

Fifty Years Since Graduation: Memories and Realities

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Eugene S. Farley, Jr. was born in Pennsylvania in 1927 and raised there. Following service in the U.S. Navy, he attended Swarthmore College from 1946 to 1950. After graduation from medical school, he interned at the Philadelphia General Hospital and received residency training in general practice at Denver General Hospital. Following two years' working in Arizona with the United States Public Health Service at the Navajo Tribal Reservation and an additional year of residency training in Vermont, he and his wife Linda, a 1955 graduate of the U. of R. School of Medicine and Dentistry, entered general practice in Trumansburg N.Y. After seven years of rural general practice, he enrolled at Johns Hopkins School of Hygiene and Public Health where he earned a M.P.H. degree, specializing in learning about programs in other countries that dealt with inadequate supplies and uneven distributions of physicians. He returned to the University of Rochester to start the country's third Family Medicine Program. Subsequently, he has served as Chairman of the Family Medicine Departments at the Universities of Colorado and Wisconsin Schools of Medicine. Now retired, he and his wife continue part time medical student teaching and are involved with social and political issues emphasizing the need for universal health care.

There have been tremendous changes in medical education, medical care and the medical care system in the 50 years since graduation from medical school. The following is a random potpourri of some incomplete, but hopefully reasonably accurate, memories, realities, and dreams relating to those years and the future. Tidbits from politics and every day events are included. Many relate to Linda's and my own experiences since they usually reflect some of the realities of the times.

1950-54

- The Class of 1954 contained the largest number of World War II veterans, which meant the students' average age was older.
- Medical school yearly tuition was \$600, with living expenses in the same range. We could usually earn that in the summer.
- Summers in the first two years were unscheduled. Dean George Whipple advised us to consider doing non-medical work during those summers since we would be involved in a medical career for the rest of our lives. Many worked at Eastman Kodak Laboratories, some worked in medical labs, and some did everything but medicine. I worked as a Seasonal Ranger Naturalist at Bryce Canyon National Park.
- The class was small – 69 people.
- Women students were few in numbers: 3 in our class.
- The emphasis was on cooperation, not competition. Classmates shared and worked together – we were reassured when Dean George Whipple said he expected all of us to pass. If a person was having problems he/she was called into the dean's office to see how they could help.

- Racial discrimination against large groups of Americans was institutionalized, severely limiting opportunities for non-Caucasian Americans – they were limited to no more than one or two per class.
- Garage architecture – The school, and therefore the rest of us, had pride that money was spent on education and equipment, not fancy walls, surroundings, or light fixtures.
- Strong Memorial and Rochester Municipal Hospitals shared facilities; both in the midst of open fields of what formerly had been a tree nursery.
- Professors John Romano and George Engel integrated psychiatry into all 4 years of our education, with Saturday morning lectures and strong emphasis in our clinical patient care rotations. George Engel strongly emphasized psychosomatic medicine and the importance of a bio-psycho-social approach to the understanding of health and illness in the care of our patients.
- Physiology - smoked drum kymographs, shellac and x-ray film for markers.
- Clinical rotations of 12 weeks each, patients often hospitalized for prolonged periods, allowing a student to get to know them and to follow the progress of their disease and its response to treatment.
- Many of our professors, such as William Bradford of Pediatrics and William McCann of Medicine, were active clinicians who made house calls and were excellent bedside teachers.
- Adrenalectomy was new and risky – adrenal corticosteroid use was limited and just coming into use.
- Classmate D.A. Henderson and others tried to get public health integrated into the curriculum.
- Little recognition of, or concern about, the need for truly informed patient consent.
- Parties in the medical school gym – that’s where I first met Linda (my wife).
- Professor John Romano developed an excellent two-year rotating internship that would provide a broader preparation for entering other specialty programs or practice.
- Most of our faculty advisors believed a career in General Practice was a dead end, since it was being replaced by the many subspecialties.
- Last big polio epidemic, porches on two wings of the hospital filled with patients in iron lungs –helping care for these patients paid for my senior year of medical school.

Personal experiences after graduation

1954-56

- Rotating Internship (which Professor Larry Young referred to as “vibrating internships”), at Philadelphia General Hospital, a historically great public teaching hospital.

On call every other night, \$55/month plus room and board.

This hospital was torn down in the 1970s with the advent of Medicare and Medicaid, supposedly reducing the need for public hospitals.

This internship was a tremendous experience - unfortunately, I learned a lot of acute medicine trying to save the lives of women who came in septic from botched abortion jobs. (Hopefully we will never return to that.)

- General Practice Residency, at Denver General Hospital

Rotation through various specialties, with the ability to follow patients and families over time, in the General Medical Clinic developed by Professor Fred Kern. This was my only experience with outpatient continuity care prior to entering the Indian Health Service. It served as a model for integrating continuity of care into the Family Medicine Program at Rochester 11 years later.

1956-58

- Exposure to community medicine and what is now called “community-oriented primary care” on the Navajo Indian Reservation.

This involved working with a community advisory committee, all of whom were Navajo, a full-time medical anthropologist, and Health Assistants. We served the entire population within an 800 square mile area in the central part of the Navajo Reservation.

I was involved with a research project to study outpatient treatment of tuberculosis, and provide full ambulatory primary care to the population in the study area. This experience made me realize all medical practices could be research practices, since doctors are proficient at collecting and organizing, analyzing, and responding to data in their daily practices. During its development, many of the concepts gained from this experience were integrated into the Family Medicine Program at the University of Rochester.

1958-59

- Another year of residency to catch up on inpatient care.

1959-66

- Most graduates started their own practices or joined small groups of like-minded physicians. Fee for service was the dominant method of payment. Insurance, when present, mostly covered in-patient care. Doctors still controlled the health/medical care of their patients and thereby the system. Large populations in America were underserved. Practice start-up costs were not excessive.
- Linda and I entered rural practice with hopes of being able to serve the population and develop a longitudinal study of the “evolution of health and disease in the population served”.
- House (9 rooms), 1200 square foot side wing for office, 3 acres and a barn – \$15,000; plus another \$5,000 to remodel the office and a \$2,000 loan for the down payment meant an \$18,000, fifteen year mortgage at 4.5% interest.
- Equipping the office cost \$5,000 for equipment for 3 examining rooms, a minor surgery room, laboratory, and “front office”. The salesperson at the surgical supply company brought all the equipment to Trumansburg, helped set it up and said we could pay it off whenever we could – no interest was charged.

- Office calls \$4.00, house calls \$5.00, hospital care \$5.00 – Blue Shield paid \$5.00/day for hospital care, even if you were there all day using all your medical knowledge while working on one patient with pulmonary edema and renal failure. It paid \$45 for the 10 minutes needed to brace a fractured clavicle, which I learned to do as an 18-year-old pharmacist mate in the navy.
- Welfare from one county paid \$2.50 for an office call; the other two counties served paid \$3.00. Many patients were not eligible for any assistance and could not afford these charges, particularly the elderly, most of who had extremely limited income.
- Much care provided by home visits.
- No house staff at hospital; practitioners took turns staying overnight in the hospital to cover emergencies.
- No emergency room staff; each physician responded on his/her own patients.
- No Emergency Medical Technicians – undertakers using their hearses provided ambulance services. If the patient died, the undertaker would usually get the funeral.
- No Intensive Care or Coronary Care Units. No electric paddles.
- The only reason to admit someone with a myocardial infarction was so that they could be anti-coagulated.
- Polio epidemics became a thing of the past thanks to mass polio vaccination of the population.
- Measles, mumps, and chicken pox epidemics were still predictable and sometimes severe. Measles vaccine came in during this time, and we then stopped seeing measles epidemics.
- An outstanding group of Public Health Nurses served the area.
- Strong community support systems – there were no strangers.
- Most patients with pneumonia, congestive failure, etc. were treated at home since few had health insurance.
- A one-day stay in the hospital cost \$17/day. Most expensive private room cost \$27/day. Most expensive private room at Strong Memorial Hospital cost \$50/day – and we wondered how anyone could afford such expenses.
- The pill.
- The sexual revolution.
- Caring for a big percentage of the local population made one very aware of epidemiological patterns, the evolution of health and disease in some of those you cared for, and the results of your interventions.
- Malpractice insurance \$70/year – even while delivering about 100 babies a year.

- My bag contained BP cuff, stethoscope, diagnostic set, bandages, commonly needed medications such as penicillin, and some other starter drugs, plus digoxin, adrenaline, morphine and Demerol, Compazine, atropine, sterile equipment for catheterizing, for performing a tracheotomy, and for starting and maintaining an IV.
- Had to “get the professor off my shoulder” when I began to realize individual emotional/psychological problems could not be separated from the family. People I greatly respected and admired had taught us one should never counsel more than one family member at a time. In reality, I had to learn a lot by the “seat of my pants”.
- In many places you still had to belong to the American Medical Association (AMA) and State Medical Society if you were to get hospital privileges.
- Medicare and Medicaid legislation passed but was resisted by the AMA and other conservative groups. It provided health care coverage for those individuals whom health insurance companies did not want because they could not pay the premiums or who had too many health problems for the companies to be able to make a profit.
- AMA fought hard against Medicare and Medicaid legislation. In the 1940s it had been against Blue Cross Blue Shield, group practices, and universal health care. (Over time it has changed little, except it finally recognizes that doctors who are employees of HMOs, large groups, or for-profit-insurers may need to unionize if they are not to be controlled by business managers whose concerns are profits for investors.) – November, 2003 addendum – AMA and other doctor groups supporting the Medicare “reform” act that will “allow Medicare to wither on the vine”.
- The combination of too many patients, too few doctors, too many older doctors dying, an inability to recruit anyone to practice in the area, and the medical education system was discouraging doctors from going into general practice, rural practice, or areas that were underserved.
- Once Medicare and Medicaid were fully in place, it was easier for patients to get care and for doctors to practice in areas of need since there were many fewer patients whose care could not be paid for. As a result, this significantly helped increase the average income of physicians.

1966-67

- Left practice to go to Johns Hopkins School of Hygiene and Public Health in order to find out how other nations with shortages and a maldistribution of physicians handled the problem. Stimulating exposure to people from all over the world and to new ways of looking at health, medicine, the population and systems of health care.

1967-1999

- In response to the increasingly urgent need for more primary care physicians, the University of Rochester School of Medicine and Dentistry became a leader in the development of primary care residency programs.
- I accepted the opportunity to direct the residency program in Family Medicine, the nation’s third, at Highland Hospital in Rochester. This program was largely due to the

efforts of Drs. Jacob Holler, Robert Haggerty, Robert Berg, John Romano, George Trombetta, Larry Young, Harry Kingsley, and the administrator of Highland Hospital, Allen Anderson. Organizing concepts for this program included what is now known as “community-oriented primary care” and “the practice as a laboratory”.

- Residency programs in Primary Care in Pediatrics and in Internal Medicine developed.
- Practice based research developed, led by Dartmouth Coop program. Rochester faculty and local clinicians played a significant role in the development of pediatric networks (PROS) and Family Medicine networks (North American Primary Care Research Group (NAPCRG)), and the Ambulatory Sentinel Practice Network (ASPN). Internal Medicine followed along with many state and regional practice-based research networks.
- Health Maintenance Organizations (HMOs) became the “wave of the future” with the hopes they would restrain rapidly rising health care costs, increase and improve preventive services and care, and allow more people to have health care services coverage.
- Medical schools around the country began to incorporate many of George Engel’s concepts of the bio-psycho-social determinants of health and disease into their first and second year curricula.
- Thanks to reports of commissions, sponsored by the AMA, AAGP, AAMC and others to study medical/health care manpower needs, more medical schools and hospitals began to recognize the need for well-trained primary care clinicians. This was reinforced when the state and federal governments began to put dollars into the residency education of such physicians.
- The number of medical schools and positions for those wanting to go into medicine increased dramatically. As a result, the number of graduates in all specialties, particularly primary care specialties, increased.
- Roe v. Wade and women’s choice.
- Nursing became increasingly professional, often with educational focus on advanced education, theory, research and administration, sometimes at the expense of traditional bedside nursing.
- The University of Rochester became a leader in providing new career opportunities for nurses, thanks to Loretta Ford and the Nurse Practitioner program. Emphasis is put on nursing aspects of care more than medical aspects. Sometimes the boundaries were and remain unclear.
- Physician Assistant programs developed based on the experiences of the military services, which had always trained a group of care providers who could work closely with doctors to increase the availability of care or to provide a specialized technical service.
- Increasing use of Medical Assistants and Nursing Assistants, often to fill gaps in care left by the more fully and technically trained.

- AMA became less suspicious of group practices; court decisions and case law prevented hospitals from denying staff membership to qualified physicians who were not members of the AMA.
- Civil Rights campaign and Martin Luther King awoke us all to the need to make America be for all Americans, not just European-Americans. Lyndon Johnson got Congress to pass Civil Rights legislation, voter rights legislation and other legislation to outlaw all government and institutional efforts to deny full protection of citizenship and the law to all Americans. Many conservative groups fought against this.
- Affirmative action in place – required all Americans to work together to overcome some of our past institutional and personal behavior that excluded large groups of Americans from opportunities for which they were highly qualified.
- More medical practices became integrated and schools, including University of Rochester, became more representative of the racial and cultural mix of Americans and our nation.
- Worldwide AIDS epidemic and increasing recognition of other new and deadly organisms.
- Universal Health Care Security became a national issue killed by the complexity of the one offered and the efforts of those groups which profit the most from the then present system.
- Drastic changes in the medical care system, increasing takeovers of the practices and systems by large corporations. More and more doctors throughout the country becoming employees of large for-profit health care corporations. Business managers and investor profits, more than quality of patient care, determined the direction of the system. Productivity was often the driving force.
- Increasing numbers of people with no health care insurance. 36+ million had none when changes were first proposed, now 44+ million are uninsured and the numbers are rising by about 1 million a year. The increase results from people being dropped from Medicaid, fewer businesses offering health care coverage, and individuals with lower wage jobs being less able to afford health care coverage.
- We are now at the point where the United States has the developed world's most expensive, complicated, administratively top-heavy, bureaucratic and rationed health care system that still leaves 44+ million people uncovered. We spend over \$5000/person/year which includes the 44+ million who are not covered. Germany has the second most expensive system and spends a little over \$2000/person/year and covers over 98% of the population. Canada has the third most expensive system and spends a little less per person than Germany does and covers 100% of the population. The individual and population health care outcomes of 11 industrialized nations are better than are those of the U.S.
- Changes in what we have to offer patients are tremendous. Immunizations for increasing numbers of infectious diseases. Small pox eliminated thanks to the leadership efforts of our classmate, D.A. Henderson. Things that were only dreamt of are now common:

coronary by-pass, heart, liver, and lung transplants, success in treating some malignancies. Antibiotics in increasing numbers along with increasing numbers of drug resistant organisms.

- Increased efforts to reduce or eliminate the 400,000 extra deaths each year associated with tobacco (nicotine) addiction. Increasingly, tobacco companies' efforts to deny the truth, and their outright lies, were being exposed.
- More people are accepting the reality that health care should be a right, not a privilege, that the ethics of making investor and corporate profits from denying health care are questionable, and that the per capita costs of health care in this country (almost twice as much as the next most expensive nation) mean we are paying more than enough for universal care, but not getting it. All of this money comes from the pocket of citizens and should be called "taxes" – "taxes" which assure high CEO salaries and investor profits and keep many of the neediest from getting health care coverage.
- Tremendous increase in administrative costs of giving care due to the need to deal with 1200+ different insurers (Medicaid and Medicare are considered insurance programs) and many different HMOs, all set-up to make sure they don't have to pay for any service or person not covered by their program or policies.

1999 to the present

- For 24 years after graduation I emphasized my role as a clinician. During the latter part of that time I combined this with program development and teaching. The last 18 years before my retirement saw my evolution from clinician to administrator/developer. As the latter responsibilities increased, inability to keep as clinically current as I would like led me to give up my clinical responsibilities – I wasn't worried about being a "half-assed" chairman, but I knew I did not want to become a "half-assed" doctor.

In retirement, Linda and I are working hard to help people understand the NEED, rationality and affordability of Universal Health care using the Canadian single payer system as a prototype. We are convinced a "caring, sharing, and just society" is a non-violent society, and universal health care is an important component of a just society.