G. Gayle Stephens *Festschrift*

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Gayle Stephens, MD, has long been, and remains today, a central figure in the emergence and evolution of family medicine as a specialty. He has participated in all phases of its development from general practice and has provided thoughtful guidance connecting us to the past and charting alternatives into our future.

On this occasion of the unveiling of a new format for *Family Medicine,* it is most appropriate that we call attention to and honor the many contributions Gayle has made to our discipline over the years, for his writings are seamless in time, drawing from history, and always looking to the future.

Born in 1928 in Ashburn, MO, Gayle spent his early years there. After college he attended the University of Missouri School of Medicine and graduated from Northwestern University Medical School with distinction in 1952. After completing a rotating internship at Wesley Hospital in Wichita, KS, in 1953, he entered general practice in Wichita.

During his early practice years, Gayle became part of a national debate over the future of the generalist in American medicine. Three major reports in 1966 were instrumental in propelling our discipline toward specialty status: the Folsom Report, the Millis Report, and the Willard Report. Though varying in details, all called for the training of more generalist physicians. The Willard Report called them family physicians and proposed the establishment of a certifying Board in Family Practice. These reports and developments over the first 2 decades of our new specialty are well described in a chapter by Gayle titled "Developmental Assessment of Family Practice: An Insider's View" that appeared in a 1987 book, *Family Medicine: The Maturing of a Discipline*, edited by William Doherty and colleagues.[1]

In 1967, 2 years before family practice was approved as the 20th specialty in American medicine, Gayle was asked by Wesley Medical Center to transform the existing general practice residency to family practice. He moved his practice there and was followed by 1,000 of his patients during the first year of operation.[2] The new family practice residency was one of the leading programs in the country. It was one of the seven programs that I visited in 1969 when I took on the same task at Sonoma County Hospital in Santa Rosa, CA. I will always remember Gayle's cordial and helpful advice, his thoughtful consideration of ways forward, as well as his emphasis on the value of the Medical Center's library. He was well known to the librarians, and the library was a major resource for him.

Gayle soon gravitated to teaching and leadership positions, both locally and nationally. He became active in many ways beyond running the new residency, including chairing the Education Committee of the Kansas Academy of Family Physicians, serving as a consultant to the Residency Assistance Program and the Residency Review Committee for Family Practice, as a reviewer of federal training grants, and as president of the Society of Teachers of Family Medicine (STFM) from 1973 to 1975. He was the editor of *Continuing Education for the Family Physician* from 1977 to 1986.

After 5 years leading the Wesley residency to its strong position as a pioneering program, Gayle accepted a position in 1973 as the founding dean of the University of Alabama's new School of Primary Medical Care at Huntsville. With that School's programs up and running, Gayle moved to Birmingham 4 years later to chair the University of Alabama's Department of Family Practice. Retiring in 1988 from full-time employment, he has remained active as a professor emeritus of family practice, including organizing ongoing teaching programs in physical diagnosis for optometry students and serving as a locum tenens for his brother Charles in rural Kansas.

Over the years, Gayle has been honored by many organizations. Within family medicine, these include the American Academy of Family Physicians' Thomas Johnson Award for Excellence in Family Practice Education (1975), STFM's Certificate of Excellence (1980), the W. Victor Johnson Oration Award by

From the University of Washington School of Medicine (Professor Emeritus of Family Medicine).

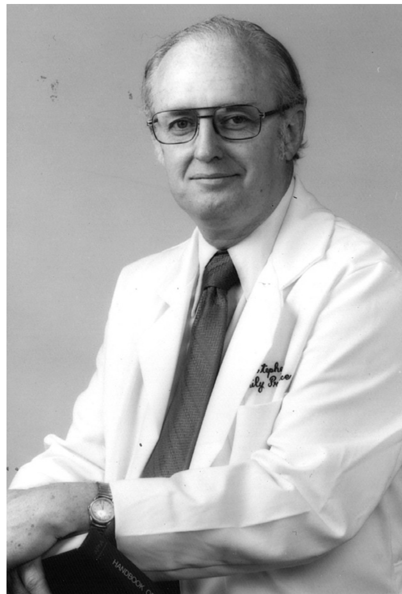
the College of Family Physicians of Canada (1992), the John G. Walsh Founder's Award (1996), and STFM's Marian Bishop Award (2005). In 2006, Gayle was elected to the Institute of Medicine of the National Academies of Science.

Selected Excerpts From His Bibliography

Gayle's bibliography over the last 50 years has been extensive, and it is difficult within space constraints here to do justice to the breadth, depth, and quality of his writings. I will take a chronological approach and attempt to focus on several recurrent themes of his work. This gives us an opportunity to see how he has reacted to the many changes in family practice and the health care system over these years and reveals how his own thinking has matured.

The Physician as Healer (1965)
Not surprisingly, this subject drew Gayle's interest in his first solo refereed publication. This excellent article drew attention to the potential loss of the healing touch as the emphasis on reductionistic scientific medicine gathered steam. While acknowledging the importance of clinical practice being grounded on science, he offered these cautionary observations:

> One of the paradoxes of our time is that the healing relationship seems most in jeopardy at a time when we need it most. There are many forces which threaten to depersonalize the meeting of a doctor and patient . . .. A preoccupation with disease instead of a person is detrimental to good medicine. . . . Health is not a commodity that can be purchased in any quantity as long as one has the money. One can buy the mechanical appurtenances of healing but one cannot buy that essential ingredient—a physician who really cares about the patient.[3]



G. Gayle Stephens, MD, during his tenure as chair of the Family Practice Department at the University of Alabama, Birmingham, from 1977 to 1982.

Teaching and Learning of Clinical Wisdom (1974)
Gayle's article on this subject in the inaugural issue of *The Journal of Family Practice* in May 1974 was to become typical of his writing—groundbreaking in its reach and originality. Based on an assumption that clinical competence includes a dimension beyond technical considerations, he described the various ways in which this is so, outlined the component behaviors of clinical wisdom, and set out educational objectives for teaching them. Here are some excerpts from this timeless article:

> Every clinical diagnosis, except the most trivial and transient, should include an appropriate assessment of the patient's personality . . . The wise physician knows that it is not enough to determine what condition the patient has, but also what patient has the condition. Accurate personality assessment has relevance for all aspects of the clinical situation and enables the physician to make a number of informed decisions about management and to predict important characteristics of the developing doctor-patient relationship. . . . As in marriage, the ongoing clinical relationship operates under the terms of an informal 'contract' that is often more powerful than the formal one. Clinical competence is more often at the mercy of the strictures of the informal contract than the fund of biomedical information the physician possesses. One can only guess at how often diagnoses are delayed, unnecessary and risky tests are ordered and inappropriate treatment prescribed because objectivity is subverted by unrecognized personality factors.[4]

Reform in the United States (1976)
Here Gayle explores the history of reform in this country in an effort to better understand the rise of family practice. As he wrote at the time:

> How is one to understand the development of the family practice education movement in the United States in the latter half of the twentieth century? The time is over when it could be dismissed as trivial or evanescent. Too much has happened in the last decade for that. Legitimate questions remain, however, about the significance of the movement, its present and future growth, and its ultimate place in American medicine.... Beginning about 1890, historians have identified several themes of reform in the United States which have been expressed culturally, politically, and socially. Each of these themes, agrarianism, bureaucratization of the professions, and utopianism, has influenced medicine and medical education—first at the turn of the century in the activities of the AMA in promoting public health and in establishing the

> natural sciences as a basis for medical education and practice. Since the end of World War II, additional reform themes have become visible which are also influencing medicine. Among these are humanism, consumerism, and the women's movement. It is [my] thesis that the present vitality and future development of family practice as a discipline is more dependent on its capacity and willingness to be identified with these expressions of reform than on its negotiations and compromises within the medical education establishment.[5]

The Physician as a Moral Agent (1979)

After delving into the history of moral philosophy and ethics, Gayle describes four aspects of medical practice that bear on this subject: (1) the fate of altruism, (2) the style of practice, (3) individual and group morality, and (4) the uses of counseling and psychotherapy. With regard to altruism, for example, he notes that public service is one of the main foundations of professionalism. Further:

> If physicians lose the compulsion for public service, they will also lose the protection and prerogatives for self-discipline and professional autonomy that the medical profession has enjoyed for centuries. There is no doubt that these have already been seriously eroded, but the way to repair the damage is by convincing the public that physicians intend to be responsible for the public's well-being, and will use their power and influence to protect the weak and the sick who are at the bottom of the ladder of privilege . . . Physicians need to keep in touch with their own tradition and with public welfare if they are to be considered moral by the society that sponsors them, and from which they take their strength and privilege.[6]

Family Medicine as Counter Culture (1979)

In a talk about the future of family practice presented at the 1979 Annual Spring Conference of the Society of Teachers of Family Medicine in Denver, Gayle examined our roots and the extent to which it was facilitated by various reform initiatives of the 1960s. He had this to say:

> I have sometimes thought that our cumulative effect on the body politic of medicine has been conservative more than liberal or radical. In many ways, by our success, we have 'taken the heat off' the medical profession from the public; therefore, the status quo is being preserved. That is conservative. More radical solutions to perceived problems will not be imposed as long as the public thinks that something is being done.

He went on to point out that the rise of family medicine drew from agrarianism in its commitment to rural practice, from utopianism in its commitment to serving the underserved, from humanism in its practice of personal medicine without subjugation to machines, and to consumerism by its requirements for recertification quality assurance, patient education, and patient advocacy. But he also concluded that however much the new specialty owed its start to a reform environment, that it soon abandoned much of that energy in its efforts to join the medical establishment.

Gayle observed that the reforms of the 1960s did not resolve the country's health care problems:

> The doctor shortage was short-lived, but the maldistributions remain. Rural communities are medically underserved, and the numbers of people who lack access to ordinary medical care have increased. The industrialization of medicine has further attenuated the personal relationships between physicians and patients…. There is still no reliable, stable 'front door' to the medical care system staffed by quarterbacks, captains or senior partners.

He concluded that family practice could have had much more impact on improving the health care system than it had:

> We have expended our energy on professional legitimation and enfranchisement rather than reform.

He called on our discipline:

> We need to perpetuate the reform ethos, to expand our numbers, to join with other primary care physicians and other specialties in working for some sort of national health program that will give access to everybody, regardless of ability to pay . . . My hope is that we can find leaders who are willing to rethink the priorities of medical education on the basis of the medical needs of the public rather than on the basis of preserving the professional self-interest of organized medicine.[7]

The Intellectual Basis of Family Practice (1982)

This book was published in 1982 and focused broadly on the knowledge base of family medicine, roles of the family physician, and future directions for the specialty. In his Foreward to the book, Ian McWhinney, MD, Professor and Chair of Family Medicine at the University of Western Ontario, had this to say:

> One has only to read these pages to realize that they are written by a physician who has not only thought deeply, but also

> felt deeply about life and medicine . . . . To read them is to see unfolded a coherent philosophy of medicine, a philosophy which includes technology, but places it in its correct perspective as servant, not master.[8]

Gayle noted that none of the specialties in medicine were established on epistemological grounds but instead by virtue of political, economic, or technological factors (eg, pediatrics by age of patients and social forces, otolaryngology by parts of the body, and radiology by connection to machines). He further noted that:

> All efforts to define family practice or the family physician in terms of technical procedures the physician may or may not perform will fail if approached as a rational problem of knowledge. These are problems of political relationships among professional societies within organized medicine and have more to do with hospitals, lawyers, and insurance companies than with knowledge.

Gayle saw patient management as the *sine qua non* of the family physician's role, knowing patients by name and carrying on therapeutic relationships with relatively large numbers of unselected patients with unselected conditions over time. As he observed:

> This is what we should be teaching and learning and practicing. Everything else is secondary.

But he didn't stop there. He also challenged us to deal effectively with other less obvious situations, such as these:

- Complaints that are obscure, vague, or undifferentiated
- Complaints that seem out of proportion to physical or laboratory findings
- Complaints that are unusual, bizarre, non-physiologic, or non-anatomical
- Complaints that result from life change, conflict, or stress
- Conditions that require moral or ethical decisions[9]

Gatekeeper Role (1989)
As family medicine and primary care became immersed in the managed care movement in the late 1980s, Gayle was one of the first among us to voice serious concerns about its impact on the doctor-patient relationship. In a 1989 debate on the issue in *The Journal of Family Practice,* he cautioned:

> My experience with contracted gatekeeping is that it is an untenable and hopelessly conflicted role that undermines the voluntarism and earned trust which lie at the heart of the family physician's effectiveness. By introducing elements of compulsion and control into the physician-patient relationship, gatekeeping transforms an intimate, covenantal relationship into a hard-edged contract between strangers—a bad exchange under any circumstances. Gatekeeping involves family physicians in structures of power, secrecy, and risk that are foreign to their traditions and ideals and reduces their role to that of a corporate watchdog. This role is so untenable that I predict it will be eliminated in future versions of managed care.[10]

This insight into the potential perils of gatekeeper roles was prescient, as the public came to reject the idea of any barriers to direct access to specialist care. The more restrictive HMOs soon gave way to insurers' new products of PPOs and PSOs, which removed gatekeeper barriers to referral to specialists.[11] Unfortunately, family medicine and primary care were caught up in the backlash against managed care.

Family Practice in the 1980s: A Second Decade of Essays (1990)
Many of Gayle's essays were brought together and published by the STFM Foundation in 1990 as the book *Family Practice in the 1980s: A Second Decade of Essays*. This includes essays on varied subjects ranging from reflections on family practice in a market economy to clinical and semi-clinical subjects and a number of editorials written while editing *Continuing Education for the Family Physician*. This is a must read for all of us in family medicine and reflects the remarkable sweep of Gayle's thinking over the years. Here is just one sample of the nuggets that fill this book, drawn from a talk, Reflections of a Post-Flexnerian Physician, presented to the Kaiser Family Foundation on the Task of Medicine in 1987:

> If war is too important to be left to generals, health is surely too important to be left to an impersonal professionalism that is bound to become coercive as it becomes more authoritarian. If the 20th century has learned anything about science, it surely is that science is not socially, politically, or morally neutral. The biological sciences, no less than physics and engineering, must be kept under civilian control. Such control is an issue in every physician-patient encounter. The pure science of medical knowledge must be tempered by other forms of human knowing, and for its own good, should always be subject to judgment within a larger frame of reference than itself.[12]

After Professionalization, What? (1991)

Early on, Gayle perceived the hazard of family medicine, in an effort to get along in the mainstream of medical education and practice, placing its priorities on fitting into the medical establishment by professionalizing general practice. As he said in 1991:

> Family practice grabbed the rings of reform and professionalization at a historically propitious moment and swung high and exhilaratingly for a while; now we are overstretched and in danger of losing our grip on reform in favor of an increasingly scary ride on the not-so-merry go-round of professionalization. In this respect we are recapitulating the experience of the medical profession as a whole, which throughout its history in the United States seems to have preferred professionalization to reform . . . . We all have a tremendous stake in seeing that every citizen is included justly. This is not likely to happen if physicians are more preoccupied with defending the profession and their own specialty's turf than working for fairness and appropriateness of medical care.[13]

Family Doctors as Agents of Political and Social Change (2000)

At the Keystone III conference in Colorado in 2000, Gayle continued his exploration of the origins of family medicine and the unfinished business of health care reform. In his paper on Family Doctors as Agents of Political and Social Change, he observed:

> Among the lessons that ought to have been learned during the last 30 years is that the 'natural' evolution of change is not necessarily in the public interest; that the *bête noir* of change is not necessarily 'socialized medicine' as the AMA tirelessly warned us for decades—compared to the draconian intrusions of industrialized medicine on free choice and privacy; and that organized medicine, hospitals, and medical schools are not dependable fountains of wisdom and leadership in the midst of change. Our 'expert' institutions and organizations have exposed themselves to be bastions of resistance, self-interest, and exploiters of the public purse. More than anything else they resemble the medieval clergy in maintaining their death-grip on privilege, power, and self-aggrandizement.

Gayle called us to task for our failures as reformers:

> On balance, I judge that we have squandered some public credibility in our evolution despite our success in having created a specialty. We probably confused the public early on when we changed our name from General Practice to Family Practice, and we confused ourselves in drawing finer distinctions with the addition of Family Medicine, Community Medicine and Primary Care. We all know the reasons for these changes, but they held no interest for the public, conveyed no weight of meaning, and sometimes allowed us to mistake the cart for the horse . . . . We took a hit to our public credibility when we were suckered into 'gatekeeping' by managed care organizations. We ought to have nurtured our main asset better and demanded from our educational settings the permissions and wherewithal to prepare students and residents for full service practice in communities of need.[14]

Remembering 40 Years, Plus or Minus (2010)

In an invited address to the leadership of the American Board of Family Medicine in 2010, Gayle was disappointed by the decline of family medicine and primary care after its surge in the l970s and 1980s. As he said at the time:

> The task of reinvigorating family medicine feels very much like the same task that was faced in the 1960s. And our strategies seem very similar; ie, to improve family doctors through education, redesign the system of medical care in which they work, and improve the quality and scope of services. The Future of Family Medicine Project is a great deal more sophisticated than the Willard Report, but the stated goal—'to . . . transform and renew the discipline of family medicine to meet the needs of patients in a changing health care environment'[15]—is familiar, developmental, and congruent . . . . Family physicians and their professional organizations have usually not supported the reforms in medical care that would facilitate their goals and favor their best interests. . . . The centerpiece of family practice is the durable clinical relationship and listening is its method. Whatever we can do to preserve and enhance this exchange is good.[2]

Coda

When I first talked to Gayle after *Family Medicine* Editor John Saultz, MD, had agreed that this Festschrift on Gayle's body of work would be an essential part of *Family Medicine's* "new look," he was pleased and honored that we should do this but also wanted me to "be critical." So here I will try to do so, difficult as it is.

Gayle has never been one to be overly prescriptive. In his *Family Medicine as Counter Culture* talk, he demurred in this way:

> I do not present these ideas in a pejorative or derogatory way. I am attempting to describe rather than judge.[7]

The only criticism I have is to wish that Gayle had been more prescriptive, by holding us and our organizations to even closer account for our abandonment of reform and by being more outspoken about our organizations' conflicts of interest. Our discipline could have been more effective in bringing forward recommendations to address the increasingly urgent need for a system of universal access, but instead we have chosen not to rock the boat. Together with the rest of organized medicine, we have been subsumed without resistance by the medical marketplace.

The last 4 decades have witnessed an explosion of health care costs that have priced health care beyond the reach of much of our population. We have a cruel and inequitable system with tens of millions of uninsured and underinsured. This will continue even after the enactment of health care 'reform' through this year's Patient Protection and Affordable Care Act (PPACA). Crafted as it was by corporate interests, their lobbyists and willing politicians, this 'reform' law will fall far short of fixing the nation's access, cost, equity, and quality problems in our largely for-profit, investor-owned medical industrial complex.

With the exception of some individuals within our ranks and a few health care organizations (eg, Physicians for a National Health Program, Physicians for Social Responsibility), medicine and family medicine have abdicated leadership roles toward real health care reform. We have only to look at some of our organizations to make this point. The Academy's task force on health policy never took on the issue of asking whether we should continue with our mostly for-profit, multi-payer private financing system with 1,300 insurers or consider a not-for-profit single payer system coupled with a private delivery system. Almost all of our medical organizations have been in bed for decades with the drug industry, to the point that they depend on such income for many of their activities. How could we expect them to advocate for patients' interests in having the government negotiate drug prices, as the VA does so effectively, or to allow importation of prescription drugs from foreign countries? It is ironic that the Center for the History of Family Medicine, a project of the AAFP Foundation which now houses all of Gayle's collected papers, is dependent on a long list of corporate donors, including these:[16] Pinnacle Level: PhRMA and 11 drug companies and Grand Patron Level: 15 corporations, mostly drug companies.

So we in family medicine and in our medical profession are more complicit with today's problems than reformers. Our patients, neighbors, and families are confronted with increasing hardships in gaining access to affordable care, and our market-based system continues on without much resistance or leadership from our profession.

But a leading light in the story of family medicine over the last 40 years is Gayle's timeless voice. He has been, and remains, by far the most original, thoughtful, and eloquent voice in our field and among the few who best represents the moral conscience of the entire medical profession. His wide-ranging intellect connects us with history, gives context for where we are now, and envisions alternative futures for our specialty, our profession, and society. Truly a renaissance man among us.

Thank you, Gayle, for your scholarship, profound insights, and gentle guidance over the years; for your dedication to the intellectual and moral obligations of our discipline and of medicine; for asking us to look beyond ourselves and think over the horizon; and for being you!

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