ANNALS OF FAMILY MEDICINE

Online Supplementary Material

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Supplemental Oral History: John P. Geyman, MD

Finding a Career in Medicine

I went into the Navy not knowing what I wanted to do. I knew I wasn't going to be long term in the Navy, but it was a good 3 years with a lot of responsibility early on. My dad gave me a book by one of his anatomy professors, Logan Clendenig, and I read his book at sea and I liked it. It intrigued me.[1] I wasn't sure what I was going to do. I went back to Berkeley and did a year and a half of pre-med. I entered UC-San Francisco in 1956. In my personal statement, I said I wanted to be a family physician in a small town and be part of a community. Interesting. I never changed my mind. I wanted to be a small-town generalist. What I wanted to do was something that counts.

I was 1 of 7 in our class of 84 who went into general practice. I liked everything in medical school. The California Academy of General Practice had a summer preceptorship, and I took 2 of those. I was with Bill Reynolds up in Dunsmuir, and I thought his practice was great. He worked hard, and he was the center of the system. I did a preceptorship in Santa Rosa with an older physician who had a different style of practice. That was also a good experience. But we were encouraged not to do general practice. The culture of San Francisco was pretty elite. The jargon of your teachers was "the local physician from up country." But I still thought that was where the action was.

It was 1960 and I looked around for a good rotating internship and decided on LA County. There were 3,500 beds, second biggest hospital in the country, 160 rotating interns, and I had a great experience there. Then I wanted to prepare myself well for rural practice. There were 8 or 10 pretty darn good general practice residencies in the country, and 1 of them was in Santa Rosa. It was a program that had started in about 1950 and had 5 residents a year for 2 years. We had a full-time director who was mostly an administrator and no full-time faculty. All the consultants in town were the teachers, and they had great community participation. I think I ended up with excellent training in most areas. It was weak in preventive medicine and behavioral science, but it was really strong in biomedicine. It was strong in anesthesia, which I ended up doing a lot of in practice.

Practice

So I finished my residency in '63, and my wife, Gene, and I tripped north and looked things over. The first place we went is where we ended up, Mt Shasta. We stopped to see the doctor who I had preceptored with in Dunsmuir as a medical student. He mentioned a possibility at Mt Shasta, 8 miles north. There were 3 doctors, and 1 of them was dying of a glioblastoma multiforme. I bought his practice for $3,500 from his wife. I started practice a week later. All I got for it was a

bunch of 3 × 5 cards with up to 5 years of patient information on one side, even including whether or not they had paid for a procedure.

Solo practice in a little office downtown, and I started from scratch. A sense of being needed is a big deal. We went to where we thought we were needed. It was also a place where you could be who you think you are or who you want to become.We had a 28-bed hospital in town, and there were 3 other communities within a radius of 12 miles that used the hospital. We served 20,000 people in the southern part of Siskiyou County. There were working folks, farmers, loggers, railroad, small-business people, and all that. There were 8 of us. I think we had a really good medical community. They'd all done residency training, kind of putting it together like I did. We worked closely together in the hospital, we all did obstetrics, we all did C-sections, we all did trauma care, we all covered the emergency room at the hospital, and 3 of us did anesthesia. Only 2 out of the 8 of us ever wanted to develop a group coverage of any kind. It never happened because of the rugged individualism of mountain doctors. I threw myself into it. I loved it. I worked most of the time.

I started to get involved with systems things. During that time, I started a coronary care unit [CCU], and for a little while, it was the smallest hospital in the country with a CCU. We set up a 2-bed unit and got telemetry going with Sacramento, 300 miles away, and trained the nurses as volunteers to be CCU nurses. When I left, I analyzed our stats, and we had an 8% mortality in our patients when the national average was 12% to14%. We did pretty well.[2] Another big problem was that we didn't have an ambulance system, so we got a committee started. Each of the 4 towns were used to competing against each other and there wasn't a system. It seemed to me there should be a system with good ambulances, radio communication, and well-trained people. Didn't happen while I was there but did 2 or 3 years after I left.

I had this 18-year old woman come for in for a prenatal visit and her eyes were a little blue. Oh, osteogenesis imperfecta. I had heard about that, but what's different if you're pregnant? Here we are, 65 miles from the referral center, and I called an OB consultant down there and he didn't know. I called a classmate who was an OB fellow at UC-San Francisco, terrific guy, and he sent me some journal articles. We didn't have Index Medicus, we didn't have a computer. So I went down to San Francisco—300 miles—and a spent a day and a half in the library because I wanted to find out about prenatal care, about delivery, about the kid. I read, took notes, came back, and got a second consult at UC-SF after that. So I learned a lot, finished my literature search, did a case report, and got it published in *California Medicine*.[3] The way I've learned to write is by reading other writing that I like. So I looked at a bunch of case reports and saw how you do a case report in a pretty good journal. I just started by doing and by reading articles, and I still do that now. I learned how to write just by reading good writing. I did several case reports in practice.

I thrived on the challenge of rural practice and figured I would do it for 30 more years. I was working long hours, probably much too long. I was starting to feel the stress of a very large practice and doing other things on the side in medicine in the community, and I found myself going in later to the office in the morning. I would see 30 patients a day, 40 was a fairly hard day, and that included the hospital. It was not really the way to do it, but it's how we did it.

Beginning Family Medicine Education

In 1969, I got a call at my office at 3:30 in the middle of a busy afternoon from Ed Neal, who trained a year after me at Santa Rosa, practiced in Healdsburg, and was on the board of directors of a regional medical program grant. He said they had a search committee for the director, who would establish a family medicine residency converted from the GP program at Santa Rosa, and would I be interested in being a candidate. I liked practice a lot, but it was an uncontrolled practice, I was slow getting help; in retrospect, I wouldn't have been able to practice at that velocity much longer. If I'd have stayed there, I would have wanted to break out of the solo practice mold and recruit a partner and develop a group. There were no groups in that county.

So it caught me at a time when I hadn't thought about what I would do. I did go down and look at the program at Santa Rosa, and 3 months later we went there. The kids were still young. Gene has always been very adaptable and supportive, having moved many times when she was a child. She was raised in the city. In a way, we did not say goodbye. A lot of our roots and connectedness to a community go back to the Mt Shasta years. Our kids were in their early school years when we were there. In later life, if they were dating a girl or maybe getting married, they'd trip back to Mt Shasta.

I took the job. I was the only full-time faculty member. We had 10 residents, and I had to do all the administrative stuff. I wrote up the application for residency and got it approved. It was a very difficult first year for us because, to be candid, it was a big letdown from the strokes of being in practice. I knew who I was when I was in practice. It was pretty tough—all of a sudden I was devising a curriculum, working with people, with residents who are complaining about their call schedules. It was kind of lonely being the only full-time person.

Gene and I took time—2 or 3 weeks—to travel to see 8 or 9 places where there were residency programs, including Miami, Rochester, McMaster in Canada, South Carolina, Oklahoma, and Wichita, Kansas. There were only a small group of residency programs. Each place was different, and although the curriculum might have the same rotations, they were all totally different. Everyone felt like a pioneer and it was exciting. It was a small fraternity, a network, and you would know about the other programs and there was a lot of sharing.

There was this blank slate and 2 pages of Essentials for Family Practice, which would determine how the new residency programs would be accredited. We knew it was going to be a 3-year residency and that we were going to train people to do comprehensive care with more emphasis on prevention and behavioral science. There were many challenges in developing those early residencies. How do you teach common problems and make them exciting? What kind of conferences were needed? How do you establish teaching practices that emulate the principles of continuity, comprehensive care, and a screening and prevention program? How do you go about modifying the medical record using the problem-oriented record and developing a functional system in a family practice center. We got the program accredited as a 3-year family practice residency program. We recruited a first-year class. We planned and built a sizable family practice center. We did get it done, but it was a thrash.

But I didn't have my own practice anymore. The residents were demanding. All the administrative work was new to me. Funding was a problem, and I was writing grants, an activity that was new for me. I didn't have any colleagues. They were out in practice doing what I used to do. I found this all a kind of identity crisis.

I was trying to educate myself about family medicine, so for 8 months I read everything I could find about family practice, and there wasn't very much. I stuck myself in our house in Santa Rosa, and at night and weekends I wrote my first book (*The Modern Family Doctor and Changing Medical Practice*). I see writing a book as a learning experience. There is a whole bunch of information I wanted to pull together. I want to learn about this area, and there's nothing in the literature about it. What is this new thing, family medicine? What's the curriculum, how do you organize it, how do you fund it, how do you teach behavioral science, how do you recruit residents? It was not a very good book, but it was the first one about family practice at the time, and it was published. I contacted different publishers and got 4 or 5 rejections, but Appleton [Appleton-Century-Crofts] published the book. I guess that was my way of dealing with my identity crisis.[4]

It was 1971, and I began to realize that starting residency programs in community hospitals would not be enough. It occurred to me pretty soon that you really have to get into the medical schools. They have student programs, residency programs, a network of affiliated programs, and a research program. I already had an appointment with the University of California-San Francisco at

that point, but I felt they weren't going to do a lot for a long time, so 2 years later we moved to Salt Lake City, where I was chair of the new Division of Family Practice at the University of Utah.

The Literature of Record

In 1972 I started to look where our journals were. *GP* (which later became *American Family Physician*) was the monthly journal of the American Academy of General Practice and was all CME and review articles; it didn't publish any original research. My feeling always was that if you're going to be an academic discipline, you need journals to report original work, to define what the content of that discipline is, and to report the outcomes of your studies. The *Journal of the Royal College of General Practitioners* was a pretty good journal and was sponsored and subsidized by the Royal College, but there was no counterpart in the United States. There was no money or interest in sponsorship of an academic journal at that time.

If you see a need, it seems to me, you should pursue the need. So I got together a group of people, and we had a meeting in the fall of '72, kind of an organizational meeting. It was pretty much the people who ended up on the first editorial board. I just wrote them and called them and said, "Can you come? We're thinking of starting a journal." Everybody came, including David Stires, who had published my book at Appleton, whose dad was a country doctor in Ohio. We might have thought of the name American Journal of Family Practice, but *The Journal of Family Practice (JFP)* seemed like the logical name to me and the others. We had a good meeting and said, "Yeah, we think we can do this."

About halfway through '73, we had enough material for the first issue. We were only quarterly, and we had to have enough material for 2 and then 3 issues. We didn't advertise much, we just started it and sent it out We had a geographically diverse editorial board, but it was a new thing for people to write in our own journal. It was a fledgling effort, but it took time. [The original editorial board and contents of the first issue are listed in the Supplemental Oral History, Tables 1 and 2, at the end of this account.]

It's a tremendous struggle for a journal to try to do what *JFP* did, and to have its entire funding paid by pharmaceutical advertising. We were a controlled circulation journal, that is how we got our advertising. Our first few issues had virtually no ads and didn't make any money for the publisher, but it did after a while. Generally, organizational dues support journals. We didn't have that opportunity. I remember every year we'd have meetings, and budgets were always a big deal. The cost of postage was going up, the cost of paper was going up. putting out 65,000 copies is big business.

With a controlled-circulation journal (a journal that one does not subscribe to but is sent off a mailing list), there is always the challenge of editorial independence. For a few years, the ads came, and we still had full editorial independence. If we wanted to start a new section of the journal, we just did. The editorial board talked among ourselves, and if we wanted a feature, for example, on the health care system, we did it. During the 17 years I was editor of *JFP,* Appleton was bought 5 times. Each time the new publisher would look at the bottom line and want to know how they could make more money. Tension between the publisher and the editorial board was a constant problem.

The early manuscripts were pretty rough compared with later years, and they were few. We didn't have a huge volume of manuscripts, and we tried to work with them and make them better. I had a secretary half-time for the journal, and we developed our paper and filing systems. When we moved to Seattle, we had 2 people in the journal office, both about 70% time. One was a senior editorial assistant who did typing and filing, author correspondence, and all that. The other was the managing editor, who is still with the *Annals of Family Medicine.* She did copy editing and had some experience in the Southeast before coming to Seattle.

I had no previous experience as an editor. I learned by doing it. Nobody had any experience. I talked with 1 or 2 others at *California Medicine,* and I talked to a couple of other people at UC-San

Francisco who had edited textbooks. I started from scratch and that was how it was. I liked *California Medicine*, they had quite a bit of original work, they had reviews, they had case reports, it looked well referenced, and it looked authentic. So I wanted those looks. I like editing a lot. It is an avocation. I feel it's important, and I like the process of editing papers and seeing a product with each issue. I see it as a living, dynamic thing, and a challenge to publish the best. It is always fun to see what comes over the transom. It is kind of a biopsy of the original work in the field. I find it exciting and challenging and not predictable.

Family physicians didn't write, almost none did. Partly they were overwhelmed by practice, partly they didn't have a journal, partly they didn't have teaching programs or have a base in medical schools. They didn't need to write. Then more people started writing, and more people started writing better, got trained, asked more questions, and learned how to get research published. More got fellowship training and master's degrees in public health, and more faculty had to get tenure, so they realized they better start writing. At first it was such a blank slate. Then more manuscripts started coming in, more variety.

I remember when we published the Virginia Study in the mid-70s. Hugh Mayo was trained as an engineer before he went into medicine, and he did all these amazing studies of patient contacts in the State of Virginia.[5,6] Here was what family practice was. I think it was important for the time.

Friday Harbor and Back to Practice

I have long been a believer in the psychologist Eric Erickson's concept of adult development which involves a major life change every five or six years throughout adulthood.[7]

I wanted to chair a department to get a lot of things done but not to stay too long either. I looked around and saw other chairs staying, I thought, too long, and I wanted to leave when things were stable and leave time for the next leadership transition. I chaired the department [Department of Family Medicine, University of Washington] for 14 years. That was long enough. I could have done a lot of different things at that point, but I felt I was distanced more and more from the core of family medicine in the chairman's role. I'd always liked the challenge and variety of rural practice, as well as the sense of community. I prepared myself again for rural practice, and I feel good about that.

There are other lives to live. So what's next? We bought a cabin up here [San Juan Island] when I was still chairman. Part of my thing has always been flying. So if I have a way to fly back and forth, why that works great. We have a good airport with an instrument approach. So when I stepped down as chair, we sold the cabin and bought this house, and I went back to practice. I was still part-time flying back and forth to Seattle.

That was a good transition. I enjoyed getting ready for practice. I spent a lot of time with a clinical pharmacist, updated my skills in ATLS [Advanced Trauma Life Support] and ACLS [Advanced Cardiac Life Support]. There was a need. There were 3 or 4 of us, and we practiced pretty well. We learned how to do ultrasound and put in an ultrasound machine. We put in some other advances. We had students.

It seems to me if we believe in continuity of care—in taking care of families over generations—a sense of place, a sense of community is key. Every community is different and every medical community is different. Some are good and some are less so, but all can get better.

I really welcomed the chance to go back and practice in a different way, because I was more experienced in certain areas. I had better skills in terms of problem solving and behavioral science. I don't think I knew any more than I did when I was practicing in California; in fact, in certain ways I knew less. But I had a good library, used consultants by phone a lot, and had more resources to call on both within and outside our group.

The bottom line, though, was I found myself to be too slow. The practice was a lot easier because it wasn't as wild as Mt Shasta, there wasn't as much acute care, and we didn't do inpatient care, plus we had a group. All that sounds easier, but I was slower because I wanted to talk to

patients more. I had more skills and more interests in the people, but it slowed me down. I was more compulsive about not missing problems and doing more prevention and incorporating all the new things. In the last couple of years of practice, I found it increasingly stressful because I was slower getting it done and got home later and later.

Going back to small-town practice was as I expected it would be. I've enjoyed taking care of people and, every time I go somewhere, seeing people I know and know something about. For me, being a part of a community is nurturing. Each time I drive to town, many houses remind me of stories. There are 6 or 8 stories between home and town. Kind of a novel in process, right? So I have liked it as much as the early years. I practiced from when I was 59 and stopped when I was 66. That was when I got interested in health policy. When I left practice, I told my patients that I was still doing some teaching at the University of Washington and was working on my writing. I actually have been full-time at research and writing for the past 9 years. I've written my fifth book in that time.

Flying

It is where my spirit lives.

I was a sophomore medical student at UC-San Francisco and saw an advertisement for $99 to solo in San Carlos, south of San Francisco. So I went down and took my $99 course and soloed for 3 times around the pattern. I had 15 minutes of solo time. Then I was out of money. That was in 1959.

So then in Mt Shasta, a year after being in practice, I could afford to go back and finish my flying lessons and had a rural instructor up there in the mountains. He was there for 6 or 8 months, couldn't make a living, and moved on. But during those few months, I completed my license. I learned in the mountains, and I've flown ever since. I was in clubs for many years with small groups of fellow pilots. I've owned my own airplane for the past 22 years, with 8 different ones over those years. I have integrated flying a lot with my life in medicine. In Mt Shasta, I could fly to the Bay Area for meetings in 2 and a half hours vs taking a whole day to drive there. I could fly to Redding, which was 65 miles, and could first assist on surgery. I could land at the airport and walk 400 yards to the hospital, assist in surgery, and still be back at the office by 11 AM. In later years, flying was very helpful in getting out to affiliated residency programs. Here on San Juan Island, Seattle is just 40 minutes away by air, and it takes at least 4 hours to get there by ferry and driving, if you don't miss the ferry. Flying has enabled me to blend ongoing involvement at the university with rural practice.

Flying has energized my life for many years and continues to do so. It is a very individual and personal experience.... For me it has been the opportunity to feel especially alive, to join with the atmosphere and the natural world. It is dynamic and always changing ways. It has been a release from the pressures and cares of everyday life, fully absorbing yet requiring absolute accountability.[7]

Online Supplementary Data

http://www.annfammed.org/cgi/content/full/5/4/368/DC1

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3. Geyman JP. Osteogenesis imperfecta and pregnancy. Report of a case in California with notes on management. *Calif Med.* 1967;107(2):171-172.
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6. Marsland DW, Wood M, Mayo F. A data bank for patient care, curriculum, and research in family practice: 526,196 patient problems. J *Fam Pract.* 1976;3(1):25-28.
7. Geyman J. *Flight as a Lifetime Passion: Adventures, Misadventures and Lessons.* Friday Harbor, WA: Avian Ridge Books; 2000:51.

Supplemental Oral History, Table 1. The First Editorial Board of *The Journal of Family Practice*

John P. Geyman, MD, Editor
Hiram B. Curry, MD
Silas W. Grant, MD
Brian Hennen, MD
Edward M. Neal, MD
Theodore J. Phillips, MD
G. Gayle Stephens, MD

Supplemental Oral History, Table 2. *The Journal of Family Practice*, Table of Contents, Volume 1, Number 1, May 1974

Title	Author
Expanding Our Literature Base	John Geyman
Psychophysiology of Pain: Diagnostic and Therapeutic Implications	J. Blair Pace
Rational Drug Therapy of Common Illnesses in Children	Hyman Strand
Evaluation and Management of Suicidal Behavior	Theodore L. Dorpat, Henry S. Ripley
Teaching and Learning Clinical Wisdom	G. Gayle Stephens
Peer Review of Small Group Practice	Theodore J. Phillips, Amos P. Bratrude, Francis C. Wood Jr.
A Competency Based Curriculum as an Organizing Framework in Family Practice Residencies	John P. Geyman
A Survey of Psychiatric Care in Family Practice	Charles K. Smith, John C. Anderson, Minoru Masuda
Recording and Retrieval of Medical Data	Jack Froom, Eugene S. Farley
Primary Care Research in a Model Unit	Henry S. Wentz, Herbert L. Tindall, Nikitas J. Zervanos