young: Yes, it would be premature prototypes of your COPC. They were done against the current. Haughton was certainly no obstacle, but the funding agency, which was the County Board hated it--in 1969 an Act of the state legislature had taken the county health system out of the County Board's hands, which they didn't like a lot, the Act created an independent governance of which Haughton was the executive director.

Haughton, I would insist, was progressive. He gave me the jail health service to take care of, which is quite something. That's where Bert King developed the care in jail there. He went on to Riker's Island (New York City's main jail). Ron Shansky would be another example. He ran one of the first outpatient clinics. Well, I'm mentioning names of docs who were necessary for anything to happen. The chief can sit in his office and issue directives but unless you have good people, nothing happens. We had a lot of good people.

Mullan: Obviously your coming to County and others electing to come was a complicated or a multifactorial decision. To the extent we can single out your efforts, or the efforts, to

emphasize the generalist training, how did they play, in terms of recruitment, in terms of acceptance, and in terms of the long term of what people had done?

Young: In the course of nine years, nearly ten, we're talking about 700 trainees. That's quite a little army at the resident level. I could say that there was a good outcome in the sense that a good person came, worked at County, committed to generalism and went on in their career. But they mostly all stayed the path. None of them, for example, took specialized training, if that negative criteria means something.

I think we probably turned out as many as 150, certainly at least 100, people who are out there now, and whatever they're doing, it's in the model of primary care. They have a balanced sense about specialty, they understand the political economics of health care, and know the particular subversive effect of hyperspecialization and its ripple effect through the system that burdens it with cost and unnecessary care, and just absence of the primary care crowded out by the over large number of specialists. So that effect was there.

I can't claim that we ever got mass dimensions where there was competition among 100 really good people for 40 places, and it was painful to know who to cut. We never reached that high level. There just was too much rebuilding to do, and County was too tough a place to track, although we got a lot of good people, there's no denying. They've expanded. I mean, they're around, many of them you know.

Mullan: Let me ask a bridging question. During the seventies a lot, the term "primary care" and the concept of primary care was linked to community health centers and linked to what I'll call remedial programs, trying to bring equity, or trying to bring services to populations that didn't have them. The whole federal community health center program was built on the notion of primary care, it's even called the Bureau of Primary Health Care now. That obviously is an important concept and an overlapping concept with the broader question of care to the whole population and to the non-core part of the population, where the notion of primary care was less talked about, it seems to me, in the seventies. Today, particularly with the HMO movement driving things, primary care is being proffered as the best instrument or the best vehicle for everyone.

Young: It is.

Mullan: I want to get the HMOs, and I don't really mean to inject that yet, but the question I'm trying to get at in too-long winded a way is, were you aware of any kind of evolution from the notion of primary care as an answer for the disenfranchised to something that was more of a general population approach?

Young: Well, there was. For example, for whatever impact it had, the Dellums Bill--it's too overwritten and too rich a mixture for any American reality--called for a national health

service, but it's clear in its various articles that it had a conception of community-based care, of primary care. It didn't make, as I recall, any address to the already disproportionate hyperspecialization, but there was that political vessel or vehicle for trying to breathe into it what you're saying. I don't get the feeling that as we went into the eighties there was a lot of talk about specialization, but I can, if you want, give you a paper I gave in '75, part of it is devoted to that, so I could argue I wrote on it. Would you want that?

Mullan: Sure.

Young: It's a short paper.

Mullan: Sure. Yes.

Young: I think I know exactly where it is.

Mullan: Good.

Young: This paper does talk about hyperspecialization, but, see, that was like challenging the market today. Even though by the '80s every one of America's medical schools were accepting family practice medicine residences, the resistance to that was very large. The state legislature had passed a law that there be a family practice program at the University of Illinois Medical

School. We don't like, in academe, law makers defining what goes in the curriculum.

Even though the University had to look to legislature for their budget, they couldn't get a family practice program going until the late eighties. They have one now. I mean, I think that's a battle won, but just as a very good metaphor for the resistance of academe, in particular to the development of primary care. And why do I single them out? Because they're the gatekeepers. They determined who got into medical school and who got out, and more to the point, what was the mental set of those students as they graduated, after four years of indoctrination, given the faculty's resistance to family practice training.

One of my first tasks at County Hospital was to fill an unfillable chair of family practice post. As chair of the Search Committee, I wooed and won Jorge Prieto. Does that mean anything?

Mullan: Oh yes. I met him. Yes.

Young: Well, Prieto's a saint. Jorge created a spectacular program. It has won all kinds of accolades. He, too, got some clinics built, and in his case, the community owned the clinic, even though the county had paid for it. The clinic board decided on fees or no fees.

[Begin Tape 1, Side B]

Young: Jorge required every one of his trainees to be bilingual. There was no fudging on that, because his major out-patient activity was in the Hispanic community. To support his program, I gave Jorge a ward. This was in contrast to the usual tension between and family practice training program.

Mullan: And that's a ward, not an award.

Young: Yes. Ward, meaning a forty-bed inpatient medical ward, and I had a lot of wards, so it's not as generous as it sounds. Nonetheless, it was unprecedented for an internal medicine department. It was a medicine ward, and the teachers, the attendings on the ward, were internists, there was no problem, Jorge was comfortable with that. The people who taught its people OB/GYN were gynecologists, but the point of my story is that I was very eager to foster the growth and development of that department, and that was a practical way, beyond recruiting him, which I had done.

There's a wonderful story which we both tell about after he agreed to become chair. He calls me up one night at ten, that was not a rare hour for me to be in place, and tells me he hates to tell me this, but he just can't bring himself to leave the barrio, he can't abandon his patients. So I had my toughest selling job. We talked until 2:30 in the morning, but I convinced him that this was the poor people's hospital, he can do more good training people here, etc. And he relented. I mean, that's Jorge. Leaving his patients had broken his heart, and so

he was going to break his agreement. I talked him back into it. Best thing I ever did for County.

Mullan: Let's jump if we could to the eighties. You left County in '81, and you have been essentially back in practice.

Young: Ever since.

Mullan: Ever since. Tell me what it was like to go back into practice now in the epoch of competitive medicine or whatever we call the eighties.

Young: Well, on one side it's been very good. I'm blessed with enormously good colleagues, younger, obviously, than I am. We get along extremely well. The practice is fun. We don't have many of the infinite number of problems that can afflict a practice--competitiveness, greed, what have you, laziness. We get along very well. So in a very narrow sense, it's an entirely enjoyable event.

Mullan: Are they all generalists?

Young: Yes. Yes. But each has a kind of, like me, flirtation with specialism. The guy next to me in age, who's maybe twelve years my junior, took a G.I. fellowship at University of Chicago, and for similar reasons drifted into general internal medicine--drifted, he never was a gastroenterologist, he just did it and

said, "Forget it." Then the one next to him trained at Reese. He had been signed on to a cardiology fellowship at Michigan, a very coveted post, and he in his mind wanted to do that, because that's what everybody in medicine residencies was told to do. My partner, we were just two of us at the time, had the chutzpa to talk him out of it. You don't do that as a rule. And he convinced him that general internal medicine was the wave of the future, it's the way to go, you'll like it better, blah, blah blah.

Anyhow, it's hard, because there's no way to know what general internal medicine is, on the basis of a medical residency in a hospital. It just ain't there. I mean, there's no overlap, all the things you do as a medical resident, while it gives you a lot of knowledge and certain skills, has very little to do with the real life of a practicing internist which is overwhelming with outpatients. Now a surgeon, I think, he's learning in the hospital what he's going to be doing. He's doing what he's going to do. The internist doesn't. But David, my partner, had very great powers of persuasion, and convinced this guy to come in.

Admittedly, the most recent acquisition, Claudia, merely thought about specialism and we just talked her out of it.

So you were asking, well, what was it like. Well, there's no question that the last five, six, seven years have been extremely turbulent. At a place like Chicago, which is fairly well penetrated, I love that Freudian phallic symbolism--

Mullan: Let's be clear. Managed care.

Young: Yes. Penetration of the market means that the younger doctors must take those kind of patients. The patients are fine, they're people like everybody else, but take them on the basis of the capitation and the variety of barriers and hoops and obstacles you must pass to try to give the patient care. The older two of us, I guess because we've been around so long, we don't have any patients like that. Our hours are filled with traditional people, fee-for-service patients. So I see what's going on by the experience of our two younger partners.

One of my partners is president of the IPA, the Independent Physicians Association at Reese, which is a 200-, 300-doctor group that negotiates contracts with managed care entities. He's not a businessman, he's an uncommonly skilled and intelligent physician, but IPA had gotten in big trouble because of the practices of the agencies it dealt with. The hospital gave the IPA no discounts for the hospital beds occupied, which they always do when dealing with a large group. The naive physician-run IPA was pretty much fair game. So they literally went bankrupt. That's been fixed now. But my partner guided them through that with all the headache that implies.

He's very interesting, because he's very astute, I'd like to think partially influenced by Claudia and me. Claudia and I are both active in Physicians for a National Health Program. She's the immediate past president. So we are constantly hammering him with why this is happening. I think we've got a single-payer shop at Hyde Park Associates in Medicine. But only two of us are active. He's leading that IPA and gets, at a megalevel, the full

impact of managed care ratcheting down of compensation and onerous bureaucratic controls.

Just to give you one that came up today. In the dollar distribution, the HMO was charging the IPA three dollars per month per doctor for reinsurance. That's the money you spend to protect against catastrophe. You know what I'm talking about? If you run into a really horrendo of a case, where there's a half-million-dollar bill, that's the way you pay for it. They learned that the HMO paid twenty-eight cents per physician per month for this insurance, and the IPA proposed to self-insure, that they would pay that. The insurance company actually didn't want to do it. They have every sense of power over the doctors, because they control the patient. This has a happy ending, at least in the short run, they agreed to let the IPA take that over. But $2.72 is a huge overpayment of the capitation. The managed care agencies y were just taking it "off the top" like a Mafia group. They didn't even self-insure and say, "It's going to cost us three dollars." They went out and bought twenty-eight cents a doctor a month insurance.

Mullan: And pocketed the rest.

Young: And took the rest. And when they asked for it they said no. Well, that's almost a minor league story, but it does show the way the game is played.

Mullan: Well, let me try to tease apart the issues of managed care and what it is doing to a general practice, and, secondly, what is happening with generalism in the current environment of which managed care is a big part. Let's talk about the first, if my distinction's clear. As a practitioner in the marketplace, where turbulence, turbulence about payment systems in which varieties of managed care are all over the place, you are able to maintain a fee-for-service, or indemnity practice? How does that work when there are patients who've had, who get--

Young: Swept up.

Mullan: --swept up in their employment or whatever?

Young: That's a whole chapter in its own right. One of the things that has aroused my rage, if it needed more arousing, is the fact that patients are indeed, arbitrarily, without recourse, forced into these narrow-choice HMOs. How this has expressed itself, is that no day goes by that I'm not counseling these former patients of mine in one of several ways. Some just come, and are paying me out of pocket because they are restricted to HMO services only. Sometimes they come out of loyalty to the great care I have given them, but more times than not, they tried the HMO and they couldn't hack the hassle.

Mullan: So they've got HMO insurance elsewhere, but they come to you.

Young: They start converting their HMO into a catastrophic insurance. I get hit by a car, or if I have to have a big surgery, or even a major procedure, I'll go back. Otherwise, I'm going to just pay cash for my care. If you think a minute, that is a huge subsidy to the HMO world, because they get paid monthly whether or not the patient comes.

I have a lot of patients like that. I spend a lot of my time coaching them on how to get what they need from their HMO when to call the medical director, what threats to make. I mean, the adversary nature of health care is one of the most serious burdens that the marketplace approach has put on the health care transaction. If you think a minute, the health care interaction must be in an environment of, at a minimum, trust, preferably affection, and maybe even love, and the mood must be, to the extent humanly possible, unthreatening, comforting, safe, all the admonitions about confidentiality, all that is the accumulated experience of the healers from the most ancient days.

This goddamn system comes in there, and, with a meat axe, proceeds to chop the hell out of that, and create an environment where patients are mistrustful, angry, fearing that it's to your advantage as the treating physician not to give them what they may need, that you gain when you withhold care.

I used to make a big joke, from the podium, or even in conversation, about how these idiots with the marketplace solutions work on a premise that is ridiculous. They work on the premise that we're a nation of health-care addicts, that if you remove barriers, economic barriers, American people, like kids in

a candy shop, will just demand and get everything in health services they can. I usually do my best to ridicule it by saying, "There is a situation where that occurs, that a busy doctor may see once in a lifetime where the patient really does demand care and does create an environment of need where there is none, and that's called hypochondriasis, which is a mental disorder, which occurs extremely rarely, and yet these policy workers, economists and others, are developing a whole system on the premise that we're a nation of hypochondriacs." I used to leave it at that point of feeling that intuitively people would say, "Of course."

I go on to say that, "Nobody likes health care. How can you like something where they're sticking needles in you and tubes down you, and you have your clothes off while the other guy has his on? It's just not a situation people like. People like health, and they'll accept health care with all of its anxiety producing and discomforts and risks, in hopes of bettering themselves." Now that's what I used to say.

Now, latterly, I have to say, "There is, however, a self-fulfilling prophecy. The HMO event, in the way it evolved, not the original Kaiser Permanente model, but where the marketplace has driven it, dominated by, for-profit, investor-owned entities, with managers whose eye is on the bottom line. We now have a new kind of p patient who does indeed demand this, who does think that you, no matter how nice you are or how much they may think of you, have a motivation to deny this consultation, this referral. That's a terrible, terrible development. It has seeds

of great destruction; it deprofessionalizes; it has the capacity to heighten cost; it certainly can lead to a degradation of the health standards of the public.

But I wander.

Mullan: No, I'd like to pursue that, but let me match it with the other question which is, this new environment with all of the factors that it's injected into the medical marketplace, and the doctor-patient relationship, also has put a premium on primary care and has made the primary care provider, physician, or non-physician, a key player, and has obviously stimulated the attention, producing more, and presumably better primary care providers. What's your view of that in this colossal irony that primary care finally comes of age at the same time that it's characterized as a gatekeeper?

Young: Yes. Well, I think--I'm looking for an analogy that fits. The one I'll give won't. But it reminds me of sort of the Judenrat, the Jews, who were selected by the Nazis to keep the rest of the Jews in order as they prepared to exterminate them--that's a harsh example, but it gets me where I want to go. By calling them gatekeepers, an ugly term in its own right, and under the guise of making them the managing physician, actually make them the denying physician in many instances, is a distortion. I guess this is a very important point to inject. With a total acceptance and enthusiasm for orderly practice of medicine, I think, much of the dilemma we find ourselves in is

because it's been a disorderly practice. Everything grew willy-nilly, doctors charged what they wanted, within certain modest limitations, did whatever they wanted, necessary, unnecessary, there are the uteruses that came out shouldn't have, etc.

I'm a great believer in outcomes research, protocol and I like collegiality and doctors as peers constantly monitoring themselves. Indeed I feel that an amalgam of guides is the only way to maximize the quality of practice. I concede that last little litany of correctives and guidance, educational measures, can be infused into a reasonable HMO situation and, yes, the primary care doc can grow and become more and more efficient under those influences, but that's almost utopian.

In the real world, fighting for those contracts, one of the everyday realities of HMO, is accepted in a way that I never thought Americans with a strong sense of individuality and penchant for choice would take lying down. Maybe eventually they won't, but at the moment there's no mass reaction. For example, 1,000 people in a given company are herded into HMO A, then HMO B offers twenty-seven cents a month off the premium. All of a sudden these people are in HMO B, which may have little or no overlap in terms of the doctors. That's a dangerous disruption, not to mention the psychological, emotional, physical discomfort it that imparts. It can happen not only repeatedly, but rather frequently. It's exactly as if these insured lives were now commodities to be moved around freely.

One of the things that obscures the evil I'm describing is that in a given year, 85 percent of the people really don't get

sick. They get colds or they need an influenza shot or whatever, so they're not big HMO users. The real issue is what's happening to that 15 percent of users, and there I think it's very bad. I'll always beware of HMO satisfactions, the report cards, what have you, that don't at least separate out, for separate assessment, the people who the HMO use over a certain threshold. If you survey the 85 percent of people who went their merry way, either wisely or unwisely, didn't use the HMO, you're only going to get satisfaction reported.

But I don't know how far I've gotten from your point.

Mullan: The paradox of the generalist being celebrated, even as the system goes south, as you described it, the system becomes abusive. How do you see that playing out?

Young: Well, it depends. See, I have a dangerous proclivity toward optimistic outcomes and therefore you should be cautious. My view is that the profession is very poorly positioned to be a rescue agent, the profession has been debauched over the years by enormous economic rewards. Physicians have had virtually no limitations on what they do and how they conduct themselves. This background hasn't been the proper school for virtue. I'm not absolutely sure that the profession, which is a major player, can pull its weight in the struggle for the reconstruction and rehabilitation of medicine.

I have more hope in the patient as an activist, because the medical event, the illness event, tends to take the extra player out.

So it's a funny kind of a playing field to get forces together, but here's my answer to your question. I think there will be a showdown, and I hope we win. Victory, to me means enactment of a national health insurance and also, it is necessary to out-law for-profit publicly held health systems. This necessary because prudent managers of these systems maximizing profits are just doing what they're supposed to do. When they do what they're supposed to do, they eventually subvert health care. That's my thesis. Clearly there is a remarkable quickening of public awareness and concern, enough to justify hope for a political solution.

A crucial number of doctors will not be suborned or frightened or just fatigued out of the battle, and we can restore a unity between doctors and patients as main players with other health workers. All that implies a much different mood from labor, which is now reevaluating what it's doing.

What am I saying? I'm saying that in the best of all worlds, I'd be very comfortable with the primary care physician being just that, the person who is basically responsible for a set of patients, does. The referrals and other decisions of import and is constantly coordinating and working with available research. That's what I try to do every day, and I think it's noble. To the extent that I succeed, I think I've had a good day.

If that happens, it won't merely be unpleasant. It won't be nice to be a doctor. It'll be awful to have MBAs and business executives and other variety of interlopers making your everyday professional life at least unhappy and possibly miserable. But I think there will be much more dire outcomes than that. I don't believe that the market model works to achieve the only justifiable goal of any health system: enhancing the health status of the public it serves. I think it will degrade that goal. t must avoid taking care of sick people. To the extent that it can, it will be successful.

Mullan: One final question. Twenty years from now, what will the role of the generalist be?

Young: Well, I think we're on a roll. I think that the lessons of this period, and even the HMO interlude, mean that the primary care physician, in a community-based later will be the key player. Also, I think we will have addressed the changing source and the nature of disease, the social factors, the ecology, the lifestyle patterns, as determinants of health. The therapeutic model will no longer be dominant.

Mullan: Good. Thank you.

Young: Was that awful?

Mullan: That was terrific.

Young: You're making fun of me.

Mullan: No.

Young: I'll give you the paper, though.

Mullan: Good. Thanks.

[End of interview]